

Section 1 — Mental Disorder

- The 2007 Act abolishes the four forms of mental disorder set out in the 1983 Act.
- It simplifies the existing definition of mental disorder.
- It also removes three of the exceptions in section 1(3) — immorality, promiscuity and sexual deviancy — leaving in only 'dependence on alcohol or drugs'.

A collage of newspaper headlines related to mental health, including 'INFAMY', 'U.S. ATTACKED', 'DEVIANT', 'MAD OF WAR', 'MADNESS ATTACK', and 'NEW FORMS, PENITENCE'.

The four forms of mental disorder



1983 Act

A person may only be placed on one of the longer-term 6 month orders if two doctors agree that s/he suffers from:

- Mental illness, or
- Mental impairment, or
- Severe mental impairment, or
- Psychopathic disorder

By section 1(3), no one may be dealt with as mentally disordered by reason only of:

- Promiscuity or other immoral conduct
- Sexual deviancy
- Dependence on alcohol or drugs.

1983 Act as amended

- Whatever the section, it is now only necessary to show that the patient suffers from a 'mental disorder'.
- 'Mental disorder' means 'any disorder or disability of mind.'

By section 1(3), no one may be dealt with as mentally disordered by reason only of:

- Dependence on alcohol or drugs.

'Psychopathic disorder'



1983 Act

"Psychopathic disorder" means "a persistent disorder or disability of mind ... which results in abnormally aggressive or seriously irresponsible conduct on the part of the person concerned."

No one may be dealt with under the Act as having a psychopathic disorder by reason only of:

- Promiscuity or other immoral conduct
- Sexual deviancy
- Dependence on alcohol or drugs.

1983 Act as amended

'Mental disorder' means 'any disorder or disability of mind.'

No one may be dealt with under the Act as mentally disordered by reason only of:

- Dependence on alcohol or drugs.

‘Any disorder or disability of mind’

3.2 Mental disorder is defined for the purposes of the Act as “any disorder or disability of the mind”. Relevant professionals should determine whether a patient has a disorder or disability of the mind in accordance with good clinical practice and accepted standards of what constitutes such a disorder or disability.

3.3 Examples of clinically recognised conditions which could fall within this definition [include] ...

- eating disorders, non-organic sleep disorders and non-organic sexual disorders
- learning disabilities
- autistic spectrum disorders (including Asperger's syndrome)
- behavioural and emotional disorders of children and adolescents

The learning disability exception

- This general definition of mental disorder is subject to one exception:

“A person with learning disability shall not be considered by reason of that disability to be suffering from mental disorder for the purposes of the [long-term sections].”

- The purpose of this exception is to preserve the present position that a person with a learning disability may not be placed on one of the longer-term/six month sections unless their ‘learning disability’ is associated with abnormally aggressive or seriously irresponsible conduct.

“learning disability” means a state of arrested or incomplete development of mind which includes significant impairment of intelligence and social functioning.



Autistic spectrum disorders

3.16 The learning disability qualification does not apply to autistic spectrum disorders (including Asperger's syndrome). It is possible for someone with an autistic spectrum disorder to meet the criteria for compulsory measures under the Act without having any other form of mental disorder, even if their autistic spectrum disorder is not associated with abnormally aggressive or seriously irresponsible behaviour. While experience suggests that this is likely to be necessary only very rarely, the possibility should never automatically be discounted.



Anomalies

- A tribunal finds that Mr Jones suffers from a state of arrested or incomplete development of mind which includes significant impairment of intelligence but not significant impairment of social functioning.
- According to the new section 1, he does not have a learning disability and the prohibitions in section 1 on using section 3, etc, do not apply to him.



The new section 1

1.(2) In this Act—

“mental disorder” any disorder or disability of mind and “mentally disordered” shall be construed accordingly ...

(2A) But a person with learning disability shall not be considered by reason of that disability to be—

(a) suffering from mental disorder for the purposes of the provisions mentioned in subsection (2B) below; or
(b) requiring treatment in hospital for mental disorder for the purposes of sections 17E and 50 to 53 below, unless that disability is associated with abnormally aggressive or seriously irresponsible conduct on his part.

(2B) The provisions are—

(a) sections 3, 7, 17A, 20 and 20A below;

(b) sections 35 to 38, 45A, 47, 48 and 51 below; and

(c) section 72(1)(b) and (c) and (4) below.

(3) Dependence on alcohol or drugs is not considered to be a disorder or disability of mind for the purposes of subsection (2) above.

(4) In subsection (2A) above, “learning disability” means a state of arrested or incomplete development of mind which includes significant impairment of intelligence and social functioning.

‘Medical treatment’

145.–(1) In this Act, unless the context otherwise requires ... “medical treatment” includes nursing, ~~and also includes care, habilitation and rehabilitation under medical supervision~~, ~~psychological intervention and specialist mental health habilitation, rehabilitation and care~~;

145.–(3) 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.



Example

- Mr Jones is receiving psychological intervention.
- Ms Smith is being cared for and supervised by a social work member of the local CMHT.
- No doctor is involved in their cases.
- Both are receiving 'medical treatment' for the purposes of the Act.

[What about hospitals?](#)

Case
Examples

NEW ROLES



New roles: AMHPs

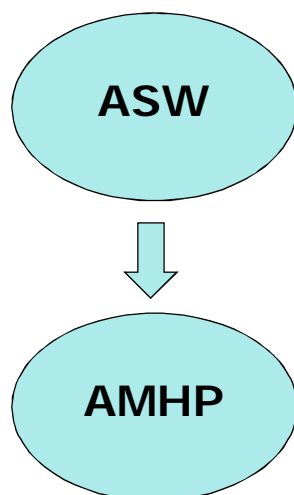
114 Approval by local social services authority

(1) A local social services authority may approve a person to act as an approved mental health professional for the purposes of this Act.

(2) But a local social services authority may not approve a registered medical practitioner to act as an approved mental health professional.

(3) Before approving a person under subsection (1) above, a local social services authority shall be satisfied that he has appropriate competence in dealing with persons who are suffering from mental disorder.

New roles: AMHPs



Persons eligible to be an AMHP

Any person approved to perform the Function by a local social services Authority, other than a medical Practitioner.

The function will therefore no longer be confined to social workers. For example, nurses and OTs are eligible to be trained as AMHPs.

New roles: Clinicians

Approved Clinician

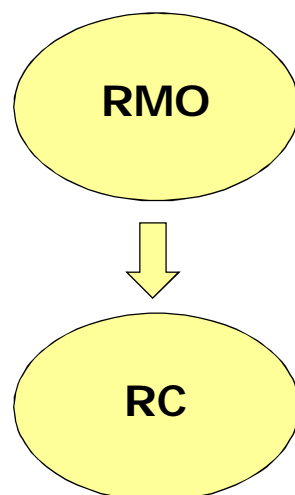
- Section 145: 'means a person approved by the Secretary of State (in relation to England) or by the Welsh Ministers (in relation to Wales) to act as an approved clinician for the purposes of this Act.'

Responsible Clinician

- 'Responsible clinician' replaces 'responsible medical officer'.
- Section 34: 'in relation to a s2 or s3 patient, or a community patient, the responsible clinician is 'the approved clinician with overall responsibility for the patient's case.'

- 'Approval need not be restricted to medical practitioners, and may be extended to practitioners from other professions, such as nursing, psychology, occupational therapy and social work.'
- [Explanatory Notes, para. 52.](#)

New roles: Clinicians



Persons eligible to be an RC

Anyone who has been approved as An 'approved clinician'

The function will therefore no longer be confined to doctors. For example, nurses, OTs, psychologists and social workers may seek approved clinician status.

The responsible clinician

The responsible clinician has [overall responsibility for the case](#) but may not be in control of all aspects of the patient's treatment.

Responsible for:

- Granting section 17 leave;
- Attaching conditions to such leave;
- Barring discharge by the nearest relative;
- Making community treatment orders and recalling patients subject to such orders;
- Examining patients and renewing their detention or guardianship under section 20;
- Discharging patients under section 23;
- Providing reports to the Secretary of State on restricted patients.
- It is the approved clinician in charge of the treatment in question who completes any necessary Form 38 (consent to treatment form).
- Similarly, section 63 now provides that the patient's consent is not required for any medical treatment, other than ECT and medication administered after the first three months, [which is given under the direction of the 'approved clinician in charge of the treatment.'](#)

The nearest relative

- The Act amends the list of persons who may be a patient's nearest relative by giving a civil partner equal status to a husband or wife.
- It also introduces a new right for a patient to apply for an order displacing the nearest relative on the same grounds currently in existence for other applicants, and on the additional ground that the nearest relative is unsuitable.
- It changes the requirement that the acting nearest relative must, in the court's opinion, be a "proper person" to act to whether the person is, in its opinion, a "suitable" person to act.



Suitability

8.13 ... factors which an AMHP might wish to consider ... could include:

- any reason to think that the patient has suffered, or is suspected to have suffered, abuse at the hands of the nearest relative (or someone with whom the nearest relative is in a relationship), or is at risk of suffering such abuse;
- any evidence that the patient is afraid of the nearest relative or seriously distressed by the possibility of the nearest relative being involved in their life or their care; and
- a situation where the patient and nearest relative are unknown to each other, there is only a distant relationship between them, or their relationship has broken down irretrievably.

PART II PROCEDURES

Part II procedures

1. The basic section 2, 3 and 4 procedures remain as they are now: you need an applicant and one or two medical practitioners providing medical recommendations.
2. Time limits remain as they are now.
3. Sections 2 and 4 are essentially unchanged.
4. The section 3 regime does change:
 - The four forms of mental disorder are abolished and it is now only necessary for the doctors to specify that the patient suffers from 'mental disorder' (consider the effect on those with personality disorder);
 - the 'medical treatment' which the person needs to be detained to receive may legally consist only of specialist care or psychological intervention;
 - The treatability test is abolished, and is now replaced by an appropriate medical treatment test, which applies to all patients (consider the effect on hospital transfers and s.17 leave);
 - A community treatment order may be made in respect of a section 3 patient.

Formalities

The Mental Health (Conflict of Interest) (England) Regulations 2008 set out the circumstances in which a potential conflict of interest prevents an AMHP making an application and a doctor giving a recommendation. The AMHP and doctors are collectively referred to as the "assessors".

An AMHP may not make an application, and a doctor may not give a recommendation, if:

- S/he "directs the work of, or employs, ... one of the other assessors"; or
- S/he and the other two assessors are all "members of the same team," that is they are all "members of a team organised to work together for clinical purposes on a routine basis."
- The Code of Practice states that the phrase "directs the work of" refers to a line-management relationship.

Interface with the MCA

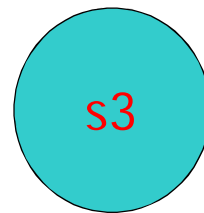
- 4.14 The fact that patients cannot consent to the treatment they need, or to being admitted to hospital, does not automatically mean that the Act must be used. It may be possible to rely instead on the provisions of the Mental Capacity Act 2005 (MCA) to provide treatment in the best interests of patients who are aged 16 or over and who lack capacity to consent to treatment.
- 4.15 This may be possible even if the provision of treatment unavoidably involves depriving patients of their liberty. Deprivation of liberty for the purposes of care or treatment in a hospital or care home can be authorised in a person's best interests under the deprivation of liberty safeguards in the MCA if the person is aged 18 or over.



APPLICATIONS FOR ADMISSION

Section 3

- The **four forms of mental disorder have been abolished**.
- Consequently, a person with a personality disorder may be placed under section 3 even though s/he would not today satisfy the criteria for having a psychopathic disorder.
- The **treatability test is abolished**, and replaced by an appropriate medical treatment test, which now applies to all patients.
- According to the Act, **references to appropriate medical treatment** are references to medical treatment which is appropriate in the patient's case, taking into account the nature and degree of their mental disorder and all other circumstances of his case.
- Although it is no longer necessary that the treatment is likely to alleviate the patient's condition, or prevent it from worsening, the **purpose of any treatment** provided must still be to alleviate, or prevent a worsening of, the disorder, or one or more of its symptoms or manifestations.
- **Treatment need not be under medical supervision**, or involve a doctor, and may consist only of specialist care or psychological intervention.
- The **renewal and tribunal discharge criteria** are modified accordingly.



The new section 3 criteria

3.—(1) A patient may be admitted to a hospital and detained there for the period allowed by the following provisions of this Act in pursuance of an application (in this Act referred to as "an application for admission for treatment") made in accordance with this section.

(2) An application for admission for treatment may be made in respect of a patient on the grounds that—

(a) he is suffering from **mental disorder** of a nature or degree which makes it appropriate for him to receive medical treatment in a hospital; and

(b) repealed ['treatability test']

(c) it is necessary for the health or safety of the patient or for the protection of other persons that he should receive such treatment and it cannot be provided unless he is detained under this section; and

(d) **appropriate medical treatment is available for him.**

(3) An application for admission for treatment shall be founded on the written recommendations in the prescribed form of two registered medical practitioners, including in each case a statement that in the opinion of the practitioner the conditions set out in subsection (2) above are complied with; and each such recommendation shall include—

(a) such particulars as may be prescribed of the grounds for that opinion so far as it relates to the conditions set out in paragraphs (a) and (d) of that subsection; and

(b) a statement of the reasons for that opinion so far as it relates to the conditions set out in paragraph (c) of that subsection, specifying whether other methods of dealing with the patient are available and, if so, why they are not appropriate.

(4) **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.**

‘Appropriate medical treatment’

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

- the patient’s physical health ...;
- 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 ... e.g. a prison sentence.

Example

- According to the *Briefing Note on the Bill*, ‘Decision makers will have to consider not only the clinical factors, but also, for example, whether treatment will be culturally appropriate, how far from the patient’s home the proposed service is and what effect it will have on the patient’s contact with family and friends.’

Mr Jones is detained under section 3. His diagnosis is anti-social personality disorder. His case comes before a tribunal. He argues that the treatment he is receiving in a private hospital 150 miles from his home in London does not constitute appropriate treatment. It is not culturally appropriate, there is no psychological input, he has no contact with family and friends and it is too far from home. Furthermore, it is not medical treatment because the purpose of his detention is simply public protection, not alleviating or preventing a worsening of his condition.



But

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.



Formalities

- Section 3 medical recommendations:
 - “Enter name of hospital(s). If appropriate treatment is available only in a particular part of the hospital, say which part.”
 - Remember the learning disability qualification.
- Medical recommendations either side of midnight on the 2nd/3rd of November 2008.
- Conflicts of interest (next slide)

Form A1
Regulation 41(6)(g)

Mental Health Act 1983 section 3 — medical recommendations for admission to hospital

I (PRINT full name and address of practitioner, or registered medical practitioner, recommending this) (PRINT full name and address of patient) is admitted to a hospital for treatment in accordance with Part 2 of the Mental Health Act 1983.

I last examined this patient on [date]

I had previous acquaintance with the patient before I conducted that examination

I am registered under section 17 of the Act as having special experience in the diagnosis or treatment of mental disorder.

(Delete if not applicable)

In my opinion:

(a) this patient is suffering from mental disorder of a nature or degree which makes it appropriate for the patient to receive medical treatment in a hospital.

AND

(b) it is necessary

(i) for the patient's own health

(ii) for the patient's own safety

(iii) for the protection of other persons

(delete the words not applicable)

that this patient should receive treatment in hospital.

AND

(c) such treatment cannot be provided unless the patient is detained under section 3 of the Act.

because — (Your reasons should cover (a), (b) and (c) above. As part of them describe the patient's symptoms and behaviour and explain how those symptoms and behaviour led you to your opinion. Say whether other methods of treatment or care (eg outpatient treatment or social services) are available and, if so, why they are not appropriate; indicate why informal admission is not appropriate.)

.....

If you need to continue on a separate sheet please indicate here [] and attach that sheet to this form

I am also of the opinion that, taking into account the nature and degree of the mental disorder from which the patient is suffering, and all the other resources of the hospital, appropriate medical treatment is available to the patient at the following hospital (or one of the following hospitals):

.....

(Enter name of hospital(s). If appropriate treatment is available only in a particular part of a hospital, say which part.)

Signed:

Date:

Section 2 or 3?

4.27 Section 3 should be used if:

- the patient is already detained under section 2 (detention under section 2 cannot be renewed by a new section 2 application); or
- the nature and current degree of the patient's mental disorder, the essential elements of the treatment plan to be followed and the likelihood of the patient accepting treatment on a voluntary basis are already established.



Renewals



- Renewals of detention are based on an examination by the responsible clinician, who may not be a medical practitioner.
- Before renewing the section, another person who has been professionally concerned with the patient's medical treatment, but belongs to a different profession, must state in writing that s/he agrees that the renewal conditions are satisfied. This person also need not be a medical practitioner.

Commentary

- It seems inconsistent that recommendations from two medical practitioners are required before a person may be detained under section 3 but the person's detention can then be renewed for 12 months on the basis of an examination by a non-medically qualified person.
- Is a medical opinion a necessary prerequisite of detaining someone for six or twelve months, or not? Is it a requirement of the European Convention or not?



"PSYCHOPATHIC DISORDER"



Psychopathic disorders

- *Long-term detention no longer requires the existence of a persistent disorder or disability of mind that results in abnormally aggressive or seriously irresponsible conduct.*
- *Dealing with someone as mentally disordered by reason only of sexual deviancy, or promiscuity or other immoral conduct, is no longer prohibited by section 1(3).*
- *Admission under section 3 or 37 require that the person's condition is treatable.*
- *The appropriate treatment that is provided may consist only of specialist social care, without any medical supervision, etc. This will be particularly relevant to CTOs.*



Example

Case
Examples

- John Smith has just moved into the area of your local NHS mental health trust. He lives with his wife who in the past has worked as a childminder. Around ten years ago, he was released from prison after serving an eight-year sentence for sexually assaulting two young children, aged 6 and 4.
- John has always denied the offence and he refused to engage in any treatment programmes in prison. His wife also continues to protest his innocence.
- John's brother visited him yesterday and was concerned to find that he is living next to a local primary school and that he stood in his front-garden talking to many of the school children on their way home. He invited one of them to drop by for tea after school next week. He is also expecting a visit from an old friend, his co-defendant in the most recent case.
- John's case has been referred to MAPPA and you have been asked whether there are any statutory frameworks that can now be used under the Mental Health Act 1983 to manage the risks.

Example

Case
Examples

- John has not been assessed by local mental health services but, based on police and prison information, it is likely that (a) he was sexually abused as a child and was taught that sexual relations involving an adult and child are entirely normal and indeed a proper expression of affection; (b) he is fully aware that society disapproves and that this kind of activity is unlawful; (c) he has had no treatment in the past from mental health services; (d) he continues to present a significant risk to children because he has not had treatment; (e) medical interventions have nothing to offer; (f) he requires social supervision and rehabilitation, in the form of specialist support from a social worker; (g) there is a probation hostel in the area that accepts former sex offenders.
- What are the options now under the 1983 Act?

THE SHORT-TERM SECTIONS

Section 5

- '5.(2) If, in the case of a patient who is an in-patient in a hospital, it appears to the registered medical practitioner or approved clinician in charge of the treatment of the patient that an application ought to be made under this Part of this Act for the admission of the patient to hospital, he may furnish to the managers a report in writing to that effect; and in any such case the patient may be detained in the hospital for a period of 72 hours from the time when the report is so furnished.'

s5(2)

Sections 135 & 136

- 135.—(3A) A constable, an approved mental health professional or a person authorised by either of them for the purposes of this subsection may, before the end of the period of 72 hours mentioned in subsection (3) above, **take a person detained in a place of safety under that subsection to one or more other places of safety.**

s135/6

Consider the effect of the new definition of "mental disorder" on section 136.

PART III

Offender provisions Part III

s.36	No longer limited to mental illness or severe mental impairment.
s.37	In cases not involving mental illness or severe mental impairment, magistrates' court can make order without convicting where appropriate.
s41	Power to make limited-term restriction orders abolished.
s45A	Crown Court's power to give hospital and limitation directions no longer limited to cases of psychopathic disorder.
s48	As with s36, no longer limited to mental illness or severe mental impairment.

Offender provisions Part III

Transfer from prison to hospital for treatment pre-sentence (ss. 36 and 48)

→

No longer limited to persons suffering from mental illness or severe mental impairment

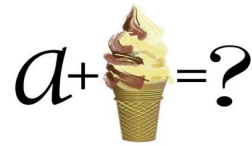
Hybrid orders under section 45A (Punishment + treatment)

→

No longer limited to persons suffering from Psychopathic disorder

Anomalies

- The following persons are arrested and remanded in custody:
- Peter has a diagnosis of severe personality disorder, is charged with manslaughter and has set fire to his cell.
- Liam suffers from paranoid schizophrenia and believes the gaolers are trying to kill him.
- Adrian has an IQ of 65 and is well-behaved but his social functioning is impaired and he is bullied and frightened by the other inmates.
- Derek has an IQ of 67 and impaired social functioning, and he is charged with indecent assault.
- *Which of them cannot be remanded or transferred to hospital pending trial?*



ECT

ECT — Patients with capacity


s58A

PATIENTS WITH CAPACITY		
<p>Adult with capacity consents to ECT</p> <p>(Section 2 patients and those on treatment orders)</p>	<p>Adults detained under section 2 or for treatment who have capacity to make their own decision and consent to having ECT</p>	<p>Approved clinician in charge of the treatment or a SOAD must complete the statutory consent form.</p>
<p>Child with capacity consents to ECT</p> <p>(Section 2 patients, those on treatment orders and informal patients)</p>	<p>Children, other than those subject to a CTO, including children who are informal patients, who have capacity to make their own decision and consent to having ECT</p>	<p>SOAD certifies their consent and also that ECT is appropriate</p>
<p>Adult or child with capacity refuses consent</p> <p>(Section 2 patients and those on treatment orders and, in the case of children, informal patients)</p>	<p>Adults detained under section 2 or for treatment who have capacity but who refuse to consent to ECT</p> <p>Children, other than those subject to a CTO, including children who are informal patients, who have capacity but who refuse to consent to ECT</p>	<p>ECT may not be given under s.58A</p>

ECT — Patients without capacity

s58A

PATIENTS WHO LACK CAPACITY		
<p>Adult or child on a relevant section who lacks capacity to consent to ECT</p> <p>(Section 2 patients and those on treatment orders)</p>	<p>Adults and children detained under section 2 or for treatment who are not capable of understanding the nature, purpose and likely effects of ECT</p>	<p>SOAD certifies that patient is not capable, that ECT is appropriate, and that it would not conflict with a valid advance decision, or a decision made by a donee or deputy.</p>
<p>Child who is an informal patient lacks capacity to consent to ECT</p>	<p>Children who are not detained under section 2 or for treatment, or subject to a CTO, and are not capable of understanding the nature, purpose and likely effects of ECT</p>	<p>SOAD certifies that patient is not capable and that ECT is appropriate and, in addition, there is authority to give the treatment to an informal child patient, e.g. parental consent.</p>

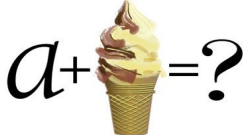


Urgent ECT (Section 62)

YES	NO
If immediately necessary to save the patient's life.	If (not being irreversible or hazardous) is immediately necessary to alleviate serious suffering by the patient.
If (not being irreversible) is immediately necessary to prevent a serious deterioration of his condition.	If (not being irreversible or hazardous) is immediately necessary and represents the minimum interference necessary to prevent the patient from behaving violently or being a danger to himself or to others.

Example

- John Smith is detained under section 2. He is capable of understanding the nature, purpose and likely effects of ECT, and refuses it.
- He may not be given ECT unless s.62 applies.
- Jane Smith is detained under section 3. She is not capable of understanding the nature, purpose and likely effects of ECT. Before she was detained, and when she still had capacity, she made an advance decision refusing ECT.
- She may not be given ECT unless s.62 applies.
- Jack Smith is aged 17 and detained under section 2. He is capable of understanding the nature, purpose and likely effects of ECT, and consents to having it.
- A SOAD visit is required.



SUPERVISED COMMUNITY TREATMENT

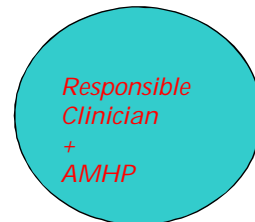
Introduction

- The supervision application ('supervised discharge') provisions are repealed. It will not be possible to make a supervision application from 3 November 2008 onwards.
- In their place is a 'Supervised Community Treatment' order.
- Following discharge into the community, the scheme is similar to that of conditional discharge under a restriction order, with the responsible clinician taking the role of the Minister of Justice.
- The original section 3 application/section 37 order remains in existence, and does not require renewal, while the patient remains subject to the CTO. If the CTO is revoked then the patient is again liable to detention under the original section 3 application/section 37 order.

Who makes the order?

17A(4) The **responsible clinician** may not make a community treatment order unless—

- (a) in her/his opinion, the relevant criteria are met; and
- (b) an **approved mental health professional** states in writing—
 - (i) that s/he agrees with that opinion; and
 - (ii) that it is appropriate to make the order.



The criteria

- (5) The relevant criteria are—
- (a) the patient is suffering from mental disorder of a nature or degree which makes it appropriate for him to receive medical treatment;
 - (b) it is necessary for his health or safety or for the protection of other persons that he should receive such treatment;
 - (c) subject to his being liable to be recalled as mentioned in paragraph (d) below, such treatment can be provided without his continuing to be detained in a hospital;
 - (d) it is necessary that the responsible clinician should be able to exercise the power under section 17E(1) below to recall the patient to hospital; and
 - (e) appropriate medical treatment is available for him.

The notice of recall

- 25.55 The responsible clinician must complete a written notice of recall to hospital, which is effective only when served on the patient ...
- 25.56 Once the recall notice has been served, the patient can, if necessary, be treated as absent without leave, and taken and conveyed to hospital ... The time at which the notice is deemed to be served will vary according to the method of delivery.
- 25.57 It will not usually be appropriate to post a notice of recall to the patient ... First class post should be used. The notice is deemed to be served on the second working day after posting, and it will be important to allow sufficient time for the patient to receive the notice before any action is taken to ensure compliance.
- 25.58 ... if the patient is unavailable or simply refuses to accept the notice ... the notice should be delivered by hand to the patient's usual or last known address. The notice is then deemed to be served (even though it may not actually be received by the patient) on the day after it is delivered – that is, the day (which does not have to be a working day) beginning immediately after midnight following delivery.

The effect of recall

MAXIMUM DETENTION PERIOD OF 72 HOURS

- "When the patient arrives at hospital after recall, the clinical team will need to assess the patient's condition, provide the necessary treatment and determine the next steps. A recalled patient may be transferred to another hospital" (Code, Para. 25.63).
- The patient must be released after 72 hours if by then s/he has not been released and nor has the community treatment order has been revoked.

EXAMINATION AND REVOCATION OF THE CTO

- Where a community patient has been recalled, the RC may revoke the community treatment order if s/he is of the opinion that the section 3 conditions are satisfied and an AMHP agrees with that opinion and that it is appropriate to revoke the order.

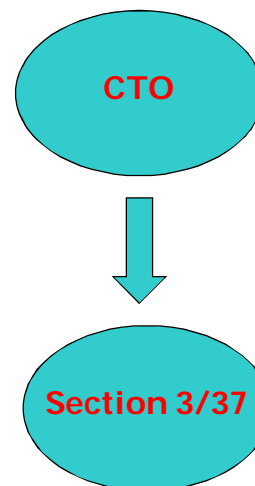
Treatment during the recall period

24.28 In general, SCT patients recalled to hospital are subject to sections 58 and 58A in the same way as other detained patients. But there are three exceptions ...:

- a certificate under section 58 is not needed for medication if less than one month has passed since the patient was discharged from hospital and became an SCT patient;
- a certificate is not needed under either section 58 or 58A if the treatment in question is already explicitly authorised for administration on recall on the patient's Part 4A certificate; and
- treatment that was already being given on the basis of a Part 4A certificate may be continued, even though it is not authorised for administration on recall, if the approved clinician in charge of the treatment considers that discontinuing it would cause the patient serious suffering. But it may only be continued pending compliance with section 58 or 58A (as applicable) — in other words while steps are taken to obtain a new certificate.

Revoking the CTO

- "If the patient requires in-patient treatment for longer than 72 hours after arrival at the hospital, the responsible clinician should consider revoking the CTO. The effect of revoking the CTO is that the patient will again be detained under the powers of the Act" (Code, Para. 25.65).
- The effect of revoking the CTO is that the managers have the same power to detain the patient under s.6(2) of the 1983 Act as if s/he had never been discharged; and for section 20 renewal purposes the patient is deemed to have been admitted under section 3 on the day that the order is revoked.



Discharge and tribunals

- CTO patients may be discharged in the same way as detained patients, by the tribunal, the hospital managers, or for Part 2 patients the nearest relative (subject to the dangerousness ground).
- The responsible clinician may also discharge a CTO patient at any time and must do so if the patient no longer meets the criteria for a CTO.

TRIBUNAL REFERENCES FOLLOWING REVOCATION OF CTO

- Where a community treatment order is revoked, the hospital managers must refer the patient's case to a Mental Health Review Tribunal as soon as possible after the order is revoked.



Mental Health Act Commission
Subsidiary to the Director of all people
detained under the Mental Health Act 1983



MHAC's remit

- (a) to visit and interview in private patients detained under this Act in hospitals and registered establishments **and community patients** in hospitals and establishments of any description and (if access is granted) other places; and
- (b) to investigate—
- (i) any complaint made by a person in respect of a matter that occurred while he was detained under this Act in, **or recalled under section 17E** above to, a hospital or registered establishment and which he considers has not been satisfactorily dealt with by the managers of that hospital or registered establishment; and
- (ii) any other complaint as to the exercise of the powers or the discharge of the duties conferred or imposed by this Act in respect of a person who is or has been so detained **or is or has been a community patient.**

Treatment on the CTO

TREATMENT REQUIRES

SOAD CERTIFICATE

1. *If s.58-type treatment*
2. *SOAD certifies treatment is appropriate*
3. *(certificate required one month after CTO was made in the case of medication)*

AUTHORITY TO GIVE IT

- (1) *the patient has capacity and consents to it;*
- (2) *An LPA donee or a Court of Protection deputy has consented to it;*
- (3) *Giving the treatment is authorised under section 64D [or 64G]*

Consent

- For **section 58 treatments**, a **SOAD certificate** stating that it is **appropriate** to give the treatment is required, although in the case of medication only after one month has elapsed since the CTO was made.
- **Treatment also requires** that the treatment is authorised in one of three ways:
 - (1) the patient has capacity and consents to it;
 - (2) An LPA donee or a Court of Protection deputy has consented to it;
 - (3) Giving the treatment is authorised under section 64D [or 64G].

Alternative forms of authority

- **A. THE TREATMENT WAS GIVEN WITH THE PATIENT'S CONSENT**
- THE PATIENT HAD **CAPACITY TO CONSENT** TO THE TREATMENT, OR IF AGED UNDER 16 WAS COMPETENT TO CONSENT TO IT, AND CONSENTED TO IT.
- **B. THE TREATMENT WAS GIVEN WITH THE CONSENT OF THE COURT OF PROTECTION OR A PERSON AUTHORISED TO CONSENT TO IT UNDER THIS ACT AND THE MENTAL CAPACITY ACT 2005**
- [IN THE CASE OF A PATIENT AGED 16 OR OVER ONLY,] A **DONEE OF A LASTING POWER OF ATTORNEY OR A DEPUTY OR THE COURT OF PROTECTION** CONSENTED TO THE TREATMENT ON THE PATIENT'S BEHALF.

Alternative forms of authority

- **C. THE TREATMENT WAS AUTHORISED UNDER SECTION 64D OR 64F**
 - THE TREATMENT WAS GIVEN BY THE APPROVED CLINICIAN IN CHARGE OF THE TREATMENT OR UNDER THAT PERSON'S DIRECTION.
 - BEFORE GIVING THE TREATMENT, THAT CLINICIAN TOOK REASONABLE STEPS TO ESTABLISH WHETHER THE PATIENT LACKED CAPACITY TO CONSENT TO THE TREATMENT OR, IF THE PATIENT WAS AGED UNDER 16, WHETHER S/HE WAS COMPETENT TO CONSENT TO THE TREATMENT.
 - WHEN GIVING THE TREATMENT, THAT **CLINICIAN REASONABLY BELIEVED THAT THE PATIENT LACKED CAPACITY TO CONSENT TO IT OR, IF THE PATIENT WAS AGED UNDER 16, REASONABLY BELIEVED THAT S/HE WAS NOT COMPETENT TO CONSENT TO IT.**
 - **[IN THE CASE OF A PATIENT AGED 18 OR OVER ONLY] THE TREATMENT DID NOT CONFLICT WITH AN ADVANCE DECISION WHICH S/HE WAS SATISFIED WAS VALID AND APPLICABLE, OR WITH A DECISION MADE BY A DONEE OR DEPUTY OR THE COURT OF PROTECTION.**
- AND EITHER**
- THAT CLINICIAN HAD NO REASON TO BELIEVE THAT THE PATIENT OBJECTED TO BEING GIVEN THE TREATMENT;
 - OR
 - IF S/HE HAD REASON TO BELIEVE THAT THE PATIENT OBJECTED TO BEING GIVEN IT, IT WAS NOT NECESSARY TO USE FORCE AGAINST THE PATIENT IN ORDER TO GIVE IT.

CTO or section 17 Leave?

SCT or longer-term leave of absence: relevant factors to consider

Factors suggesting longer-term leave	Factors suggesting SCT
<ul style="list-style-type: none"> Discharge from hospital is for a specific purpose or a fixed period. The patient's discharge from hospital is deliberately on a "trial" basis. The patient is likely to need further in-patient treatment without their consent or compliance. There is a serious risk of arrangements in the community breaking down or being unsatisfactory – more so than for SCT. 	<ul style="list-style-type: none"> There is confidence that the patient is ready for discharge from hospital on an indefinite basis. There are good reasons to expect that the patient will not need to be detained for the treatment they need to be given. The patient appears prepared to consent or comply with the treatment they need – but risks as below mean that recall may be necessary. The risk of arrangements in the community breaking down, or of the patient needing to be recalled to hospital for treatment, is sufficiently serious to justify SCT, but not to the extent that it is very likely to happen.



CTO or guardianship?

SCT or guardianship: relevant factors to consider

Factors suggesting guardianship	Factors suggesting SCT
<ul style="list-style-type: none"> The focus is on the patient's general welfare, rather than specifically on medical treatment. There is little risk of the patient needing to be admitted compulsorily and quickly to hospital. There is a need for enforceable power to require the patient to reside at a particular place. 	<ul style="list-style-type: none"> The main focus is on ensuring that the patient continues to receive necessary medical treatment for mental disorder, without having to be detained again. Compulsory recall may well be necessary, and speed is likely to be important.



OTHER MHA 2007 ACT CHANGES

Children and young people

- A patient aged 16 or 17 who has capacity to consent and does not consent to admission to hospital cannot be admitted on the basis of parental consent (In force).
- Need to ensure environment is suitable having regard to his age (subject to his needs) and consult a CAMHS specialist about the fulfilment of this duty (From April 2010).



Independent Mental Health Advocates

- From April 2009 there will be advocacy services for patients subject to community treatment orders, guardianship or detention (except those held under sections 4, 5, 135 or 136).
- There will be a duty upon service providers to provide qualifying patients with information that advocacy services are available.
- Advocates will have an unfettered right to meet with patients in private, and to meet with professionals.
- They will have access to patient records where a capable patient gives consent. For incapable patients new rules to govern access.

THE CODE OF PRACTICE

Code of Practice

- s.118—The Secretary of State shall prepare, and from time to time revise, a code of practice ... for the guidance of ...
- (2A) The code shall include a statement of the principles which the Secretary of State thinks should inform decisions under this Act.
- (2D) In performing functions under this Act [mental health professionals, hospital managers and staff] shall have regard to the code.



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 wellbeing (mental and physical) of patients, promoting their recovery and protecting other people from harm.



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.



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. There must be no unlawful discrimination.



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.

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 achieve the purpose for which the decision was taken.

Using the principles

- All decisions must, of course, be lawful and informed by good professional practice. Lawfulness necessarily includes compliance with the Human Rights Act 1998.
- The principles inform decisions, they do not determine them. Although all the principles must inform every decision made under the Act, the weight given to each principle in reaching a particular decision will depend on the context.
- That is not to say that in making a decision any of the principles should be disregarded. It is rather that the principles as a whole need to be balanced in different ways according to the particular circumstances of each individual decision.

NEW REGULATORY BODY



Care Quality Commission

The Health & Social Care Act 2008 provides for the merger of the three health and adult social care regulatory bodies:

- Healthcare Commission (i.e., the Commission for Healthcare, Audit and Inspection)
- Commission for Social Care Inspection
- Mental Health Act Commission

The new, single, regulator for health and adult social care will be known as the Care Quality Commission.

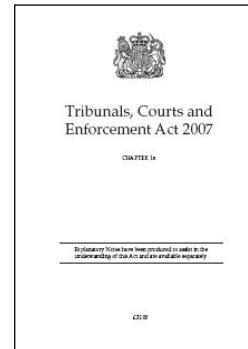
The Care Quality Commission will begin operating in April 2009.

TRIBUNALS ACT 2007

The new tribunal structure

The Tribunals, Courts and Enforcement Act 2007 creates two new tribunals:

- The First-tier Tribunal; and
- The Upper Tribunal



Chambers

- The Tribunals Act 2007 provides for the establishment of 'chambers' within the two tribunals.
- The MHRT will join the Health Education and Social Care chamber (HESC).
- A Chamber President will head each chamber.



Consequences

- The MHRT is abolished.
- Consequently, there will no longer be a separate set of MHRT Rules.
- 'MHRT' procedures will be set out in the new HESC chamber Rules, and be supplemented by Practice Directions.



Clinician's report (1)

The statement provided to the tribunal shall include an up-to-date medical report prepared for the tribunal.

(1) Unless it is not reasonably practicable, the report must be written or counter-signed by the patient's responsible clinician.

(2) This report shall include the patient's relevant medical history, to include:

(a) full details of the patient's mental state, behaviour and treatment for mental disorder;

(b) Insofar as it is within the knowledge of the person writing the report, a statement as to whether the patient has ever neglected or harmed himself, or has ever harmed other persons or threatened them with harm, at a time when he was mentally disordered, together with details of any neglect, harm or threats of harm;

Clinician's report (1)

Continued ...

(c) an assessment of the extent to which the patient or other persons would be likely to be at risk if the patient is discharged by the tribunal, and how any such risks could best be managed;

(d) an assessment of the patient's strengths and any other positive factors that the tribunal should be aware of in coming to a balanced view on whether he should be discharged;

(e) If appropriate, the reasons why the patient might be treated in the community without continued detention in hospital, but needs to remain subject to recall on SCT.

In-Patient Nursing Report

(1) This report shall include full details of:

(a) the patient's compliance with treatment;

(b) the level of observation to which the patient is subject;

(c) any occasions on which the patient has been secluded or restrained, including the reasons why seclusion or restraint was considered to be necessary;

(d) any occasions on which the patient has been absent without leave (including occasions when he failed to return when required after being granted leave of absence);

(e) any incidents where the patient has harmed himself or others, or has threatened other persons with violence.

(2) A copy of the patient's current nursing plan shall be appended to the report.

Social circumstances report

DRAFT

- (1) The statement provided to the tribunal shall include an up-to-date social circumstances report prepared for the tribunal.
- (2) This report shall include the following information:
 - (a) the patient's home and family circumstances;
 - (b) A consideration of the views of the patient's nearest relative, or the person so acting. The patient's wishes must always be ascertained prior to a consideration of whether the nearest relative needs to be consulted;
 - (c) the views of any person who plays a substantial part in the care of the patient but is not professionally concerned with it;
 - (d) the views of the patient, including his concerns, hopes and beliefs in relation to the tribunal;

Social circumstances report

DRAFT

- (e) the continuing opportunities for employment, or for occupation and the housing facilities available to the patient;
- (f) the effectiveness of the community support that is currently available to the patient and would continue to be available to the patient if discharged from hospital;
- (g) the patient's financial circumstances (including his entitlement to benefits);
- (h) an assessment of the patient's strengths and any other positive factors that the tribunal should be aware of in coming to a balanced view on whether he should be discharged;
- (i) a risk assessment.