National Institute for
Mental Health in England

Training Workbook for Hospital Managers

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TRAINING WORKBOOK FOR HOSPITAL MANAGERS

AIMS OF THE WORKBOOK

- to ensure people using the workbook have a clear understanding of the changes the MHA 2007 has brought to the MHA 1983;
- to ensure they understand the guiding principles in Chapter 1 of the revised Code of Practice;
- to ensure they understand the key elements of supervised community treatment and the different elements that managers' panels will need to consider when reviewing patient applications, extensions and barring orders;
- to ensure they understand the changes introduced in the revised Code of Practice, Chapters 30 & 31 in terms of the responsibilities of hospital managers and especially managers' panels' power of discharge;
- to enable them to carry out their duties with confidence as from 3 November 2008 when the changes made by the MHA 2007 are introduced;
- to enable them to ensure that the benefits which will accrue to patients under the amended Act are delivered within their area of responsibility.

Please note that throughout this workbook the following definitions and terminologies are used:
MHA – means the Mental Health Act 1983 as amended by the Mental Health Act 2007. Also "the Act" is used when direct quotes from the Code of Practice or the MHA are included. Occasional reference is made to the unamended MHA 1983.
Code of Practice – means the Code of Practice to the MHA. The "Code" and "COP" are also used to reference quotes from the Code of Practice or the MHA.
Reference Guide – means the Reference Guide to the MHA which accompanies the Code of Practice.

INTRODUCTION

This workbook is aimed at those who sit on panels which decide, on behalf of hospital managers, whether people should be discharged from detention under the MHA.

This workbook uses the same terminology to describe hospital managers as the revised Code of Practice to the Mental Health Act 1983:

- “hospital managers” means the organisation (or individual) in charge of a hospital (e.g. an NHS trust) – and by extension includes the individuals and committees to whom they delegate specific functions.
- “managers’ panels” refers specifically to the panels which exercise the hospital managers’ power of discharge.

Some members of managers’ panels may also undertake a wider role on behalf of the hospital managers (e.g. in overseeing the way the MHA is applied in the hospital), but some may not.

The Mental Health Act 2007 (MHA 2007) has changed the MHA 1983 in a number of important ways but has left unchanged the central role of hospital managers in the operation of the MHA.

In particular, it has retained the power for hospital managers – through their managers’ panels – to decide whether patients should continue to be detained.

This workbook is to help members of managers’ panels understand the changes that will affect their role and the way they carry it out.

Before you begin...

Try to answer the following questions.

You will find the suggested answers on the next page.

	YES	NO	NOT SURE
1. The Mental Health Act 2007 replaces the Mental Health Act 1983.			
2. The definition of mental disorder is being widened.			
3. Learning disabilities are not mental disorders unless they cause abnormally aggressive or seriously irresponsible behaviour.			
4. The appropriate medical treatment test is just the "treatability test" by another name.			
5. The appropriate medical treatment test has been introduced to enable the detention of people with personality disorders.			
6. The Government wants approved mental health professionals to be health professionals employed by NHS trusts.			
7. Supervised community treatment is only for people who need medication in the community.			
8. A person does not have to be detained in hospital first for a community treatment order to be made.			
9. The Code of Practice is stronger than before			
10. A patient may replace the person acting as their nearest relative with someone else whenever they wish.			

Answers

Here are the suggested answers. Check yours against them.

1. The Mental Health Act 2007 replaces the Mental Health Act 1983.	No, it does not! Basic mental health legislation remains with the Mental Health Act 1983 – the MHA just amends it. Therefore, a lot of the Act will remain the same – for example, when to use section 2 of the MHA.
2. The definition of mental disorder is being widened.	Not exactly. • New basic definition "any disorder or disability of the mind" means the same as the old definition, just shorter. But … • "Sexual deviancy" is no longer excluded – so some mental disorders related to this area are now included. • Four categories of disorder abolished – so there may be a few disorders now covered by section 3, etc., which were previously excluded from treatment in the MHA 1983.
3. Learning disabilities are not mental disorders unless they cause abnormally aggressive or seriously irresponsible behaviour.	Not quite. • Learning disability qualification excludes learning disabilities unless they "are associated with" (not "cause") abnormally aggressive/seriously irresponsible behaviour. • The qualification only applies to certain sections (NOT section 2 or section 136, for example). • The effect is basically the same as now. • People with a learning disability can develop a mental illness that needs assessment or treatment quite separately from their learning disability – and they can be detained in hospital to make sure they receive that treatment, on the same basis as anyone else.
4. The appropriate medical treatment test is just the "treatability test" by another name.	No, it isn't. • Treatability test focused on the "likelihood" of the outcome of treatment. The Appropriate Medical Treatment Test (AMTT) does not require anyone to say what is likely to happen. • AMTT goes much wider – it is about appropriateness in the round. • AMTT applies equally to all groups of patients (though not to all patients, because it is not part of the criteria for section 2 for example).

5. The appropriate medical treatment test has been introduced to enable the detention of people with personality disorders.	No, that could be done anyway, BUT it does have practical effects: • Doctors making recommendations will need to know in advance where the patient is likely to be detained (because otherwise they can't say whether appropriate treatment is available). • Risk of challenge – providers need to think about appropriateness to the individual. A one-size-fits-all mentality is now a legal issue, not just poor practice.
6. The Government wants approved mental health professionals to be health professionals employed by NHS trusts.	No, the MHA gives choice. Local Social Services Authorities (LSSAs) decide what to do. The MHA provides a power, not a duty, to train non-social workers for the role. Whoever substantively employs AMHPs, they can only assess people under the Mental Health Act if they are acting on behalf of a LSSA. LSSAs have ultimate control over who does what on their behalf (but cannot tell AMHPs what decision to reach, of course).
7. Supervised community treatment is only for people who need medication in the community.	No, it is not. "Medical treatment" goes much wider than medication. Medical treatment also includes psychological interventions, nursing, habilitation and rehabilitation.
8. A person does not have to be detained in hospital first for a community treatment order to be made.	Yes, you do. You need to be detained for treatment.
9. The Code of Practice is stronger than before.	No - it status is essentially the same as now. You can't ignore it, you can't 'just take it or leave it', but you don't have necessarily have to follow it if you can justify doing differently.
10. A patient may replace the person acting as their nearest relative with someone else whenever they wish.	No, although there is now a new right for a patient to apply to the county court for the nearest relative to be displaced. They can apply to do so on the grounds that were previously available to other applicants, or on the new grounds that the nearest relative is 'otherwise unsuitable.'

THE ROLE OF THE CODE OF PRACTICE

The revised Code of Practice (Code) to the MHA includes five guiding principles. The section provides an overview of those principles. For a more detailed exploration of the role of the guiding principles you should read the guiding principles module of the generic workbook.

Before thinking about how the Code of Practice and guiding principles may help you to apply the MHA in individual situations, the following is a brief overview of the purpose and status of the Code of Practice.

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

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

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

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

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

(COP, Introduction)

"Managers of hospitals" includes managers' panels taking discharge decisions.

How do the MHA, the Code and the guiding principles fit together?

- The Act tells us **what** to do;
- The Code explains **how** to do it; and
- The guiding principles guide us in how to apply the MHA and Code in **individual situations**.

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

THE GUIDING PRINCIPLES

So why are the principles needed?

Every decision taken involves unique individuals in unique situations. The principles guide us in individual situations by providing a framework of important considerations that should always be kept in mind when making decisions under the MHA.

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

Hospital managers in undertaking their functions under the MHA will need to have regard to the guidance in the Code of Practice and the principles contained in the Code.

The Code of Practice for the MHA contains guiding principles. These principles are designed to inform decisions: they do not determine them. However, the context will be the all-deciding factor as to how these principles are employed in a particular case. It is important that all the principles inform every decision made under the MHA. The principles are designed primarily to safeguard the rights of patients. They also cover carers and family who have the right to a fair and sensitive service for their relative.

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

The MHA requires that a statement of principles is included in the Code and it spells out the minimum issues they should cover.

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

(2A)	The code shall include a statement of the principles which the Secretary of State thinks should inform decisions under this Act.
(2B)	In preparing the statement of principles the Secretary of State shall, in particular, ensure that each of the following matters is addressed: (a) respect for patients' past and present wishes and feelings, (b) respect for diversity generally including, in particular, diversity of religion, culture and sexual orientation (within the meaning of section 35 of the Equality Act 2006), (c) minimising restrictions on liberty, (d) involvement of patients in planning, developing and delivering care and treatment appropriate to them, (e) avoidance of unlawful discrimination, (f) effectiveness of treatment, (g) views of carers and other interested parties, (h) patient well-being and safety, and (i) public safety.
(2C)	The Secretary of State shall also have regard to the desirability of ensuring: (a) the efficient use of resources, and (b) the equitable distribution of services.
(2D)	In performing functions under this Act persons mentioned in subsection (1) (a) or (b) shall have regard to the code[1].

[1] The persons in these subsections are registered medical practitioners; Approved Clinicians; managers and staff of hospitals, independent hospitals and care homes; and Approved Mental Health Professionals.

The guiding principles are addressed in chapter 1 of the Code of Practice.

The principles contained in the Code of Practice are:

1. Purpose principle

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

2. Least restriction principle

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

3. Respect principle

People taking decisions under the Act must recognise and respect the diverse needs, values and circumstances of each patient, including their race, religion, culture, gender, age, sexual orientation and any disability. They must consider the patient's views, wishes and feelings (whether expressed at the time or in advance), so far as they are reasonably ascertainable, and follow those wishes wherever practicable and consistent with the purpose of the decision.

4. Participation principle

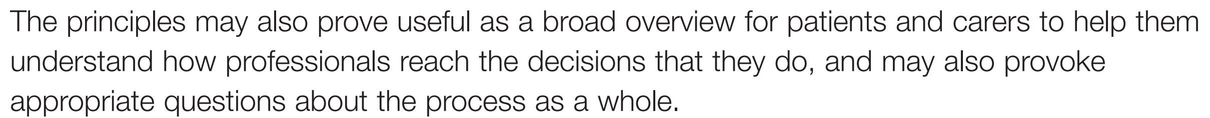
Patients must be given the opportunity to be involved, as far as is practicable in the circumstances, in planning, developing and reviewing their own treatment and care to help ensure that it is delivered in a way that is as appropriate and effective for them as possible. The involvement of carers, family members and other people who have an interest in the patient's welfare should be encouraged (unless there are particular reasons to the contrary) and their views taken seriously.

5. Effectiveness, efficiency and equity principle

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

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

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



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

Revised Code of Practice and local policies

Hosptial managers are responsible for ensuring there are local policies and procedures in place. In the development of local policies and procedures they need to be aware that there are changes throughout the Code of Practice, some of which will need to be considered when reviewing hospital policies.

The Code of Practice (Annex B) provides a useful list of all policies and procedures the Code says should be put in place locally. Please also see the **Mental Health Act 1983 - Revised Code of Practice: summary of changes from current Code** (issued by the DH, May 2008).

THE NINE KEY CHANGES

Introducing the Nine Key Changes

Key Change 1	Introducing a **Simplified Single Definition of Mental Disorder**.
Key Change 2	Abolishing the Treatability Test and introducing a new **Appropriate Medical Treatment Test**.
Key Change 3	Ensuring that **Age-appropriate Services** are available to any patients admitted to hospital who are aged under 18 (*anticipated by 2010*).
Key Change 4	Broadening the **Professional Groups** that can take particular roles.
Key Change 5	Introducing the right for patients to apply to court to displace their **Nearest Relative**.
Key Change 6	Ensuring that patients have a right to an **Advocacy Service** when under compulsion (*expected to come into force from April 2009*).
Key Change 7	Introducing new safeguards regarding **Patients and Electro-Convulsive Therapy**.
Key Change 8	Introducing a new provision to allow **Supervised Community Treatment**. This allows a patient detained on a treatment order to receive their treatment in the community rather than as an in-patient.
Key Change 9	Making provision for earlier automatic **Referral to a Tribunal** where patients don't apply themselves. This introduces the inclusion of any period spent on section 2 to be included in the first six-month referral by Hospital Managers to the Tribunal and retains the right of the Secretary of State to reduce this referral period in the future.

Other changes include:

- abolishing **Finite Restriction Orders** so that when offenders are given restricted hospital orders (under sections 37 and 41) they will always now be without limit of time.
- amendments to **Sections 135 and 136** so a person detained in a place of safety can be transferred to another place of safety, subject to the overall time limit for detention of 72 hours;
- changes to the powers of delegation for managers of **NHS Foundation Trusts**;
- introduction of section 48 to extend the **Rights of Victims** under the Domestic Violence, Crime and Victims Act 2004;
- changes to the arrangements for **Informal Admission of Patients aged 16 or 17**;
- the need for a '2nd professional' to agree to section 3 renewals.

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

KEY CHANGE 1: DEFINITION OF MENTAL DISORDER

(Chapter 3 Code of Practice)

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

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

Definition of Mental Disorder – changes to key provisions

How is mental disorder defined in the Act?

The wording of the definition of mental disorder in the MHA changes from “mental illness, arrested or incomplete development of mind, psychopathic disorder and any other disability or disorder of mind” to:

“any disorder or disability of the mind”.

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

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

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

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

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

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

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

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

(COP, 3.6)

The Learning Disability Qualification

The **Learning Disability Qualification** has been introduced to preserve the status quo (e.g. under s3, a person with a learning disability alone can only be detained for treatment or be made subject to Guardianship if that learning disability is associated with abnormally aggressive or seriously irresponsible conduct).

It now applies to all those sections that relate to longer-term compulsory treatment or care for a mental disorder (in particular s3, s7 (Guardianship), s17A (Supervised Community Treatment) and forensic sections under Part 3 of the Act).

It means that if the use of longer-term forms of compulsion are being considered solely on the basis that a person has a learning disability, that disability **must** also be associated with abnormally aggressive or seriously irresponsible conduct.

The MHA defines a learning disability as:

'a state of arrested or incomplete development of mind which includes significant impairment of intelligence and social functioning'.

(MHA, s1(2))

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

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

Exclusions from the Definitions of Mental Disorder

Three of the exclusions in section 1(3) — immorality, promiscuity and sexual deviancy — have been removed leaving only 'dependence on alcohol or drugs'.

The definition of mental disorder is widened by removing the previous references to immorality, promiscuity and sexual deviancy (but the first two make no practical difference). This applies to all sections of the MHA including short-term holding powers, e.g. police powers to detain citizens under section 136.

Exclusions on the basis of dependence on alcohol or drugs

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

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

COMMON MYTH – DEFINITION OF MENTAL DISORDER	
MYTH	**REALITY**
The definition is being widened	Not exactly. • New basic definition “any disorder or disability of the mind” means the same as the old definition, just shorter. But … • “Sexual deviancy” is no longer excluded – so some mental disorders related to this area are now included. • Four categories of disorder abolished – so there may be a few disorders now covered by section 3, etc., which were previously excluded from treatment in the MHA 1983.

KEY CHANGE 2: CRITERIA FOR DETENTION

In addition to the changes to the definition of mental disorder, the criteria for detention for treatment have changed in one respect. (The criteria for detention for assessment under section 2 of the MHA have not changed.)

You will remember that under the MHA, before anyone could be detained under the categories of Mental Impairment/and or Psychopathic Disorder, it was necessary that:

- **treatment would be likely to alleviate or prevent deterioration in the patient’s condition.**

This so-called ‘treatability test’ has been replaced with an ‘appropriate medical treatment test’ for all the longer-term powers of detention. It will not now be possible for anyone to be detained for treatment, or for their detention to be continued, unless:

- **medical treatment is available which is appropriate taking into account the nature and degree of the patient’s mental disorder and all other circumstances of the case.**

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

The appropriate treatment test needs to be applied to:

- **detention under section 3;**
- **supervised community treatment;**
- **forensic sections associated with treatment;**
- **when renewal and discharge of these sections is being considered**.

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

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

To be appropriate the treatment must:

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

What other circumstances may be considered?

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

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

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

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

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

The Code says that appropriate treatment will vary between patients.

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

ACTIVITY 1

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

1. Consider and reflect on what constitutes 'appropriate medical treatment'.
2. In reviewing a report from a responsible clinician, what evidence might you be looking for to satisfy yourself that appropriate medical treatment is available?

Medical Treatment

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

- nursing;
- psychological interventions;
- specialist mental health habilitation, rehabilitation (including education and training in work, social and independent living skills) and care.

However, the MHA also tells us that:

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

(s145 (4))

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

Nature or Degree?

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

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

Box 2. Nature or Degree?

The words "nature or degree" were already part of the criteria for the use of compulsion in the MHA 1983.

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

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

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

What might an appropriate treatment plan look like?

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

The Code chapter 6 gives an understanding of the application of appropriate treatment; and paragraph 6.12 gives a particularly good flavour of how the appropriate treatment can be applied. (chapter 6 of the Code of Practice is appended to this workbook at Appendix 2.)

'Medical treatment need not be the most appropriate treatment that could ideally be made available. Nor does it need to address every aspect of the person's disorder. But the medical treatment available at any time must be an appropriate response to the patient's condition and situation.'

(COP, 6.12)

When deciding whether patients should continue to be detained for treatment, managers' panels are going to have to ask themselves whether appropriate medical treatment – as defined in the Act – is available.

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

ACTIVITY 2 – AGNES

Please read the scenario and answer the questions which follow.
Suggested answers are on page 64-68.

Background details

Agnes is a 24 year old single woman who has a diagnosis of borderline personality disorder. She lives alone, but her parents and older brother also live locally. As a young person, she was known to the CAMHS team, before being transferred to adult services when she reached the age of 18 yrs. She is well known to the community mental health team and has an allocated worker. Initially attempts were made to help her manage her disorder and engage her with community resources such as art therapy, and other forms of social interventions such as work placements. This has not always been successfully and on occasion she has needed brief admissions as a result of her self harming behaviour. This has included overdoses of drugs and cutting her arms.

Agnes often reacts badly to change, and following the death of her grandfather a few months ago, her self harming behaviour intensified. Following a very serious overdose she was seen by the crisis team in A&E and admitted to the mental health unit. She continued to express suicidal ideas and wanted to leave. 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. She was assessed by an AMHP and section 2 doctor from her CMHT, and her GP all of whom knew her well. They all expressed concerns about the increased intensity of her self harming behaviour, but were puzzled by its cause. She had always professed to 'loathe' her grandfather. The team therefore decided to admit for assessment under section 2.

During the assessment period, contact with her family helped staff to get a better understanding of Agnes's situation. After her grandfather's funeral, Agnes had become very distressed, and had accused her mother of 'not protecting her' from her grandfather. She made allegations about him, claiming that he had physically abused her. Family members were very angry with her for 'dragging his name through the dirt'. Her mother is no longer willing to speak to her. Her older brother is more sympathetic. As a result, many of her usual support systems are no longer available to her.

Agnes continues to need regular and intensive support, even on the ward, to keep her safe. After 3 weeks, she is reassessed by the AMHP, RC and GP and together they decide she needs continuing treatment, and this can only safely be provided on a hospital ward.

Assessment of the need for ongoing detention

It is now some 8 weeks since Agnes was admitted. Her treatment has consisted of general nursing care aimed at helping her to understand and better manage her mood swings. Her

RC is the consultant psychiatrist from the CMHT, who had already arranged for her to be assessed for CBT. This is still thought to be the best option for her, however, she is on a long waiting list but it is hoped this can start in about 3 months time.

She has made some progress while under general nursing care; however she has continued to manifest self-harming behaviour, and to express suicidal ideas. This has included an attempt at self poisoning using cleaning materials.

Agnes has recently returned to the ward following the poisoning attempt, and is on 1:1 observation. Her brother and father visited her whilst she was in the poisons' unit and are very concerned about her behaviour, but her mother continues to insist she will not see her daughter.

Consider the following questions, giving full explanations for your answers.

1. **How long will Agnes's detention last from the point when she was assessed as needing detention in hospital for compulsory treatment (under section 3)?**
2. **Who has responsibility for considering whether Agnes's detention should be renewed when the time comes? What new policies might hospital managers need to have in place now to manage this stage?**
3. **What role do the hospital managers have in respect of the decision to renew Agnes's detention?**
4. **What are the criteria on which such a review would be considered?**
5. **If Agnes had not appealed to the tribunal during her time in hospital, at what point would you expect the hospital managers to have made the referral themselves?**
6. **For the purposes of coming to a decision, what do you understand by the term 'mental disorder'? Does it appear to you that Agnes is suffering from such a disorder and that it is of a nature or degree that makes it appropriate for her to receive treatment in hospital?**
7. **How would you interpret the requirement for appropriate medical treatment to be available for her?**
8. **Agnes has been referred for CBT, but it is not currently available. If it is correct that this would be the most appropriate treatment for her, can she continue to be detained without it being available to her?**
9. **It seems that Agnes 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?**
10. **How should the managers' panel proceed if it comes to the conclusion that Agnes does not meet the criteria for her detention to be continued?**

KEY CHANGE 3: AGE-APPROPRIATE SERVICES

(See chapter 36 in both the Code of Practice on Children & Young People the Reference Guide to the Mental Health Act 1983).

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

Who is responsible for making sure this happens?

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

When will these requirements start?

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

Factors determining whether an environment is suitable

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

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

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

Each of these questions is considered below.

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

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

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

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

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

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

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

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

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

(COP, 36.71)

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

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

When thinking about "discrete accommodation":

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

Interests of other children and young people

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

Duty to provide information on age-appropriate facilities

Primary care trusts (PCTs) in England and local health boards (LHBs) in Wales are required to advise the local social services authorities in their area of hospitals providing accommodation or facilities designed to be specially suitable for patients under 18 (MHA, s140).

Courts considering whether to make a hospital order (s37), an interim hospital order (s38), remanding the person to hospital for a report on their mental condition (s 35) for treatment (s36) or committal by Magistrates (s44) can require that PCTs and LHBs provide them with information on the availability of accommodation or facilities designed to be specially suitable for patients under 18 (MHA, s39 (1A)(1B)).

Admission to hospital

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

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

The MHA has been amended so that now 16- and 17-year-olds who have the capacity to make such decisions can either consent to, or refuse, admission to hospital for treatment for mental disorder, without those decisions being overridden by a person with parental responsibility.

Such young people who have the capacity to do so, may consent to their own admission to hospital for treatment for mental disorder, even if a person with parental responsibility does not agree or wishes to discharge them.

Likewise, young people who have the capacity to consent, but who do not do so, may not be admitted or kept in hospital for treatment on the basis of consent provided by a person with parental responsibility.

COMMON MYTH – AGE-APPROPRIATE SERVICES

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

KEY CHANGE 4: PROFESSIONAL GROUPS – NEW WAYS OF WORKING

This is potentially a big change: it must be noted however that this is permissive rather than prescriptive legislation. This means that hospitals or Trusts can choose whether they wish to take advantage of the options that this change in legislation gives them. Let us look at the professionals involved in the MHA:

- responsible medical officer (RMO) - consultant psychiatrist in charge of the patient's care and treatment;
- other doctors (not in charge of care and treatment but able to make medical recommendations) – including doctors specially approved under section 12 of the Act as having special experience in the diagnosis or treatment of mental disorder;
- approved social worker (ASW) responsible for making applications founded on two medical recommendations; identifying the patient's nearest relative (NR) under the Act, and a host of other related duties.

Note: the patient's NR could and can still make applications, but this has been and will continue to be a rare occurrence.

First change – approved mental health professionals

ASW has changed to approved mental health professional (AMHP). As with ASWs, AMHPs will be mental health professionals with specialist training in mental health legislation and applying a social perspective to care. The role will be open to social workers, mental health and learning disability nurses, clinical psychologists and occupational therapists. Local Authorities will be responsible for approving AMHPs as they are now for ASWs. AMHPs carrying out their duties as such will continue to do so on behalf of a local social services authority (LSSA).

Training for AMHPs will be as rigorous as it currently is for ASWs. On 3 November 2008 ASWs will automatically become AMHPs and thereafter over time depending on the pressure for additional AMHPs to meet the on-call requirements, etc., there will be an increasing number of non-social worker AMHPs drawn from the other qualifying professional groups.

Second change – approved and responsible clinicians

The role of RMO is abolished. In its place are two new roles – approved clinician (AC) and responsible clinician (RC). These are open to nurses, occupational therapists, clinical psychologists and social workers as well as doctors.

This radical change means that the person 'in charge' no longer has to be a doctor, but that the role can also be taken by a psychologist, nurse, occupational therapist, social worker or a doctor, and the RC has overall responsibility for a detained patient's care.

Role of responsible clinician – overall responsibility for patients' cases

For detained patients, the RC is the AC in overall charge of a patient's case. A practitioner cannot be an RC unless they are an AC.

Responsible clinicians are responsible for taking most of the decisions previously taken by RMOs, including:

- granting leave of absence (section 17);
- discharging patients (section 23) – including the new power to discharge patients onto SCT (section 17A) – see Key Change 8;
- barring discharge by nearest relatives (section 25);
- renewing detention under section 20 – but they now need the agreement of a second professional (see below).

The choice of RC should be based upon the individual needs of the patient concerned, and where, for example, a patient's treatment needs alteration, a change of RC might be made. For example, if psychological therapies became central to the treatment of the patient, then a psychologist might take on the role of RC.

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

'Hospital managers should have local protocols in place for allocating responsible clinicians to patients. This is particularly important when patients move between hospitals or from the hospital to the community and vice versa. The protocols should:

- *ensure that the patient's responsible clinician is the available approved clinician with the most appropriate expertise to meet the patient's main assessment and treatment needs;*
- *ensure that it can easily be determined who a particular patient's responsible clinician is;*
- *ensure that cover arrangements are in place when the responsible clinician is not available (e.g. during non-working hours, annual leave, etc.);*
- *include a system for keeping the appropriateness of the responsible clinician under review.'*

(COP, 14.3)

It is also important that the suitability of the RC be kept under review by hospital managers. Any change of RC must be considered carefully and be consistent with the changing needs of the patient. The RC and hospital managers should discuss any suggested change with anyone involved with the patient (including their carer) as well, of course, as the patient themselves.

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

Renewal of detention – second professional

Where previously the RMO had been able to renew detention alone, RCs must now obtain the agreement of a **'second professional'** before renewing detention.

'Before it expires, responsible clinicians must decide whether patients' current period of detention should be renewed. Responsible clinicians must examine the patient and decide within the two months leading up to the period of expiry of the patient's detention whether the criteria for renewing detention under section 20 of the Act are met. They must consult with one or more other persons who have been concerned with the patient's medical treatment.'

(COP, 29.2)

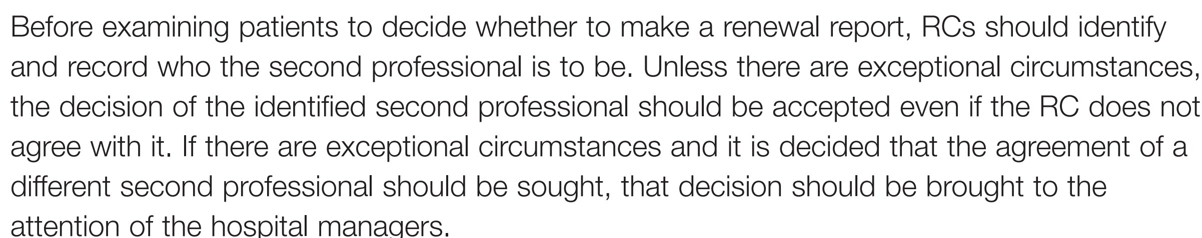
When the RC is satisfied that the criteria are met they must submit a report to the hospital managers.

Before the report can be submitted to the hospital managers RCs are required to obtain the written agreement of another professional ('the second professional') that the criteria are met. The second professional must be professionally concerned with the patient's treatment and must not belong to the same profession as the RC.

'Apart from that, the Act does not say who the second professional should be. Hospital managers should determine their own local policies on the selection of the second professional. Policies should be based on the principle that the involvement of the second professional is intended to provide an additional safeguard for patients by ensuring that:

- *renewal is formally agreed by at least two suitably qualified and competent professionals who are familiar with the patient's case;*
- *these two professionals are from different disciplines, and so bring different, but complementary, professional perspectives to bear; and*
- *the two professionals are able to reach their own decisions independently of one another.'*

(COP, 29.5)



Before examining patients to decide whether to make a renewal report, RCs should identify and record who the second professional is to be. Unless there are exceptional circumstances, the decision of the identified second professional should be accepted even if the RC does not agree with it. If there are exceptional circumstances and it is decided that the agreement of a different second professional should be sought, that decision should be brought to the attention of the hospital managers.

The new role for the second professional doesn't change the duty on the hospital managers when they receive a renewal report. Managers' panels will still need to decide whether the patient should be discharged instead.

KEY CHANGE 5: NEAREST RELATIVE

The MHA confers various rights and powers on patients' nearest relatives in connection with detention, supervised community treatment and guardianship under the MHA. These include the right to:

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

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

How to decide who on the list should be considered as the nearest relative is determined by a complex set of rules (more detail can be found in chapter 33 of the Mental Health Act Reference Guide).

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

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

The first change made by the Mental Health Act 2007 is that civil partners are now treated on an equal basis with husbands and wives. Similarly, people living with each other as if they were civil partners are treated on an equal basis with people living with each other as if they were husband and wife. These changes have been in force since 1 December 2007.

Changes 2 & 3: How to change the nearest relative – processes for displacement

The second change to affect the nearest relative is that of 'displacement'. Changes to the MHA now mean that the patient themselves can apply to court to replace their nearest relative with someone of their choice rather than accepting the decision of the 'list'. It is anticipated that independent mental health advocates and AMHPs will support or provide information to patients who wish to displace their nearest relative. (For more on independent mental health advocates, see Key Change 6.)

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

The Process for Displacement

Who can displace a nearest relative?

There are a number of people who can apply to the County Court to displace a nearest relative:

- the patient;
- any relative of the patient (i.e. anyone in the list of possible nearest relatives in the MHA);
- anyone who lives with the patient;
- an AMHP.

What are the grounds for displacement?

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

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

Note: the last ground for displacement has been added by the MHA 2007.

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

The County Court, who will have to hear the application, would have to consider everyone's point of view, including not just the point of view of the patient but also that of the person they wish to replace.

KEY CHANGE 6: ADVOCACY SERVICES

(Chapter 20 Code of Practice)

There is now a duty on the Secretary of State to provide independent mental health advocacy services for all detained patients (except those under the short-term powers (sections 4, 5, 135, 136, etc.), and for those on guardianship and supervised community treatment. There are also new duties on hospital managers and others to ensure that qualifying patients are provided with information that such services are available. Independent mental health advocates (IMHAs) will have the right to meet with the patients in private and to meet with professionals involved in delivery of care to the patient for whom they are advocating. They will have a right of access to relevant patient records (see below).

Key aspects of IMHA services

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

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

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

IMHAs will also help patients obtain information about and an understanding of their rights, and help them to exercise those rights. In order to provide this help, IMHAs will be able to:

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

Access to records

An IMHA will only be able to look at records

either

when the patient has capacity and gives consent

or

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

(MHA, s130B)

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

Responding to referrals

IMHAs will have a duty to visit a patient when a reasonable request is made by a nearest relative, RC or AMHP. However, the patient can decline support from the advocate.

Qualifying for an IMHA

Patients will qualify for an IMHA if they are:

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

Informing patients and nearest relatives about IMHA

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

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

ACTIVITY 3

Independent Mental Health Advocates are due to be introduced in April 2009 and it is vitally important that protocols on how this new system will work and be supported are put in place prior to this safeguard for patients being introduced. What factors might you consider for inclusion in such protocols?

KEY CHANGE 7: ELECTRO-CONVULSIVE TREATMENT (ECT) SAFEGUARDS

Previously, ECT was covered by section 58 of the consent to treatment rules (along with medication for mental disorder after three months) and could be given if the detained patient had capacity and had consented (Form 38); or, with the agreement of a second-opinion appointed doctor (SOAD) if the patient could not or would not consent (Form 39).

ECT now comes under section 58A of the MHA. Unless it is an emergency (as defined in s62):

- patients who have the capacity to consent to ECT may only be given it if they have consented to it. In other words, detained patients who have capacity may refuse a section 58A treatment.
- patients who lack the capacity to consent can be given it if it is approved by a SOAD. But SOADs cannot approve treatment which goes against a valid and applicable advance decision to refuse the treatment, or against a decision validly made on behalf of the patient by a donee of lasting power of attorney, a deputy, or the Court of Protection.

In addition, except in an emergency, patients under the age of 18 (whether or not they are detained) may not be given a section 58A treatment for mental disorder unless it is approved by a SOAD, even if they consent to it. If the young person is not detained, then as well as the certificate, it will still be necessary to have the normal legal authority to treat – for example, the patient's own consent or a court order.

In other words:

- if someone has capacity and refuses to have ECT, they can only be forced to accept it in an emergency;
- except in an emergency, if a detained patient lacks capacity, they can only be given ECT if a SOAD agrees the ECT is appropriate treatment for the patient, and that they do not have capacity to consent **and** there is no valid advance decision or other authority that objects to the use of ECT;
- if there is a valid advance decision or other authority opposed to ECT, the treatment could only be given under section 62 as emergency treatment;
- no under-18-year-old can be given ECT unless a SOAD agrees (except in an emergency);
- however, an informal patient who lacks capacity could be given ECT under section 5 of the MCA (best interests) as long as there is no valid advance decision or other valid authority that objects to the use of ECT.

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

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

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

Note: as well as ECT itself, medication administered as part of ECT is covered by section 58A.

KEY CHANGE 8: SUPERVISED COMMUNITY TREATMENT

(Chapter 25 of the Code of Practice and chapter 15 of the Reference Guide to the Mental Health Act 1983)

Supervised Community Treatment (SCT)

(Sections 17A to 17G).

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

(COP, 25.2)

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

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

Community treatment orders (CTOs) may only be made in respect of patients liable to detained under section 3 or under an unrestricted hospital order, hospital direction or transfer direction under Part 3 (sections 37, 45A, 47 and 48).

Before granting a detained patient leave of absence for more than seven consecutive days in total, RCs are required to consider whether the patient should be discharged onto SCT instead.

Criteria

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

- the patient is suffering from a **mental disorder of a nature or degree**[2] which makes it appropriate for him to receive medical treatment;
- it is **necessary** for his health or safety or for the protection of other persons that he should receive such treatment;

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

- subject to his being liable to recall … such treatment can be provided without his continuing to be detained in hospital;
- it is necessary that the RC should be able to exercise the power … to recall the patient to hospital;
- appropriate medical treatment is available.

(MHA, s17A(5))

How does the RC decide if SCT is necessary?

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

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

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

The RC must be satisfied that the relevant criteria are met. An AMHP must agree that the criteria are met and that SCT is appropriate (Form CTO 1).

ACTIVITY 4 – NICK

Please read the scenario and answer the following questions, giving explanations for your answers. Suggested answers are on page 69-70.

This scenario and the questions relate to the criteria for the use of SCT.

Nick is 32-years-old and has been known to mental health services for 13 years. He dislikes medication and following discharge from detention has always reduced the dose he takes to the point where it ceases to have a clinical benefit. At this point, he loses insight and refuses to take any medication at all. When he becomes unwell, Nick becomes paranoid, carries knives for protection and has been known to leave his council flat to live on the street. This is because of his conviction that government agencies are tracking him with a view to killing him for the 'chip' in his head. He has also 'allowed' drug dealers to use his flat, which has put his tenancy at risk.

Nick has previously been seriously assaulted while living on the streets and once assaulted a police officer when he was detained on s136. He has been detained annually for the last four years. These admissions have been lengthy, as Nick takes a long time to get better. Unless detained, he would not cooperate with medication. He is currently subject to section 3 of the MHA and has been building up periods of home leave. Nick has now increased his leave to two days (including an overnight stay) twice a week. His care is now being reviewed.

1. Who would take responsibility for instigating the process for discharging Nick onto SCT?
2. Does the RC have to gain agreement from anyone else when SCT is being actively considered?
3. Does the RC need to consult anyone else besides the AMHP in reaching a decision on the SCT?
4. What criteria should the RC apply in deciding whether SCT would be suitable for Nick?
5. If the AMHP and the RC are in full agreement, how is the CTO actually put into effect?

Conditions

CTOs must specify conditions which the patient will be expected to comply with.

All CTOs must include 'mandatory conditions' requiring patients to make themselves available for examination so that: the RC can decide whether to extend the CTO under s20A; and: a second-opinion doctor can decide whether to give a Part 4A certificate authorising medication, etc., for the patient while on SCT is appropriate.

The CTO may include other conditions which the RC thinks are necessary or appropriate to:

- ensure that the patient receives medical treatment;
- prevent risk of harm to the patient's health or safety; or
- protect other people

The AMHP must agree that these conditions are necessary and appropriate.

Note: the conditions (with the exception of the mandatory conditions) are not directly enforceable, but if a patient fails to comply with any condition, the RC may take that failure into account when considering using the power to recall the patient to hospital.

Variation and suspension of conditions

The RC may vary the conditions or may temporarily suspend any of them at any time. The agreement of an AMHP is NOT required. The RC must record any variation on Form CTO 2 and must send this to the hospital managers and the patient.

Reference to variation of conditions is made in the Code:

'The responsible clinician has the power to vary the conditions of the patient's CTO, or to suspend any of them. The responsible clinician does not need to agree any variation or suspension with the AMHP. However, it would not be good practice to vary conditions which had recently been agreed with an AMHP without discussion with that AMHP.'

(COP, 25.41)

No particular form needs to be used to record the suspension of a condition.

Effect of CTO

A CTO is an order for the patient's discharge from detention in hospital, subject to the possibility of recall to hospital for further treatment if necessary. As with any other discharge from detention, the patient does not necessarily have to leave hospital immediately (or may already have left on leave of absence). The CTO comes into effect on the date specified on the form.

Note: while the CTO is in force, the section 3, or order/direction under Part 3, on the basis of which the patient was originally detained, remains in force, but the hospital managers' authority to detain the patient is suspended. The authority to detain does not need to be renewed while it is suspended, and so will not expire while the patient remains under SCT.

However, an order or direction under Part 3 may come to an end for another reason: e.g. the patient's conviction is quashed on appeal, in which case then so too will the CTO come to an end.

When a CTO comes to an end (for any reason except revocation – see below) the patient will be discharged absolutely both from SCT and the underlying authority for detention.

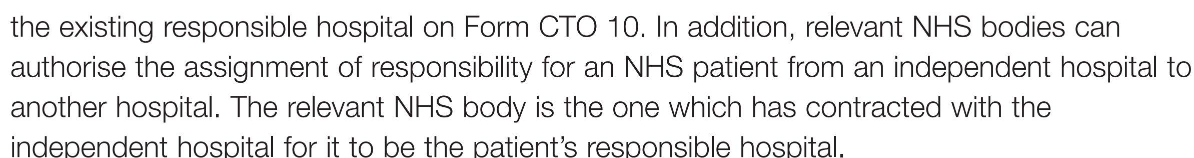
Where the MHA refers to patients who are "detained" or "liable to be detained" this does not include SCT patients. Likewise, references in other legislation to patients detained or liable to be detained under the MHA do not include SCT patients.

Responsible hospital

Every SCT patient has a "responsible hospital". The hospital managers of that hospital have various responsibilities in relation to the particular SCT patient, whether or not the patient is actually being treated at the hospital or by its staff.

Initially, the responsible hospital is the hospital in which the patient was liable to be detained immediately before becoming a SCT patient.

Responsibility can subsequently be assigned to another hospital. If the hospitals are under the same management, no particular process has to be followed. Otherwise the assignment must be agreed between the managers of the relevant hospitals and authorised by the managers of



the existing responsible hospital on Form CTO 10. In addition, relevant NHS bodies can authorise the assignment of responsibility for an NHS patient from an independent hospital to another hospital. The relevant NHS body is the one which has contracted with the independent hospital for it to be the patient's responsible hospital.

Recall to hospital

SCT patients may be recalled to hospital if the RC decides they need treatment for mental disorder in hospital and that, if they were not recalled, there would be a risk of harm to their health or safety or to others. There is also the power to recall if the patient fails to comply with one of the mandatory conditions (see above).

RCs may recall patients by giving written notice (as with s17 leave) and a copy must be sent to the managers of the hospital to which the patient has been recalled. If that is not the responsible hospital, the RC must also inform those managers of the name and address of the responsible hospital because the patient may be recalled to any hospital. In practice, patients should not be recalled to a particular hospital unless the hospital can accept them and managers are not obliged to accept patients just because a RC has issued a recall notice.

Note: recalled patients do not have to be admitted as in-patients; they could, for example, be recalled for out-patient treatment. Patients may be recalled even if they are already in hospital at the time. For example: if a patient attends hospital either voluntarily or to comply with a CTO condition, but then refuses to accept the treatment, the patient could be formally recalled to allow treatment without consent, if the patient or someone else would be at risk if treatment is refused.

Effect of recall to hospital

The issue of a recall notice gives the hospital managers the power to detain the patient at the specified hospital for up to 72 hours from the time at which the patient is first detained there as a result of recall. The 72-hour period **does not run** from the time the recall notice was issued unless the patient was already in the hospital at the time and was immediately detained as a result. The start of detention must be recorded using Form CTO 4.

If recalled patients do not come to hospital as required (or go absent from hospital once there), they are considered to be absent without leave (AWOL) and may be taken into custody and returned to hospital.

Transfer of recalled patients to another hospital

Transfer to another hospital may be authorised for patients in hospital on recall. The maximum 72-hour period of detention on recall continues to run from the original time that the patient was detained regardless of any transfer.

No particular procedure need be followed if patient is transferred to a hospital under the jurisdiction of the same managers (as for s19 transfer of detained patients).

To authorise transfer of a recalled patient to a hospital under different managers, Form CTO 6 must be used. The managers of the new hospital must also be given a copy of Form CTO 4 (which records the time at which the patient was first detained on recall).

If an NHS patient is recalled to an independent hospital, the relevant NHS body may also authorise the patient's transfer to another hospital under different management – the relevant NHS body being the one which is funding the patient's care.

Release from recall

A recalled patient may only be detained for a maximum of 72 hours unless the CTO is revoked otherwise the patient is automatically released at the end of that period (and must be allowed to leave hospital). The 'holding powers' in section 5 **may not** be used to keep the patient in hospital after the end of 72 hours.

The RC may release a recalled patient at any time before the 72-hour period. On release the patient continues to be a SCT patient and so remains on the CTO and its conditions, as before, unless those conditions have been varied (or suspended) in the normal way while the patient was recalled to hospital.

Revocation of CTOs

If the patient meets the criteria for admission for treatment the clinician may revoke the CTO subject to the AMHP agreeing not only that the criteria are met but that revocation is appropriate. The SCT can only be revoked while the patient is detained in hospital as a result of recall, and must be done using Form CTO 5 which must be sent to the managers of the hospital to which patient was recalled, who must in turn send a copy to the hospital which was, until then, the responsible hospital (if different).

Effect of revocation

The patient becomes subject to the suspended treatment order they were on before they were discharged on SCT and this treatment order starts again, with renewals after six months, then again after six months and then a year.

On revocation of a CTO the hospital managers must refer the patient for a Tribunal hearing.

Expiry and Extension of CTOs (s20A & 20B)

Unless extended, a CTO expires at the end of the six months starting on the day on which it is made, i.e. the date specified in Form CTO 1 as the date from which the CTO is to be effective: (so, if it is made on 1 January, it expires at the end of the 30 June, i.e. midnight!). It can be extended for a further six months, and then for a year at a time.

As with renewals for detained patients, at some point during the final two months of the first and each subsequent period for which the CTO is in force, the RC must examine the patient in order to decide whether the criteria for extension are met. If the patient does not attend voluntarily, the RC may recall the patient to hospital for this purpose, because being available for examination is one of the mandatory conditions included in all CTOs.

The criteria for extension mirror those for making the CTO in the first place. If the RC believes the criteria are met a report must be made to that effect to the managers, but first they must consult with one or more professionals involved with the patient's treatment (as with S20 of the MHA), and RCs may not make the report unless an AMHP confirms in writing that the criteria are met and that extension is appropriate.

The report and the AMHP's statement must be made on CTO7 and sent to the managers of the responsible hospital. The effect is to extend the CTO for six months or a year (as applicable) from the date it would otherwise expire, and not the date of the report itself. The patient must be informed of the extension and reasonable steps must be taken to inform the NR.

As with renewal of detention, when the RC submits the report extending a patient's CTO, the Hospital Managers must decide whether the patient should be discharged from SCT instead.

ACTIVITY 5 – NICK CONTINUED

Please read the scenario and answer the following questions, giving explanations for your answers. Suggested answers are on page 71-72.

Six months later, Nick is still in the community and compliant with the terms of his CTO. He doesn't want it to be extended. The RC however does want to extend it because of Nick's history of relapse and submits a report extending the CTO.

1. What role would the hospital managers have to play in respect of the proposed extension? Is any action required from them?
2. What criteria have to be satisfied for extension of the CTO to be made?
3. What would be the situation if the hospital managers conclude that Nick should be discharged?

Discharge of Part 2 SCT patients by their nearest relatives (sections 23 & 25)

Nearest relatives may discharge Part 2 SCT patients (*this means section 3 patients who are discharged onto SCT*) from their CTO and therefore also from the underlying application for admission for treatment. They must give a written discharge order under s23 and must give the hospital managers not less than 72 hours' notice in writing of their intention; the 72 hours starts from the time when this is received by the managers or authorised person or is delivered by post to the hospital.

Again as with Part 2 detained patients, if the RC considers that if discharged from CTO the patient is likely to act in a manner dangerous to others or themselves, the 'danger principle', they may report to this effect using Form M2 and send it to the managers (administrator) before the end of the 72 hour period. (Form M2 is the equivalent of the old barring form 36). This vetoes the nearest relative's decision and prevents them from discharging the patient from the CTO at any time in the six months following the date of the report; and the NR must be informed in writing without delay and, as with nearest relatives' requests for discharge from s3, they may apply to the Tribunal instead.

If the RC does not make a report the patient must be discharged from the CTO. If they happened to be recalled at the time, they would have to be released from hospital because the authority to recall them would no longer exist.

Nearest relatives cannot order patients to be released from hospital (except by ordering discharge from SCT itself as described above).

Nearest relatives cannot order the discharge of a Part 3 patient (as with s37 Hospital Order) (this means patients detained under Part 3 who are then discharged onto SCT) but can apply to the Tribunal in certain circumstances.

ACTIVITY 6 – NICK CONTINUED

Please read the scenario and answer the following questions, giving explanations for your answers. Suggested answers are on page 72.

The CTO is extended, but a month later Nick's nearest relative gives notice of the intention to discharge him from SCT using their power of discharge. The RC immediately makes a report barring this discharge. Nick therefore remains subject to the CTO.

Answer these questions.

1. **Does the RC have the power to bar discharge from SCT by the nearest relative?**
2. **Do the hospital managers have any role to play in respect of the action taken by the RC?**
3. **If the hospital managers decide to review Nick's case following the action taken by the RC, are there any specific matters that they should address?**

Discharge of SCT patients by the RC

RCs may discharge SCT patients at any time, by making a written order which should be sent to the managers or administrator. This will automatically discharge them from the suspended treatment order as well.

Discharge of SCT patients by hospital managers (see below for details)

Hospital managers also have the power to discharge SCT patients. A managers' panel must or may consider doing so when:

- the RC extends the CTO;
- when a SCT patient requests discharge;
- when a barring order is received.

This means that three or more authorised people must consider any of the above (as for Part 2 detained patients). The managers cannot order patients to be released from a recall to hospital.

Discharge of SCT patients whose responsible hospital is an independent hospital – powers of the Secretary of State and NHS bodies

The Secretary of State may at any time make an order to discharge a SCT patient if the patient's responsible hospital is an independent hospital. If the patient is an NHS patient, the relevant NHS body may also order discharge from SCT. The relevant NHS body is the one which has contracted with the independent hospital to act as the responsible hospital.

Discharge of SCT patients by the Tribunal

The Tribunal is an independent and impartial judicial body which has the power to decide whether or not patients should continue to be detained or remain subject to guardianship. Under the MHA it will also now have the power to decide whether or not a patient should continue to be on SCT. As with detention, the burden of proof is on those keeping the patient liable to recall to hospital. Patients are not required to prove that they should be discharged.

The Tribunal does not have the power to discharge patients from detention onto SCT by making CTOs (although it can recommend that the patient's RC considers it). Nor can it order the release of SCT patients who are detained temporarily as a result of being recalled to hospital. However, it can discharge patients from SCT itself (even if they happen to be recalled to hospital at the time).

Duty to inform nearest relatives of discharge onto SCT (s133)

Whatever steps are practicable must be taken by the managers of the responsible hospital to inform the NR that a detained patient is to be discharged (unless the patient or relative has asked that such information should not be given or there is no NR). This applies equally where patients are to be discharged onto SCT. If practicable the information should be given at least seven days before discharge.

Duty of hospital managers to give information to SCT patients and their nearest relatives (s132A)

'There is a duty on hospital managers to take steps to ensure that patients understand what SCT means for them and their rights to apply for discharge. This includes giving patients information both orally and in writing and must be done as soon as practicable after the patient goes onto SCT. Hospital managers' information policies should set out whether this information is to be provided by the responsible clinician, by another member of the professional team or by someone else. A copy of this information must also be provided to the nearest relative (subject to the normal considerations about involving nearest relatives).'

(COP, 25.37)

KEY CHANGE 9: REFERRAL TO THE TRIBUNAL

The MHA changes the rules about when hospital managers must refer patients' cases to the Tribunal.

Referral after six months

Under the MHA, hospital managers must refer patients detained on section 3 at the end of six months if they haven't applied themselves (and no-one else has applied on their behalf or referred their case to the Tribunal).

This now applies to section 2 patients as well, if they are still detained after six months (either because they are now on section 3 or because their section 2 has been extended pending the outcome of an application to the County Court to displace their nearest relative).

When working out if they need to refer a case at the six-month point, hospital managers must ignore applications or referrals made while the patient was on section 2.

Referral after three years

Hospital managers must still refer patients' cases to the Tribunal if three years have passed without the patient's case being considered by the Tribunal.

But there are two important changes:

- the referral must now be made as soon as the three years is up – hospital managers must no longer wait until the patient's detention is next renewed.
- the special rule requiring referrals after one year for patients under 16 now applies to 16- and 17-year-olds as well.

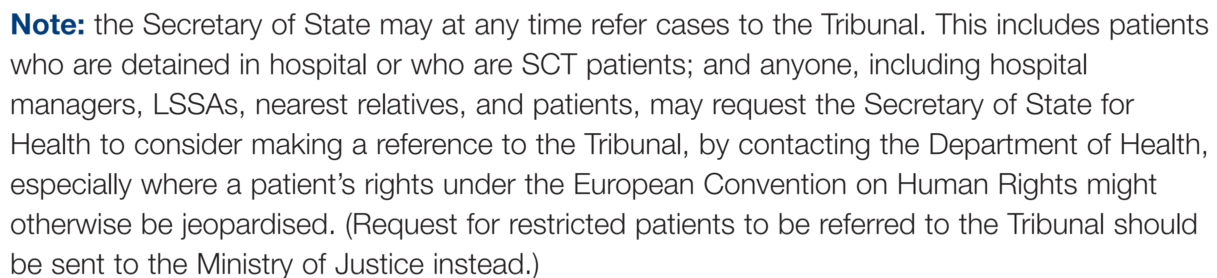
SCT patients

The duties to refer after six months and three years (one year for under 18s) also apply to SCT patients. The six months start from when the patient was first detained (whether under section 2 or 3), not from when they first went onto SCT.

In addition, whenever a SCT patient's community treatment order (CTO) is revoked, the hospital managers must refer the patient's case to the Tribunal as soon as practicable.

Power to reduce the six-month period

The Secretary of State now has a power to make an order reducing the six-month referral period (he already had a power to reduce the three-year and one-year periods). The Government has said this won't be used until Tribunal and NHS resources allow.



Note: the Secretary of State may at any time refer cases to the Tribunal. This includes patients who are detained in hospital or who are SCT patients; and anyone, including hospital managers, LSSAs, nearest relatives, and patients, may request the Secretary of State for Health to consider making a reference to the Tribunal, by contacting the Department of Health, especially where a patient's rights under the European Convention on Human Rights might otherwise be jeopardised. (Request for restricted patients to be referred to the Tribunal should be sent to the Ministry of Justice instead.)

Changes to the Tribunal

Under the Tribunals, Court and Enforcement Act 2007, the Mental Health Review Tribunal (MHRT) in England is abolished and its functions taken over by the Health, Education and Social Care Chamber of the new First-tier Tribunal from 3 November. (There will still be a MHRT for Wales.)

With two important exceptions, this should not make a great difference to the way that MHA cases are handled.

First, there will be new procedural rules and practice directions. They will probably include some changes to the rules about what hospital managers must include in the reports they give the tribunal.

Second, there will be a new right of appeal to an Upper Tribunal on a point of law. This will largely take the place of judicial reviews of Tribunal decisions. But there will be one crucial difference. If patients appeal, it will be for the hospital managers to decide whether, and if so how, to oppose that appeal, even if the appeal is alleging that the Tribunal did something wrong. Hospitals will probably need need legal advice to decide how to respond to appeals. (Hospitals won't have to respond directly to appeals by restricted patients – the Ministry of Justice will take the lead on those.)

THE HOSPITAL MANAGERS' FUNCTIONS

(Code of Practice Chapters 30 & 31)

Identification of Hospital Managers

'In England, NHS hospitals are managed by NHS trusts, NHS foundation trusts and primary care trusts (PCTs). For these hospitals, the trusts themselves are defined as the hospital managers for the purposes of the Act.

In an independent hospital, the person or persons in whose name the hospital is registered are the managers for the purposes of the Act.'

(COP, 30.2)

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

(COP, 30.3)

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

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

The Wider Role of Hospital Managers

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

- responsibility for age-appropriate accommodation for young people;
- responsibility for the ways in which the hospital as a whole operates mental health law;
- requesting a social circumstances report from the relevant local social services authority where a patient has been admitted under the MHA on the basis of an application by their nearest relative;
- making sure that when they delegate duties to other people (for example, to nurses who receive papers on their behalf) that those people are able to exercise those duties competently;
- ensuring that transfer to other hospitals is for the benefit of the patient's care;
- authorising detained patients' transfers to other hospitals;

- hospital managers are also the managers of the "responsible hospital", i.e. the hospital in which the patient was liable to be detained immediately before going onto SCT. It is the managers of the responsible hospital who are responsible for making sure SCT is used lawfully, and for various specific legal functions (including providing reports for the Tribunal, referring patients to the Tribunal where that is required, and deciding whether to discharge the patient from SCT). Responsibility can be assigned from one hospital to another (and therefore one set of managers to another) in accordance with regulations;
- it is the managers of the responsible hospital who are responsible for making sure SCT is used lawfully.

Delegation of Hospital Managers' Functions

As now, *'...unless the Act or the regulations say otherwise, organisations may delegate their functions under the Act to anyone and in any way which their constitution or (in the case of NHS bodies) NHS legislation allows them to delegate their other functions.'*

(COP, 30.9)

'The arrangements for who is authorised to take which decisions should be set out in a scheme of delegation. If the hospital managers are an organisation, that scheme of delegation should be approved by a resolution of the body itself......'

(COP, 30.9)

There are particular rules about the delegation of the hospital managers' power of discharge to managers' panels – see below.

'Organisations (or individuals) in charge of hospitals retain responsibility for the performance of all hospital managers' functions exercised on their behalf and must ensure that the people acting on their behalf are competent to do so. It is for the organisation (or individual) concerned to decide what arrangements to put in place to monitor and review the way that functions under the Act are exercised on its behalf ...'

(COP, 30.10)

There are particular rules about the delegation of the hospital managers' power of discharge to hospital mangers' panels – see below.

The Role of Hospital Managers (detail)

Transfer between hospitals

Transfers are potentially an interference with the patient's right to respect for privacy and family life under Article 8 of the European Convention on Human Rights and care should be taken when deciding to authorise a transfer. The revised Code gives more extensive guidance than before on transfers:

'People authorising transfers on the hospital managers' behalf should ensure that there are good reasons for the transfer and that the needs and interests of the patient have been considered. Transfers are potentially an interference with a patient's right to respect for privacy and family life under Article 8 of the European Convention on Human Rights, and care should be taken to act compatibly with the Convention when deciding whether to authorise a transfer.'

(COP, 30.15)

'Requests made by, or on behalf of, patients should be recorded and given careful consideration. Every effort should be made to meet the patient's wishes. If that cannot be done, the patient (or the person who made the request on the patient's behalf) should be given a written statement of the decision and the reasons for it.'

(COP, 30.21)

ACTIVITY 7

The Code of Practice deals in detail with the consideration of the transfer of patients to different hospitals. Although there is no specific requirement for a policy to be provided on this, if you were a hospital manager with responsibility for ensuring that the transfer of patients is managed effectively, what factors might you wish to see reflected in any local policy?

Transfers to guardianship

Regulations allow hospital managers to authorise the transfer of most detained patients into guardianship instead, with the agreement of the relevant LSSA. This is a procedural alternative to discharging the patient from detention and then making an application for guardianship. Again, this decision may be delegated to officers, including the patient's RC.

As with transfers between hospitals, people taking decisions on behalf of hospital managers and LSSAs should ensure that there are good reasons for any transfer and that the needs and interests of the patient have been considered.

Transfer of SCT patients recalled to hospital

The managers of a hospital to which a SCT patient has been recalled may authorise the patient's transfer to another hospital during the 72-hour maximum period of recall. (See Key Change 7).These decisions may be delegated in the same way as other transfer decisions described above.

Information for patients and relatives

Sections 132, 132A and 133 of the Act and regulations require hospital managers to arrange for detained patients, SCT patients and (where relevant) their nearest relatives to be given important information about the way the Act works and about their rights. For further guidance on the exercise of these duties, see **Chapter 2 of the Code**.

There is a requirement for hospital managers to ensure that there is a policy in place on how this is to be done and what information needs to be given. This is clearly set out in Chapter 2. The Code is helpful in highlighting the following:

'Information must be given to the patient both orally and in writing. These are not alternatives. Those providing information to patients should ensure that all relevant information is conveyed in a way that the patient understands.'

(COP, 2.9)

'It would not be sufficient to repeat what is already written on an information leaflet as a way of providing information orally.'

(COP, 2.10)

It is important to note that the new Mental Health (Hospital, Guardianship and Treatment) (England) Regulations 2008 (especially regulation 26) now contain more detailed requirements about informing nearest relatives and patients about certain events and decisions. These largely take the place of the items on current statutory forms which asked hospital managers to record that people had been given information. These requirements are in addition of duties in sections 132, 132A and 133 to give patients (and nearest relatives) information about their status and rights.

Duties in respect of victims of crime

Amendments to the Domestic Violence, Crime and Victims Act 2004 place a number of new duties on hospital managers in relation to certain unrestricted Part 3 patients who have committed sexual or violent crimes. Separate guidance on hospital managers' duties under the Domestic Violence, Crime and Victims Act 2004 has been issued by the Department of Health and Ministry of Justice[3]. Protocols will need to be in place to ensure the professionals involved in assessing or agreeing to accept transfer of these patients to the hospital notify the managers if individuals are subject to the Domestic Violence, Crime and Victims Act 2004.

Patients' correspondence (this duty has not changed)

'Section 134 allows hospital managers to withhold outgoing post from detained patients if the person to whom it is addressed has made a written request to the hospital managers, the approved clinician with overall responsibility for the patient's case, or the Secretary of State that post from the patient in question should be withheld. The fact that post has been withheld

[3] www/dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_089408)

must be recorded in writing by an officer authorised by the hospital managers, and the patient must be informed in accordance with the regulations.'

(COP, 30.32)

The managers of high-security psychiatric hospitals have wider powers under section 134 to withhold both incoming and outgoing post from patients in certain circumstances. The Secretary of State for Health has also issued directions requiring the managers of these hospitals to take similar action in respect of correspondence between patients within the hospital, phone calls and items brought in for patients from outside. Their decisions are subject to review by the Mental Health Act Commission.

Duty to refer cases to Tribunals

Hospital managers are under a duty to refer a patient's case to the Tribunal in the circumstances set out in section 68 of the MHA. See pages 275 & 6 of the Code for a table identifying those circumstances. For more detail please see Key Change 9.

Hospital Managers' Power of Discharge

(Code of Practice, Chapter 31)

Section 23 of the MHA gives hospital managers the power to discharge most detained patients and all SCT patients. They may not discharge patients remanded to hospital under sections 35 or 36 of the MHA or subject to interim hospital orders under section 38, and they may not discharge restricted patients without the consent of the Secretary of State for Justice.

The MHA has not changed the rules about how managers' panels should operate when they think about whether or not to discharge someone from section, but Chapter 31 of the revised Code does lay stress on a number of new areas of concern for hospital managers.

In addition, the criteria for the use of compulsion have changed and these are also reflected in the criteria considered for discharge – and hospital managers now have the power to discharge patients from SCT.

Exercise of power of discharge on behalf of managers

The new Code distinguishes between the general duties and functions of the hospital managers and the specific power of discharge. Like this workbook, it refers to the people to whom the latter functions are delegated as 'managers panels' to distinguish them from the hospital managers per se.

Except in an NHS foundation trust:

'*a managers' panel may consist of three or more people who are:*

- *members of the organisation in charge of the hospital (e.g. the chair or non-executive directors of an NHS trust); or*
- *members of a committee or sub-committee which is authorised for the purpose.*'

(COP, 31.4)

In an NHS trust or PCT, none of the members may be an officer (i.e. an employee) of the trust.

'In independent hospitals, *managers' panels should not include people who are on the staff of the hospital or who have a financial interest in it.'*

(COP, 31.7)

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

(COP , 31.5)

But none of them may be executive directors or employees of the trust.

Managers' panels

In all cases, the board (or the equivalent) of the organisation concerned should ensure that the people it appoints properly understand their role and the working of the MHA. It should also ensure that they receive suitable training to equip them to understand the law, work with patients and professionals, reach sound judgments **and properly record their decisions**. This should include training in how risk is assessed and how to comprehend a risk assessment report.

'Appointments to managers' panels should be made for a fixed period. Reappointment (if permitted) *should not be automatic and should be preceded by a review of the person's continuing suitability.'*

(COP, 31.9)

Documentation should be drawn up to assist managers' panels to not only check that they have considered all the relevant criteria, but are also able to write the reasons they have arrived at their decisions relating to the criteria they are reviewing.

When to review detention or SCT

Hospital managers:

- **may** undertake a review of whether or not a patient should be discharged at any time at their discretion;
- **must** undertake a review if the patient's RC submits to them a report under section 20 of the MHA renewing detention or under section 20A extending SCT;
- **should** consider holding a review when they receive a request from (or on behalf of) a patient; and
- **should** consider holding a review when the RC makes a report to them under section 25 barring an order by the nearest relative to discharge a patient.

Criteria to be applied

The MHA does not define specific criteria that the managers' panels must use when considering discharge. The essential yardstick is whether the grounds for continued detention or continued SCT under the MHA are satisfied. To ensure that this is done in a systematic and consistent way, managers' panels should consider the questions set out below, in the order stated.

For patients detained for assessment:

- is the patient still suffering from mental disorder?
- if so, is the disorder of a nature or degree which warrants the continued detention of the patient in hospital?
- ought the detention to continue in the interests of the patient's health or safety or for the protection of other people?

For other detained patients:

- is the patient still suffering from mental disorder?
- if so, is the disorder of a nature or degree which makes treatment in a hospital appropriate?
- is continued detention for medical treatment necessary for the patient's health or safety or for the protection of other people?
- is appropriate medical treatment available for the patient?

For patients on SCT:

- is the patient still suffering from mental disorder?
- if so, is the disorder of a nature or degree which makes it appropriate for the patient to receive medical treatment?
- if so, is it necessary in the interests of the patient's health or safety or the protection of other people that the patient should receive such treatment?

- is it still necessary for the RC to be able to exercise the power to recall the patient to hospital if that is needed?
- is appropriate medical treatment available for the patient?

Making a Decision:

- if three or more members of the panel (who between them make up a majority) are satisfied from the evidence presented to them that the answer to any of the questions set out above is "no", the patient should be discharged.

Reviewing section 25 barring order

- where the answer to all the relevant questions above is "yes", but the RC has made a report under section 25 barring a nearest relative's attempt to discharge the patient (either from detention or SCT), the panel should also consider the following question: would the patient, if discharged, be likely to act in a manner that is dangerous to other people or to themselves?
- if three or more members of the panel (being a majority) disagree with the RC and decide that the answer to this question is "no", the panel should usually discharge the patient.
- however, the hospital managers retain a residual discretion not to discharge in these cases, so panels should always consider whether there are exceptional reasons why the patient should not be discharged.

Managers' discretion

'In all cases, hospital managers have discretion to discharge patients even if the criteria for continued detention or SCT are met. Managers' panels must therefore always consider whether there are other reasons why the patient should be discharged despite the answers to the questions set out above.'

(COP, 31.22)

With a number of judicial reviews having overturned managers' panels' decisions the reason for this has in most cases been the fact that they have not considered all the criteria or have failed to record their reasons for arriving at their decisions adequately.

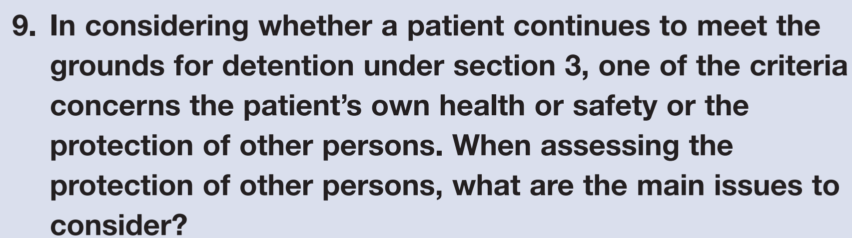
If managers' panels decide to use their discretion they must record their reasons, giving evidence as to why they arrived at their decision.

Appendix 1 contains a summary of a number of significant judicial review cases about managers' panels.

Final questions – Hospital managers

QUESTION	TRUE	FALSE
1. Which of the following statements are true in respect of the appropriate medical treatment test		
• Medical treatment must be actually available to the patient.		
• The treatment proposed must be the most appropriate treatment for the patient.		
• The treatment must take account of the nature and degree of the patient's mental disorder.		
2. Who has the power to renew the detention of a patient who has been compulsorily detained for treatment of a mental disorder?		
• The responsible clinician.		
• An approved mental health professional.		
• The hospital managers.		
3. Whose agreement must the RC obtain before renewing detention?		
• An SOAD.		
• A professional from a different professional group.		
• The hospital managers.		
4. What is the duration of a community treatment order?		
• A CTO will last initially for 12 months; it can then be extended for a further 12 months, and following that, for 24 months at a time.		
• A CTO will last initially for 12 months; it can then be extended for a further 6 months, and following that, for 12 months at a time.		
• A CTO will last initially for 6 months; it can then be extended for a further 6 months, and following that, for 12 months at a time.		

5. In which of these circumstances must the hospital managers refer an adult patient to the Tribunal • In all cases, 6 months after the initial detention, if no previous application or reference has been made while the patient was on section 3. • Where the CTO for a patient on SCT has been revoked by the RC with the AMHP's agreement. • Where a patient was not discharged by the Tribunal the hospital managers must refer again 3 years after the last renewal of the patient's detention.		
6. Which of these statements are true in respect of young people (patients aged 16 or 17)? • They may be admitted to hospital for treatment without their consent under the MHA. • They may be treated on an adult ward where there is no other more suitable accommodation available. • They may not be treated as a compulsory in-patient if there is no accommodation available that is suitable for their age group.		
7. Which of the following actions may be undertaken by an Independent Mental Health Advocate for a patient subject to a CTO? • An IMHA may apply for the patient's discharge. • An IMHA may support a patient at the MHRT. • An IMHA may obtain the patient's hospital records where they have capacity and consent.		
8. In which of the following circumstances are the hospital managers under a duty to review the case of a patient on SCT? • When they receive a request to do so from the patient. • When the RC submits a report under section 20(4) renewing the CTO. • When the RC makes a report under section 25(1) barring the nearest relative's application for the patient's discharge.		



9. In considering whether a patient continues to meet the grounds for detention under section 3, one of the criteria concerns the patient's own health or safety or the protection of other persons. When assessing the protection of other persons, what are the main issues to consider? • The nature of the potential risks. • The availability of treatment. • The likelihood of such harm occurring.		

APPENDIX 1

Case Law on Hospital Managers' Decisions

Some managers' panels have become increasingly concerned about how they arrive at their decisions and whether they are operating in line with all the legislation that has become part of our lives.

Human Rights and anti-discrimination legislation has – rightly – made panels look over their shoulders before coming to a decision in case that decision can be challenged.

It is important for panels to focus on the criteria they need to review and to ensure that they make a note as to why they have decided whether the criteria are met and on what basis they have arrived at their decision.

Panels **must** ensure that their decisions on all the criteria to be considered are noted and justified. The decision they arrive at, especially when using their discretionary power, must be one that another panel or a Tribunal might reasonably have arrived at.

Below are the main case law examples regarding hospital managers' decisions which have been challenged by judicial review. They offer some guidance to hospital managers in terms of ensuring that their decisions are sound and beyond challenge.

R v Riverside Mental Health Trust, ex p. Huzzey, QBD, 29 April 1998

FACTS

H was detained under section 3. On 20 July 1996, his nearest relative gave notice of her intention to discharge him. The responsible medical officer barred the discharge on the statutory ground that the patient would be likely to act in a manner dangerous to other persons or to himself.

The hospital managers reviewed the patient's detention on 30 July. They decided not to discharge him because he continued to satisfy the usual criteria for detention set out in section 3. H applied to have the managers' decision quashed.

HELD

Section 23 gives the managers a general discretion to discharge a patient. The question of what were the relevant considerations had to be answered by looking at the general scheme of the Act.

Clearly, the criteria set out in s3 were of fundamental importance. However, the managers also had to decide whether they were persuaded by the RMO's report that the patient was likely to act dangerously. If they were not so persuaded, that meant that their opinion was that the RMO had come to an erroneous conclusion, and the nearest relative should have been entitled to order discharge.

R (on the application of O) v West London Mental Health NHS Trust [2005] EWHC 604 (Admin)

FACTS

The nearest relative's attempt to discharge the patient was barred by the RMO. The hospital managers carried out a review and maintained the section. The patient contended that the hospital managers had failed to consider the dangerousness criteria. The person chairing the panel insisted that the issue had been taken into account. However, the relevant boxes on the trust's pro-forma decision form had been left blank, and the patient's solicitor had no recollection of dangerousness being mentioned when the decision was announced.

HELD (COLLINS J.)

The hospital managers' decision was unlawful:

> "… it does seem to me that this is a case where it would not be right to accept that the reasons subsequently given should prevail. There are too many questions and it is, after all, of considerable importance that proper reasons are given at the time. ……where a key issue has not properly, or indeed at all, been dealt with in the original reasons, it becomes very difficult to accept that it should be possible to supplement those matters subsequently when a challenge is raised."

R (on the application of the Official Solicitor on behalf of SR) v Huntercombe Maidenhead Hospital and Interested Parties [2005] EWHC 2361 (Admin)

FACTS

The patient was 15-years-old. The nearest relative's attempt to discharge the patient was barred by the RMO. The hospital managers overruled the RMO and directed the patient's discharge in three weeks' time, so that after-care could be arranged. The Official Solicitor (on behalf of the patient) sought a declaration that the decision was unlawful.

HELD

The managers' decision was unlawful. The managers had erred in law when overlooking their residual discretion as to whether or not to discharge, even after overriding the RMO's finding as to dangerousness.

In any event, on the facts of the case, the decision to disagree with the RMO on the issue of the patient's dangerousness was irrational and a decision which no reasonable Tribunal could have made.

R (Tagoe-Thompson) v Central and North West London Mental Health NHS Trust Court of Appeal, 12 March 2003

FACTS

The patient's detention was reviewed by three hospital managers who could not decide unanimously that he did not meet the criteria for detention. They refused to discharge him.

The patient submitted that their power of discharge was exercisable by a majority of any three or more members sitting together. It was also submitted that a procedure which permitted continued detention where only a minority of members opposed release led to inequality, uncertainty, delay and inconvenience, and arbitrariness.

HELD

The wording of section 23(4) favoured the view that at least three members must be prepared to express their support for an order for discharge to be made. Three members were appointed to conduct a review by virtue of their membership of a committee or sub-committee but it was as individuals that they exercised the power. The subsection did not create jurisdiction in or confer power on a panel.

It was not in the least surprising that the affirmative view of at least three lay persons was required to override the responsible medical officer's opinion concerning release. It followed from the scheme of the Act, as well as the wording of section 23(4), that there was a requirement that each of three members should support the order for discharge.

APPENDIX 2

CODE OF PRACTICE – CHAPTER 6 – THE APPROPRIATE MEDICAL TREATMENT TEST

6.1 This chapter gives guidance on the application of the appropriate medical treatment test in the criteria for detention and supervised community treatment (SCT) under the Act.

Purpose of medical treatment for mental disorder

6.2 For the purposes of the Act, medical treatment also includes nursing, psychological intervention and specialist mental health habilitation, rehabilitation and care. Habilitation means equipping someone with skills and abilities they have never had, whereas rehabilitation means helping them recover skills and abilities they have lost.

6.3 In the Act, medical treatment for mental disorder means medical treatment which is for the purpose of alleviating, or preventing a worsening of, a mental disorder or one or more of its symptoms or manifestations.

6.4 Purpose is not the same as likelihood. Medical treatment may be for the purpose of alleviating, or preventing a worsening of, a mental disorder even though it cannot be shown in advance that any particular effect is likely to be achieved.

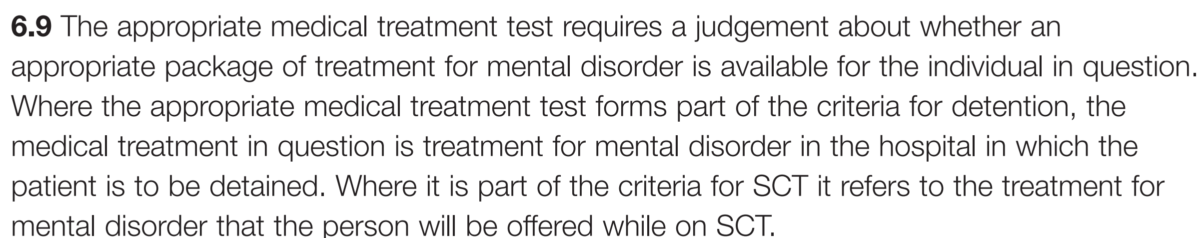
6.5 Symptoms and manifestations include the way a disorder is experienced by the individual concerned and the way in which the disorder manifests itself in the person's thoughts, emotions, communication, behaviour and actions. But it should be remembered that not every thought or emotion, or every aspect of the behaviour, of a patient suffering from a mental disorder will be a manifestation of that disorder.

6.6 Even if particular mental disorders are likely to persist or get worse despite treatment, there may well be a range of interventions which would represent appropriate medical treatment. It should never be assumed that any disorders, or any patients, are inherently or inevitably untreatable. Nor should it be assumed that likely difficulties in achieving long-term and sustainable change in a person's underlying disorder make medical treatment to help manage their condition and the behaviours arising from it either inappropriate or unnecessary.

Appropriate medical treatment test

6.7 The purpose of the appropriate medical treatment test is to ensure that no-one is detained (or remains detained) for treatment, or is an SCT patient, unless they are actually to be offered medical treatment for their mental disorder.

6.8 This medical treatment must be appropriate, taking into account the nature and degree of the person's mental disorder and all their particular circumstances, including cultural, ethnic and religious considerations. By definition, it must be treatment which is for the purpose of alleviating or preventing a worsening of the patient's mental disorder or its symptoms or manifestations.



6.9 The appropriate medical treatment test requires a judgement about whether an appropriate package of treatment for mental disorder is available for the individual in question. Where the appropriate medical treatment test forms part of the criteria for detention, the medical treatment in question is treatment for mental disorder in the hospital in which the patient is to be detained. Where it is part of the criteria for SCT it refers to the treatment for mental disorder that the person will be offered while on SCT.

Applying the appropriate medical treatment test

6.10 The test requires a judgement about whether, when looked at in the round, appropriate medical treatment is available to the patient, given:

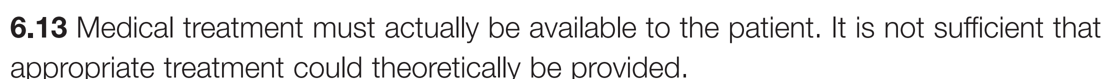
- the nature and degree of the patient's mental disorder; and
- all the other circumstances of the patient's case.

In other words, both the clinical appropriateness of the treatment and its appropriateness more generally must be considered.

6.11 The other circumstances of a patient's case might include factors such as:

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

6.12 Medical treatment need not be the most appropriate treatment that could ideally be made available. Nor does it need to address every aspect of the person's disorder. But the medical treatment available at any time must be an appropriate response to the patient's condition and situation.



6.13 Medical treatment must actually be available to the patient. It is not sufficient that appropriate treatment could theoretically be provided.

6.14 What is appropriate will vary greatly between patients. It will depend, in part, on what might reasonably be expected to be achieved given the nature and degree of the patient's disorder.

6.15 Medical treatment which aims merely to prevent a disorder worsening is unlikely, in general, to be appropriate in cases where normal treatment approaches would aim (and be expected) to alleviate the patient's condition significantly. For some patients with persistent mental disorders, however, management of the undesirable effects of their disorder may be all that can realistically be hoped for.

6.16 Appropriate medical treatment does not have to involve medication or individual or group psychological therapy – although it very often will. There may be patients whose particular circumstances mean that treatment may be appropriate even though it consists only of nursing and specialist day-to-day care under the clinical supervision of an AC, in a safe and secure therapeutic environment with a structured regime.

6.17 Simply detaining someone – even in a hospital – does not constitute medical treatment.

6.18 A patient's attitude towards the proposed treatment may be relevant in determining whether the appropriate medical treatment test is met. But an indication of unwillingness to co-operate with treatment generally, or with a specific aspect of treatment, does not make such treatment inappropriate.

6.19 In particular, psychological therapies and other forms of medical treatments which, to be effective, require the patient's co-operation are not automatically inappropriate simply because a patient does not currently wish to engage with them. Such treatments can potentially remain appropriate and available as long as it continues to be clinically suitable to offer them and they would be provided if the patient agreed to engage.

6.20 People called on to make a judgement about whether the appropriate medical treatment test is met do not have to be satisfied that appropriate treatment will be available for the whole course of the patient's detention or SCT. What is appropriate may change over time, as the patient's condition changes or clinicians obtain a greater understanding of the patient's case. But they must satisfy themselves that appropriate medical treatment is available for the time being, given the patient's condition and circumstances as they are currently understood.

APPENDIX 3

Activity Answers

ACTIVITY 2 – AGNES SUGGESTED ANSWERS

1. How long will Agnes'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 under the MHA before the MHA 2007. This means that:

Initially, Agnes will be detained for a period not exceeding six months beginning with the day on which she was admitted for treatment. Her detention may then be renewed for a further period of 6 month. At the end of the second period or renewal, her detention may be renewed for further period of one year, and then for periods of a year at a time.

2. Who has responsibility for considering whether Agnes's detention should be renewed when the time comes? What new policies might hospital managers need to have in place now to manage this stage?

It is Agnes's RC who is responsible under the MHA for assessing whether she should continue to be detention. However, they are now required to have the agreement of a 'second professional' (from a different professional background to the RC) who must agree, in writing with the continued detention. This person must be professionally concerned with the Agnes's care.

The Code (29.5) suggests that managers should have policies concerning who this second professional should be, taking into account the following:

Apart from that, the MHA does not say who the second professional should be. Hospital managers should determine their own local policies on the selection of the second professional. Policies should be based on the principle that the involvement of a second professional is intended to provide an additional safeguard for patients by ensuring that:

- renewal is formally agreed by at least two suitably qualified and competent professionals who are familiar with the patient's case;
- those two professionals are from different disciplines, and so bring different, but complementary, professional perspectives to bear; and
- the two professionals are able to reach their own decisions independently of one another. (COP, 29.5)

If the 'second professional' does not agree with the renewal of the s3, it cannot be renewed. The Code therefore suggests that in general the opinion of this 2nd professional should be respected, even if the RC does not agree. However, in exceptional situations where the RC feels that a different 2nd professional opinion should be sort, the code suggests that this should be brought to the attention of the hospital managers. (COP 29.9)
There continues to be a statutory requirement that the RC must examine Agnes 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 grounds for continued detention are met, and they have the written agreement of the 2nd professional. The RC must make a report to the hospital managers on the appropriate statutory form.

3. What role do the hospital managers have in respect of the decision to renew Agnes's detention?

The hospital managers must review a patient's detention when the RC submits a report under section 20(3) renewing detention.

The Code (31.13) suggests that if possible this review should take place before the *current period of detention expires*.

The managers' panel considering the case for discharging a patient must comprise three or more members. The MHA does not define either the grounds or the procedure for reviewing a patient's detention. However, the Code of Practice does set out that the hospital managers should consider whether the criteria for admission or continued detention under the MHA are satisfied. (COP, 31.16)

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

The criteria on which Agnes's continued detention would be judged are essentially the same as the grounds 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 Agnes is to continue to be detained for treatment under section 3, the managers panel must be sure that all three of the above criteria are met.

5. If Agnes had not appealed to the tribunal during her time in hospital, at what point would you expect the hospital managers to have made the referral themselves?

The amendments to section 68 of the MHA mean that hospital managers must include the period of detention under s2 when applying the 'six month rule' for referral to tribunals. In Agnes's case, the 3 weeks she was on s2 would therefore be 'counted' as part of the 6 month referral period, and Agnes should be referred to the tribunal 5 months and 1 week into her s3 detention.

6. For the purposes of coming to a decision, what do you understand by the term 'mental disorder'? Does it appear to you that Agnes is suffering from such a disorder and that it is of a nature or degree 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 unamended MHA 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 recognized 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.

7. How would you interpret the requirement for appropriate medical treatment to be available for her?

Section 3(4) of the MHA 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."

The purpose of medical treatment is to "*alleviate or prevent a worsening of the disorder or one or more of its symptoms*" (section 145).

Paragraph 6.11 of the Code helps by defining 'all other circumstances' of the case as

- the patient's physical health – how this might impact on the effectiveness of the available medical treatment for the patient's mental disorder and the impact that the treatment might have in return;
- any physical disabilities the patient has;
- the patient's culture and ethnicity;
- the patient's age;
- the patient's gender, gender identity and sexual orientation;

- the location of the available treatment;
- the implications of the treatment for the patient's family and social relationships, including their role as a parent;
- its implications for the patient's education or work; and
- the consequences for the patient, and other people, if the patient does not receive the treatment available. (For mentally disordered offenders about to be sentenced for an offence, the consequence will sometimes be a prison sentence.)

8. It has been suggested that Agnes might respond best to CBT. However, this is not available currently. If it is correct that CBT 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 MHA 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.

'Medical treatment need not be the most appropriate treatment that could ideally be made available. Nor does it need to address every aspect of the person's disorder. But the medical treatment available at any time must be an appropriate response to the patient's condition and situation.' (COP, 6,12)

'Medical treatment must actually be available to the patient. It is not sufficient that appropriate treatment could theoretically be provided.' (COP, 6, 13)

9. It seems that Agnes does not present any danger to the safety of anyone other than herself. Does this mean that she falls outside the grounds for continued detention?

No. It is enough for there to be a threat to Agnes's own health or safety.
The second part 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*".

10. How should the managers' panel proceed if it comes to the conclusion that Agnes does not meet the criteria for her detention to be continued?

If Agnes does not meet the criteria for continued detention, the MHA gives the managers' panel the power to discharge her from detention. Indeed, they would have a duty to do so.

It is important to remember that discharge from detention is different from discharge from hospital - Agnes could continue to stay in hospital on an informal basis if she and her RC agreed this was appropriate.

The Code (31.43 – 31.44) provides guidance on the process of decision making:

'Hospital managers have a common law duty to give reasons for their decisions. The decisions of managers' panels, and the reasons for them, should be fully recorded at the end of each review. The decision should be communicated as soon as practicable, both orally and in writing, to the patient, to the nearest relative (where relevant) and to the professionals concerned.' (COP, 31, 43)

'If the patient is not to be discharged, at least one member of the panel should offer to see the patient to explain in person the reasons for the decision. Copies of the papers relating to the review, and the formal record of the decision, should be kept in the patient's notes.' (COP 31,44)

Activity 4 - Nick – suggested answers

1. Who would take responsibility for instigating the process for discharging Nick onto SCT?

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

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

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

- agrees that the criteria for making the CTO are met, 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.

3. 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.

4. What criteria should the RC apply in deciding whether SCT would be suitable for Nick?

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.

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

SCT can only be used where it is necessary – so other options must be considered first. And in line with the guiding principles of the Code of Practice, the RC and AMHP should consider whether the objectives of the proposed SCT could safely and effectively be achieved in a less restrictive way.

If some form of compulsion is thought necessary, alternatives to consider would be:

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

Chapter 28 of the Code considers these alternatives in more detail.

6. 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 5 – Nick continued – suggested answers

1. What role would the hospital managers have to play in respect of the proposed extension? Is any action required from them?

The hospital managers must review a patient's case when the RC submits a report under section 20A(4) extending SCT.

The CTO is extended by the RC; the hospital managers must consider whether or not it is appropriate in light of the extension to exercise their power of discharge. When doing so, the Code suggests manager's panels adopt the following principles:

- adopt and apply a procedure which is fair and reasonable;
- not make irrational decisions – that is, decisions which no managers' panel, properly directing itself as to the law and on the available information, could have made; and
- not act unlawfully – that is, contrary to the provisions of the Act and any other legislation (including the Human Rights Act 1998 and relevant equality and anti-discrimination legislation). (COP 31.23)

2. What criteria have to be satisfied for renewal of the CTO to be made?

Although the Act does not define the criteria to be used by the hospital managers when reviewing a patient's CTO, the Code says

'The essential yardstick is whether the grounds for continued detention or continued SCT under the Act are satisfied.' (31.14)

So managers' panels when considering extensions of SCT should consider the same criteria that were used in making the order. These are:

- the patient is suffering from mental disorder of a nature or degree which makes it appropriate for them to receive medical treatment
- it is necessary for their own health or safety, or for the protection of others 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 hospital
- it is necessary that the RC should be able to exercise the power under section 17E(1) to recall the patient to hospital
- appropriate medical treatment is available.

With SCT, although the degree of a patient's mental disorder (i.e. the current severity of the symptoms seen or experienced) will have to be considered, it may well be that the **nature** of the patient's disorder will be of particularly interest.

For example, in Nick's case,

- what are the symptoms that he experiences, and in what context?
- What are the risks associated with relapses in Nick's mental health, and what was the context of these risks? Does the context still exist? What might the impact be if the risks were to reoccur?
- What is the pattern of Nick's illness, and has this changed?

3. What would be the situation if the hospital managers conclude that Nick should be discharged?
If they do not agree that SCT remains appropriate, the hospital managers must discharge the patient. They do not have the power to recall Nick, or revoke the SCT and return Nick to hospital under section 3 – they may only discharge him absolutely.

Activity 6 – Nick continued – suggested answers

1. Does the RC have the power to bar discharge from SCT by the nearest relative?
Yes. The RC has the power to make a report under section 25(1) which effectively bars the discharge by the nearest relative, and prevents them from making a further order for discharge for six months

2. Do the hospital managers have any role to play in respect of the action taken by the RC?
There is no specific duty on the hospital managers to undertake a review of the patient's case when the RC makes a report under section 25(1) opposing a nearest relative's application for the patient's discharge. However, they should consider holding a review in these circumstances (COP 31.11), as it is clearly in the patient's best interests for there to be as little doubt about their situation as possible. The managers in this situation would, the code suggests be 'entitled to take into account whether the tribunal has recently considered the patient's case or is due to in the near future.' COP 31.12

3. If the hospital managers decide to review Nick's case following the action taken by the RC, are there any specific matters that they should address?
As with any such review, they should concern themselves first with the question of whether the patient continues to meet the criteria for SCT.

They should also specifically address the question of whether the patient would be likely to act in a manner dangerous to other persons or to himself, if he was discharged. As part of their decision making process they will need to consider the probability of dangerous outcomes occurring – again, the nature of the patient's mental disorder over time may be particularly important.

Final quiz – Answers

QUESTION	TRUE	FALSE
1. Which of the following statements are true in respect of the appropriate medical treatment test		
• Medical treatment must be actually available to the patient.	X	
• The treatment proposed must be the most appropriate treatment for the patient.		X
• The treatment must take account of the nature and degree of the patient's mental disorder.	X	

There is no requirement for the treatment proposed to be the most appropriate that could ideally be provided, as long as it is appropriate.

QUESTION	TRUE	FALSE
2. Who has the power to renew the detention of a patient who has been compulsorily detained for treatment of a mental disorder?		
• The responsible clinician	X	
• An approved mental health professional		X
• The hospital managers		X
3. Whose agreement must the RC obtain before renewing detention?		
• An SOAD		X
• A professional from a different professional group	X	
• The hospital managers		X

It is the RC who is responsible under the Act for assessing whether the patient continues to meet the criteria for detention and the RC is the only person who has the authority to renew detention. When renewing detention the RC must have the written agreement of a 'second professional' who is from a different professional group than the RC (section 20 (5A)) and has been professionally concerned with the patient's medical treatment.

4. What is the duration of a community treatment order?		
• A CTO will last initially for 12 months; it can then be extended for a further 12 months, and following that, for 24 months at a time.		X
• A CTO will last initially for 12 months; it can then be extended for a further 6 months, and following that, for 12 months at a time.		X
• A CTO will last initially for 6 months; it can then be extended for a further 6 months, and following that, for 12 months at a time.	X	

For a CTO to be extended the RC must confirm to the hospital managers that the criteria are met; an AMHP must agree and confirm that it is appropriate to extend the order.

5. In which of these circumstances must the hospital managers refer an adult patient to the Tribunal		
• In all cases, 6 months after the initial detention, if no previous application or reference has been made while the patient was on section 3.	X	
• Where the CTO for a patient on SCT has been revoked by the RC with the AMHP's agreement.	X	
• Where a patient was not discharged by the Tribunal the hospital managers must refer again 3 years after the last renewal of the patient's detention.		X

There is a requirement for the hospital managers to refer an adult patient's case after three years if no other application or reference has been made; this referral should be made three years after the last hearing (rather than after three years and subsequent renewal of detention).

6. Which of these statements are true in respect of young people (patients aged 16 or 17)?		
• They may be admitted to hospital for treatment without their consent under the MHA.	X	
• They may be treated on an adult ward where there is no other more suitable accommodation available.	X	
• They may not be treated as a compulsory in-patient if there is no accommodation available that is suitable for their age group.		X

The duty to provide age appropriate accommodation is subject to the patient's needs. So If there really is no age appropriate accommodation, then such accommodation as there is might be better than none, depending on the particular circumstances.

7. Which of the following actions may be undertaken by an Independent Mental Health Advocate for a patient subject to a CTO?		
• An IMHA may apply for the patient's discharge.		X
• An IMHA may support a patient at the MHRT.	X	
• An IMHA may obtain the patient's hospital records where they have capacity and consent.	X	

The IMHA does not have any role in making applications on behalf of the patient, although they may support the patient in doing so.

8. In which of the following circumstances are the hospital managers under a duty to review the case of a patient on SCT?		
• When they receive a request to do so from the patient.		X
• When the RC submits a report under section 20(4) renewing the CTO.	X	
• When the RC makes a report under section 25(1) barring the nearest relative's application for the patient's discharge.		X

The hospital managers must review the case then the RC submits a report under Section 20(A) 4 renewing the CTO. In other situations they should consider holding a review.

9. In considering whether a patient continues to meet the grounds for detention under section 3, one of the criteria concerns the patient's own health or safety or the protection of other persons. When assessing the protection of other persons, what are the main issues to consider?		
• The nature of the potential risks	X	
• The availability of treatment		X
• The likelihood of such harm occurring	X	

Overall, the need is to arrive at a balanced view of the acceptability of the risks, in terms of the likelihood and the possible harm to those involved in the care of the patient and to any others who are potentially at risk.

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