Brief Workbook to Support Implementation of the Mental Health Act 2007
Dear Colleague,

The Mental Health Act is changing. In preparation, I am pleased to introduce you to this workbook which NIMHE has prepared to describe the key changes. The workbook is part of a range of training materials and resources that are well informed by the revised code of practice and look in detail at the new guiding principles in a modern, recovery oriented context.

The training resources include some powerful materials developed by service users and carers which vividly portray personal experience of compulsion. I am particularly grateful for this part of the work, which brings alive the spirit of the Act, alongside an equally important understanding of what the law now says, and why it does so.

The workbook is also available in an e-learning format which can be accessed via the NIMHE website.

I encourage you to take time to look at this workbook in light of the significant changes which are being introduced. This is an important opportunity for professionals to continue to raise standards in delivering the best possible care we can to service users, their families and to serve the whole community well as providers of confident, competent mental health services.

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

The workbook gives an overview of the key changes brought about by the 2007 Mental Health Act and then explores each change in greater detail. The design of the workbook enables both trainers and participants to undertake the workbook individually or in groups working together.

This workbook is designed for those who may only want a brief overview of the changes, for example service users, carers and those in support services. It is also available in an e-learning format which can be accessed via the NIMHE website (www.nimhe.csip.org.uk/).

It is hoped that this workbook will enable participants to be in more of a position to understand the changes contained in the Mental Health Act 2007. It is also hoped that those participants who work in support services will be better equipped to meet the needs of those requiring the support of mental health services, particularly when compulsory treatment is involved or being considered.

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

Malcolm King
National Implementation Lead
The Training Team

<table>
<thead>
<tr>
<th>CONTENTS</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>THE MENTAL HEALTH ACT 2007 BRIEF WORKBOOK</td>
<td></td>
</tr>
<tr>
<td>Background</td>
<td>1</td>
</tr>
<tr>
<td>FOUNDATION MODULE</td>
<td></td>
</tr>
<tr>
<td>Introduction to Module</td>
<td>7</td>
</tr>
<tr>
<td>Learning Outcomes</td>
<td>7</td>
</tr>
<tr>
<td>Activity 1 – Step 1: Coming into Compulsion</td>
<td>14</td>
</tr>
<tr>
<td>Activity 2 – Step 2: Making Decision</td>
<td>18</td>
</tr>
<tr>
<td>Activity 3 – Step 3: Supervised Community Treatment</td>
<td>20</td>
</tr>
<tr>
<td>Activity 4 – Step 4: Ending Compulsion</td>
<td>22</td>
</tr>
<tr>
<td>Activity 5 – What do you mean by values?</td>
<td>27</td>
</tr>
<tr>
<td>Activity 6 – Scenario: Rosemary</td>
<td>31</td>
</tr>
<tr>
<td>Activity 7 – Scenario: Carol (1)</td>
<td>32</td>
</tr>
<tr>
<td>PRINCIPLES MODULE</td>
<td></td>
</tr>
<tr>
<td>Introduction to the Module</td>
<td>35</td>
</tr>
<tr>
<td>Learning Outcomes</td>
<td>36</td>
</tr>
<tr>
<td>Activity 1</td>
<td>40</td>
</tr>
<tr>
<td>Activity 2 – Scenario: Andrew</td>
<td>41</td>
</tr>
<tr>
<td>Activity 3 – Scenario: Carol (2)</td>
<td>44</td>
</tr>
<tr>
<td>Activity 4 – Scenario: Raj</td>
<td>46</td>
</tr>
<tr>
<td>Activity 5 – Scenario: Diana</td>
<td>47</td>
</tr>
<tr>
<td>Activity 6 – Scenario: Eddie</td>
<td>49</td>
</tr>
<tr>
<td>WEBSITE LINKS</td>
<td>51</td>
</tr>
<tr>
<td>CONTRIBUTORS &amp; ACKNOWLEDGEMENTS</td>
<td>53</td>
</tr>
<tr>
<td>APPENDIX 1: COMMENTS ON SCENARIO</td>
<td>55</td>
</tr>
<tr>
<td>GLOSSARY</td>
<td>57</td>
</tr>
</tbody>
</table>
THE MENTAL HEALTH ACT 2007 BRIEF WORKBOOK

BACKGROUND

The legislation governing the compulsory assessment and treatment of certain people who have a mental disorder is the Mental Health Act 1983, and the Mental Health Act 2007 (MHA – please see box below) brings in certain amendments to the previous legislation. It is also being used to introduce “deprivation of liberty safeguards” through amending the Mental Capacity Act 2005 (MCA), and to extend the rights of victims by amending the Domestic Violence, Crime and Victims Act 2004.

The MHA is largely concerned with the circumstances in which a person with a mental disorder can be detained for assessment or treatment for that disorder without his or her consent. It also sets out the processes that must be followed and the safeguards for patients to ensure they are not inappropriately detained or treated without their consent. The main purpose of the legislation is to ensure that people with serious mental disorders that threaten their health or safety or the safety of other people can be treated irrespective of their consent where it is necessary to prevent them from harming themselves or others.

Please note that throughout this workbook the following definitions and terminologies are used:

MHA – means the Mental Health Act 1983 as amended by the Mental Health Act 2007 (occasional reference is made to the existing MHA and this refers to the Mental Health Act 1983. Also “the Act” is used when direct quotes from the COP or the MHA are included).

COP – means the Code of Practice to the MHA (the “Code” is used when direct quotes from the COP or the MHA are included).

Reference Guide – means the Reference Guide to the MHA which accompanies the COP.

Patient – means a service user, client or customer of mental health services. The MHA and COP both use this term, and for consistency this workbook will do the same.
The MHA was given Royal Assent in July 2007, and the timetable for implementation of the majority of changes brought about by the new legislation is 3rd November 2008. In order to achieve MHA implementation readiness service providers are required to have wide-ranging training provisions in place in advance of 3rd November 2008, and beyond the date to support implementation.

The Department of Health has tasked the Care Services Improvement Partnership and the National Institute for Mental Health in England (CSIP/NIMHE) to have a key role in:

- informing those involved in mental health care of the proposed changes and the impact they may have.
- supporting implementation by service providers, both directly and by signposting other sources of information.
- providing opportunities to influence national policy.

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

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

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

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

The objectives of the Training Support Programme are to:

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

**Training Materials**

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

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

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

**Who is this Workbook for?**

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

In this sense, it is important to recognise that it is not guidance and should not be used to inform legal decision-making.
“Mental health staff” refers to all those who have no statutory legislative function under the MHA, yet by virtue of their work need to be aware of its implications. This group consists of a wide range of disciplines within health, social work, voluntary and independent sectors. It also includes those working in organisations that have a close link with mental health services e.g. housing departments

Content of Workbook

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

Although the exercises are optional and can be adapted by trainers to meet the needs of participants, undertaking them will help reinforce the learning experience.

Working Alone or in a Group?

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

"Mental health staff" refers to all those who have no statutory legislative function under the MHA, yet by virtue of their work need to be aware of its implications. This group consists of a wide range of disciplines within health, social work, voluntary and independent sectors. It also includes those working in organisations that have a close link with mental health services e.g. housing departments

Content of Workbook

The content of the paper-based material is also on the web with minor differences in the location of information in the paper format

The workbook contains two colour-coded modules: one that provides an overview of MHA changes (Foundation Module), and one that covers the Guiding Principles. The Guiding Principles training materials have been developed with support and input from many individuals and groups representing both patient and service provider perspectives (see Contributors and Acknowledgements at the end of this workbook).

Workbook Objectives

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

• provide a learning experience – primarily to professionals with roles and responsibilities in relation to the MHA – but also to help others (such as patients and carers who may also access learning opportunities and resources) understand the changes underlying the operation of the MHA.
• provide learners with the opportunity to work through a number of case examples and optional exercises to help understand the implications of the MHA.
• provide learners the opportunity of understanding the principles of the COP and the effect these will have on mental health practice within a values-based framework.

How to use the Workbook

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

• An introduction to the module
• Preparation
• Learning Outcomes
• Topic text with activities, questions and reflections
• Scenarios with questions and suggested discussion points
• Self assessment questions
INTRODUCTION TO THE MODULE

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

In brief, the MHA:

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

This module, therefore, as well as increasing your knowledge of the various areas outlined above, should also equip you with the tools you need to undertake the other modules. For example, there is no point looking at the module relating to Supervised Community Treatment unless you know how, with whom and when to consider using such powers.

As you work through this module, you will find that, as well as reading the text you are asked to undertake various activities. The activities are designed to help you develop your understanding of the areas under discussion and to think about how the MHA will impact on you. The activities include looking at various scenarios, either described in the text or gained from your own experiences.

LEARNING OUTCOMES

On completion of this study you should be able to:

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

Introducing the Nine Key Changes

The Nine Key Changes in the MHA are concerned with:

- **Key Change 1**: Introducing a Simplified Single Definition of Mental Disorder.
- **Key Change 2**: Abolishing the Treatability Test and introducing a new Appropriate Medical Treatment Test.
- **Key Change 3**: Ensuring that Age Appropriate Services are available to any patients admitted to hospital who are aged under 18 (anticipated by 2010).
- **Key Change 4**: Broadening the Professional Groups that can take particular roles.
- **Key Change 5**: Introducing the right for patients to apply to court to displace their Nearest Relative.
- **Key Change 6**: Ensuring that patients have a right to an Advocacy Service when under compulsion (implemented in 2009).
- **Key Change 7**: Introducing new safeguards regarding Patients and Electro-Convulsive Therapy.
- **Key Change 8**: Introducing a new provision to allow Supervised Community Treatment. This allows a patient detained on a treatment order to receive their treatment in the community rather than as an in-patient.
- **Key Change 9**: Making provision for earlier automatic referral to a Mental Health Review Tribunal (Tribunal) where patients don’t apply themselves.

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

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

The Key Changes as Steps in a Pathway through Compulsion

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

1. **Step 1 – Coming Into Compulsion**
2. **Step 2 – Making Decisions**
3. **Step 3 – Supervised Community Treatment**
4. **Step 4 – Ending Compulsion**

Step 1 – Coming Into Compulsion

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

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

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

- **Key Change 3**: Age Appropriate Services
  When a young person (under 18) is admitted to hospital for a mental disorder, it is important they are treated in an environment suitable for their age and needs. It is hoped such services will be in place for 2010.
Step 2 – Making Decisions
Once a person has been admitted, the MHA makes four key changes as to who can be involved in making decisions concerning that person’s detention. These changes concern:

Key Change 4: Professional Groups
The MHA broadens the range of professionals who are able to take on particular roles and responsibilities in deciding whether someone should come into hospital compulsorily, and then in managing their treatment and care. Thus, the Approved Social Worker (ASW) in the existing Mental Health Act had to be a social worker, but under the MHA the ASW is replaced by an Approved Mental Health Professional (AMHP) who could be, for example, a nurse, psychologist or occupational therapist as well as a social worker. Similarly, the Responsible Medical Officer for a patient in the existing Mental Health Act always had to be a doctor; but in the MHA the corresponding role of Responsible Clinician could also be taken by a psychologist, nurse, occupational therapist or social worker.

Key Change 5: Nearest Relative
People subject to compulsion under the MHA have a “Nearest Relative” who has certain powers and responsibilities. For example, the Nearest Relative (NR) can ask for assessment, and in some cases prevent hospital admission. The MHA now gives the patient more say in who that person can be by allowing them to go to court themselves to ask that their NR be displaced in favour of someone else of the patient’s choice.

Key Change 6: The Independent Mental Health Advocacy Service
From an anticipated start date of April 2009, there will be a duty upon the Secretary of State to provide advocacy services for all detained patients (except those under holding sections 4, 5, 135 or 136), Guardianship patients and patients subject to Community Treatment Orders. Service providers also have a duty to provide qualifying patients with information that advocacy services are available.

Key Change 7: Patients and Electro-Convulsive Therapy
There are now greater protections available to people detained under the MHA concerning whether or not they should receive electro-convulsive therapy (ECT). If a detained patient has capacity, then – except in emergencies - they can decide whether or not they wish to have ECT. A detained patient with a valid advance decision opposed to being given ECT cannot be treated by it, except in an emergency. Also, unless it is an emergency, no under 18 (whether or not detained) can be given ECT without the approval of a second opinion approved doctor (SOAD).

Step 3 – Supervised Community Treatment
The MHA makes another change as to where a detained person can be treated. This involves:

Key Change 8: Supervised Community Treatment (SCT)
After a person has been detained in hospital for treatment, the MHA will now make it possible in appropriate circumstances for some patients to continue to receive their care and treatment in the community while still under compulsion. SCT patients cannot be forced to have treatment in the community but may be recalled to a hospital (or to a clinical setting which is part of that hospital) if they need to receive the treatment they are refusing and without which there would be a risk to themselves or other people.

Step 4 – Ending Compulsion
Finally, the MHA makes some changes to how a period of compulsion can be brought to an end. Specifically:

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

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

Understanding what the Key Changes mean to you
In this part of the module, you are going to work through the changes in the MHA.

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

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

<table>
<thead>
<tr>
<th>COMMON MYTH – THE MHA</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>MYTH</strong></td>
</tr>
<tr>
<td>The Mental Health Act 2007 (MHA) replaces the Mental Health Act 1983 (existing MHA)</td>
</tr>
</tbody>
</table>
THE AMENDMENTS IN DETAIL

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

STEP 1 – COMING INTO COMPULSION

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

Details Box 1. Single Definition of Mental Disorder

**Definition of Mental Disorder:**
For sections of the MHA that apply to assessment under compulsion, the wording of the definition of mental disorder is very similar to that used under the existing Mental Health Act. It changes from “mental illness, arrested or incomplete development of mind, psychopathic disorder and any other disability or disorder of mind” to “any disorder or disability of the mind”.

However, this simplified definition now applies to all sections of the Act. The four forms of mental disorder (mental illness, mental impairment, severe mental impairment and psychopathic disorder) have disappeared. This potentially means some people previously excluded from treatment are now included. For example, there may be some people with an acquired brain injury who were not covered by the term “mental impairment or severe mental impairment” who could now benefit from the protections of the Act.

The **Learning Disability Qualification** has been introduced to preserve the status quo (e.g. under section 3, a person with a learning disability alone can only be detained for treatment or be made subject to Guardianship if that learning disability is associated with abnormally aggressive or seriously irresponsible conduct) and now applies to all those sections that relate to longer-term compulsory treatment or care for a mental disorder (in particular s3, s7 (Guardianship), s17A (Supervised Community Treatment) and forensic sections under Part 3 of the Act). It means that if the use of longer-terms forms of compulsion are being considered solely on the basis that a person has a learning disability, that disability must also be associated with abnormally aggressive or seriously irresponsible conduct. This does not, of course, preclude the use of compulsion for people who have another form of mental disorder (such as a mental illness) in addition to their learning disability.

Details Box 2. Appropriate Medical Treatment

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

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

Details Box 3. Age Appropriate Services

**Admitting young people to suitable environments**
The effect of this change is that hospital managers are placed under a duty to ensure patients under 18 who are admitted to hospital for assessment or for treatment under the legislation, or who are voluntary patients are (subject to their needs) in an environment that is suitable for their age. There is flexibility in the amendment to allow for patients under 18 years to be placed on adult psychiatric wards where the patient’s needs are better met this way. This is expected to come into force in 2010, by which time it is hoped new services will be available. Section 140 of the existing Mental Health Act has also been amended to put a duty on Primary Care Trusts to let Local Social Service Authorities know where services that can admit young people in an emergency are to be found.
ACTIVITY 1 – STEP 1: COMING INTO COMPULSION

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

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

Activity Box 1. Step 1: Coming into compulsion

Summary of my example

Existing MHA

MHA

Would it make a difference?

Would it help?

Challenges and Opportunities?

STEP 2 – MAKING DECISIONS

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

Details Box 4. Broadening Professional Roles

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

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

- **The Approved Clinician (AC), the professional status a practitioner must obtain before they can become a Responsible Clinician (RC).**

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

The RC is the old Responsible Medical Officer role which has now been opened up to include social workers, mental health and learning disability nurses, clinical psychologists and occupational therapists as well as social workers. AMHPs will assess “on behalf” of Local Authorities, who will continue to be responsible for approving AMHPs and for ensuring a 24hr AMHP service is available.

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

Details Box 5. Nearest Relative (NR)

Changes give patients the right to make an application to court to displace their nearest relative and introduces a new ground for displacement: that the current NR is “otherwise unsuitable for the role”. The provisions for determining who is the NR have also been amended to include civil partners on equal terms with a husband or wife.
Details Box 6. Advocates

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

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

Details Box 7. Patients and Electro-Convulsive Therapy

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

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

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

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

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

What is an emergency? (COP, 24.33)

It is an emergency if the treatment in question is immediately necessary to:
- save the patient’s life.
- prevent a serious deterioration of the patient’s condition (and the treatment does not have unfavourable physical or psychological consequences which cannot be reversed).
ACTIVITY 2 – STEP 2: MAKING DECISIONS

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

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

Activity Box 2. Step 2: Making Decisions

<table>
<thead>
<tr>
<th>Summary of my example</th>
</tr>
</thead>
<tbody>
<tr>
<td>Existing MHA</td>
</tr>
<tr>
<td>MHA Would it make a difference?</td>
</tr>
<tr>
<td>Would it help?</td>
</tr>
<tr>
<td>Challenges and Opportunities?</td>
</tr>
</tbody>
</table>

STEP 3 – SUPERVISED COMMUNITY TREATMENT

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

Details Box 8. Supervised Community Treatment (SCT)

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

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

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

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

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

The criteria for consideration of the use of SCT include:

- the person is suffering from a mental disorder,
- the need for medical treatment,
- the existence of a risk to the patient’s health or safety or that of others,
- that appropriate treatment is available; and that the patient does not need to be in hospital to receive it but does need to be liable to recall to hospital to ensure that the risk can be managed, and
- that it is necessary for the patient’s health or safety or the protection of others that the patient remains liable to recall.
The change in Step 4 is described in Details Box 9.

Details Box 9. Mental Health Review Tribunals

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

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

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

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

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

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

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

ACTIVITY 3 – STEP 3: SUPERVISED COMMUNITY TREATMENT

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

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

Activity Box 3. Step 3: Supervised Community Treatment

Summary of my example

Existing MHA

MHA

Would it make a difference?

Would it help?

Challenges and Opportunities?
THE NINE KEY CHANGES AND BEST PRACTICE

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

This can be summarised as follows:

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

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

So why are the principles needed?

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

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

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

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

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

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

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

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

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

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

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

The Guiding Principles as a Framework of Values

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

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

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

**ACTIVITY 5 – WHAT DO YOU MEAN BY VALUES?**

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

Activity Box 5. What do you mean by values?
This exercise usually shows just what different things different people do mean by ‘values’. You will probably have found that everyone in your group came up with a different set of three words that means ‘values’ to them. However, most groups also find that when they talk through their different lists, there is a common thread, on the lines that values mean things that are important to us, in a positive or negative way, and that guide our actions.

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

**Values-Based Practice and Evidence-Based Practice**

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

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

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

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

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**The Guiding Principles in the new COP**

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

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

| Purpose | Decisions under the Act must be taken with a view to minimising the undesirable effects of mental disorder, by maximising the safety and well-being (mental and physical) of patients, promoting their recovery and protecting other people from harm. |
| Least restriction | People taking action without a patient’s consent must attempt to keep to a minimum the restrictions they impose on the patient’s liberty, having regard to the purpose for which the restrictions are imposed. |
| Respect | People taking decisions under the Act must respect the diverse needs, values and circumstances of each patient, including their race, religion, culture, gender, age, sexual orientation and any disability. They must consider the patient’s views, wishes and feelings (whether expressed at the time or in advance), so far as they are reasonably ascertainable, and follow those wishes wherever practicable and consistent with the purpose of the decision. There must be no unlawful discrimination. |
| Participation | Patients must be given the opportunity to be involved, as far as is practicable in the circumstances, in planning, developing and reviewing their own treatment and care to help ensure that it is delivered in a way that is as appropriate and effective for them as possible. The involvement of carers, family members and other people who have an interest in the patient’s welfare should be encouraged (unless there are particular reasons to the contrary) and their views taken seriously. |
| Effectiveness, efficiency and equity | People taking decisions under the Act must seek to use the resources available to them and to patients in the most effective, efficient and equitable way, to meet the needs of patients and achieve the purpose for which the decision was taken. |
Balancing Different Values

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

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

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

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

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

Figure 1. Framework of Principle

PUTTING IT ALL TOGETHER

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

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

ACTIVITY 6 – SCENARIO: ROSEMARY

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

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

1. What values may be important here?

2. Consider the principles and discuss how they may apply to this situation.

DISCUSSION POINTS

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

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

- other legislation
- other policies
- other good practice guidance

End of Module

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

Further Reading


Activity 7 – Scenario: Carol (1)

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

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

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

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

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

Discussion Points

You can get comments responding to the above questions in Appendix 1, page 55

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

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

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

The principles from the COP are:

1) Purpose principle
2) Least restriction principle
3) Respect principle
4) Participation principle
5) Effectiveness, efficiency and equity principle

PREPARATION

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

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

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

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

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

Evidence-based approaches are:

“...interventions for which there is consistent scientific evidence showing that they improve client outcomes” (Drake et. al., 2001).

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

Values-based approaches are complex and in their broadest sense are associated with ethics. This could include anything that is valued by any person. Values-based approaches are based upon mutual respect and attend to the values of everyone concerned (Woodbridge and Fulford, 2004).
How do the MHA, the Code of Practice and the Guiding Principles fit together?

As shown in the previous module:

- The MHA tells us What to do
- The COP explains How to do it
- The Guiding Principles help us apply the MHA and COP in Individual Situations

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

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

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

(a) respect for patients’ past and present wishes and feelings,
(b) respect for diversity generally including, in particular, diversity of religion, culture and sexual orientation (within the meaning of section 35 of the Equality Act 2006),
(c) minimising restrictions on liberty,
(d) involvement of patients in planning, developing and delivering care and treatment appropriate to them,
(e) avoidance of unlawful discrimination,
(f) effectiveness of treatment,
(g) views of carers and other interested parties,
(h) patient wellbeing and safety, and
(i) public safety.

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

(a) the efficient use of resources, and
(b) the equitable distribution of services.

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

Guiding Principles
(Assisting the application of the Act in ‘individual situations’)

Code of Practice
(‘How to do it’)

Mental Health Act
(‘What to do’)

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

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

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

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

- 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.
ACTIVITY 1

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

THE PRINCIPLES IN DETAIL

1. Purpose principle

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

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

ACTIVITY 2 – SCENARIO: ANDREW

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

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

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

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

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

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

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

DON'T FORGET!

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

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

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

Risk management is a component of the Purpose principle and is of paramount importance and, in order that the safety of the patient and others is maintained at all times, this cannot be overlooked.
ACTIVITY 3 – SCENARIO: CAROL (2)

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

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

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

DON’T FORGET!

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

3. Respect principle

The diversity of a population has to be respected and acknowledged by others, and this is also true of mental health patients. It is unfortunate that mental health patients are often marginalised by others in society. Therefore an anti-discriminatory approach must be upheld at all times to ensure equitable and fair practice. For example, such an approach should be to the fore in any interactions with Black and Minority Ethnic (BME) patients who are disproportionately over-represented in receiving compulsory treatment.

The wishes and feelings of the patients must also be taken into account, whether offered in advance or at the time of any intervention, so far as these may be reasonably ascertained; and wishes should be respected wherever that is practicable. There must be avoidance of unlawful discrimination and a respect for diversity as stated in the Equality Act (2006).
ACTIVITY 4 – SCENARIO: RAJ

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

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

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

DON’T FORGET!

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

ACTIVITY 5 – SCENARIO: DIANA

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

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

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

4. Participation principle

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

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

DON’T FORGET!

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

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

DON’T FORGET!

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

ACTIVITY 6 – SCENARIO: EDDIE

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

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

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

1. What resources are already in place? And which other agencies need to be involved?
2. How might the agencies/teams be encouraged to work together?
3. How can it be ensured that knowledge is combined and shared?
4. How might this approach enhance the care and/or treatment of Eddie?
In conclusion, the Guiding Principles are to be used to inform the decision-making process and should be heeded by all practitioners. While some case examples have been offered here, the Guiding Principles should be considered and applied in all cases. It is also vital to remember that none of the Guiding Principles carries more weight, importance or significance than any other. The principles provide a framework of important considerations that should always be kept in mind when decisions are made under the MHA, and may also be used in general practice.

END OF MODULE

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

Further Reading

References
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The Implementation Team would like to thank all those who helped develop this workbook, particularly those involved in the consultation and piloting stages of production.
APPENDIX 1:
COMMENTS ON SCENARIO

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

FOUNDATION MODULE ACTIVITY 7 –
SCENARIO: CAROL (1)  (p32)

Question 1

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

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

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

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

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

5. Effectiveness, efficiency and equity principle
In the decision regarding how to respond to Carol’s needs, decision makers must seek to use the resources available to them and to patients in the most effective, efficient and equitable way. They must also consider other people’s perspectives on what is required.
**Question 2**

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

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