Mental Health Alliance

Community treatment orders – involvement of patient, carers and nearest relative

Page 19, line 24, at end insert –

(c) the following persons have been consulted about the making of the order under section 17A and the conditions to which the patient is subject specified under 17B -

i. the patient;
ii. the nearest relative;
iii. any carer who the responsible clinician believes will play a substantial part in the care of the patient after he leaves hospital; and
iv. any person with parental responsibility.

and any views expressed by the persons consulted under this paragraph have been taken into account.

Purpose of the amendment

This amendment ensures that a CTO cannot be made without prior consultation with the patient, nearest relative, any persons with parental responsibility and any other person involved in providing substantial care to the patient in the community. (Where a patient objects to the nearest relative being consulted, we expect that, as in section 25B of the current Act, the responsible clinician would need to respect that wish unless there are exceptional circumstances.)

Reason for amendment

In the Bill a clinician can make a Community Treatment Order (CTO) if an Approved Mental Health Professional (AMHP) agrees – but there is nothing in statute to require a clinician to consult with the patient nor with the primary carer who will be responsible for providing most of the care when the CTO is in place.

The responsible clinician and the AMHP may not have met the patient before the current admission to hospital and may not have in-depth knowledge about the patient's home life, or the needs of their carers. This could lead to assumptions made about the patient and unreasonable expectations on the carers to supervise the patient, transport them to specified meetings, police the conditions or even house the patient.

A duty to consult will help to ensure that the needs of all of those providing care for the patient are taken into account when making a CTO. It will ensure that the conditions

placed on a CTO – such as accommodation requirements – are proportionate and have the support of those implicated by them – i.e. carers living with the patient at home.

Government response

At Committee Stage in the House of Commons, a similar amendment was tabled to ensure that patients, nearest relatives and carers are consulted before a CTO is made and informed about its implications before a CTO begins. The wording of the amendment was taken from existing wording in the aftercare under supervision provisions of the 1983 Mental Health Act (these provisions are to be replaced by the supervised community treatment arrangements according to the Government's plans).

The Government responded by stating that:
"those are the very provisions that we want to repeal, because they are ineffective and have not been used. One of the reasons is that they are excessively bureaucratic […]"

" that does not mean that we regard consultation with the patient and/or parties with an interest in their care as unimportant. I believe firmly that, without proper consultation, supervised community treatment will not work, because patients will be unlikely to engage with it. […] That is obvious, but we do not think that the right approach is to put very prescriptive requirements into the Bill. Rather, we want that kind of patient and carer involvement to be seen as far as possible as routine good practice integral to the operation of the Act, an idea reinforced by the good work that we did with the Opposition on clause 10, which contains some of the issues that we expect to be part of the principles of the Bill."

Mental Health Alliance response

The Alliance is willing to accept that the mechanisms for patient and carer consultation and information in existing section 25A (aftercare under supervision) may be seen as bureaucratic to practitioners. In response to the Government's concerns, we have returned with an amendment which requires for consultation, without excessive prescription of how this consultation will be achieved.

We agree with the Government that a CTO will only work - in the limited circumstances where it might be therapeutically beneficial - where there is co-operation between the clinician, patient and others involved in providing care. It does not follow, however, that consultation will occur as a matter of course. Nor does it follow that clinicians will wish to use CTOs in circumstances where there is a good level of understanding between themselves and the patient. Indeed, clinicians might wish to use CTOs precisely when there is doubt as to how co-operative a patient will be after leaving hospital. Therefore, securing a degree of consultation between the parties concerned, and ensuring that the order and the conditions imposed as part of that order are acceptable to those people who will be directly affected by it, needs to be a requirement of the process of making an order.

Finally, we do not accept that we can rely on routine good practice to ensure that consultation with patients and carers occurs during the making of a CTO. Nor do we accept that we can assume that Clause 8 - the fundamental principles – imply that consultation should take place at the point of making the order. While service user consultation may be a matter of good practice in the provision of most mental health

services, here it has a specific, crucial role in safeguarding the rights of the patient where their liberty is denied. For this reason, we need to set out a statutory right for the patient, and others who are directly implied in supervising, accommodating or providing care to the patient, to be involved in the process of making the order.