



The  
British  
Psychological  
Society

Professional Practice Board

Code of Practice  
Mental Health Act 1983  
(as amended by the Mental Health Act 2007)

## Interim Supplementary Guidance for Chartered Psychologists seeking approval and acting as Approved Clinicians

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on behalf of the BPS Professional Practice Board  
Mental Health Act Working Party

*March 2009*

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## ISBN

Printed and published by the British Psychological Society.

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Incorporated by Royal Charter Registered Charity No 229642

# Introduction

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The Mental Health Act 2007 (MHA 2007) amends the Mental Health Act 1983. Thus, the Mental Health Act 1983 (“the Act”) remains in force. The MHA 2007 also amends Mental Capacity Act 2005 (MCA 2005) in relation to mentally disordered persons, and Section 40 of the MCA 2005.

It is recommended that the Act and the MHA 2007 are read in conjunction with the revised *Code of Practice for the Mental Health Act 1983* (CoP; Department of Health, 2008a)<sup>1</sup> and the *Reference Guide to the Mental Health Act 1983* (Department of Health, 2008b). The revised CoP provides guidance to approved clinicians (ACs), hospital managers and approved mental health professionals (AMHPs) on how they should discharge their responsibilities under the Act. Compliance with the CoP is not a legal requirement. However, those with responsibility for implementing the Act must have regard to the CoP and will need to carefully record and justify any departures from it that might result in a legal challenge. The revised CoP applies to England only. The Welsh Assembly Government will publish a separate CoP for Wales in the near future.

The aim of the *Reference Guide* is to facilitate understanding of the provisions of the Mental Health Act 1983 (as it is amended by the MHA 2007) and the associated secondary legislation. It replaces the Memorandum on the Act last published by the Department of Health and the Welsh Office in 1998. The *Reference Guide* is about the Act as it applies in England. There are a number of differences in the way it applies in Wales.

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<sup>1</sup> The main differences between the revised Code and the previous Code (published in 1999) are summarised in an online document (Department of Health, Mental Health Act Implementation Team (2008), [www.dh.gov.uk/en/Healthcare/NationalServiceFrameworks/Mentalhealth/DH\\_4132161](http://www.dh.gov.uk/en/Healthcare/NationalServiceFrameworks/Mentalhealth/DH_4132161)).

# Code of Practice – Statement of Guiding Principles

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Chapter 1 (pp.5–6) of the revised CoP contains a new set of guiding principles (which replace the principles in the previous CoP) and explains how the principles should be considered and inform all decision-making under the Act. In summary, the five guiding principles are:

1. *Purpose principle* – any decision taken under the Act must aim to minimise the undesirable effects of mental disorder,
2. *Least restriction principle* – those acting without a patient’s consent must minimise the restrictions they impose on the patient’s liberty.
3. *Respect principle* – those taking decisions under the Act must recognise and respect the diverse needs, values and circumstances of each patient.
4. *Participation principle* – patients, and where appropriate, carers, family and others with an interest in the patient’s welfare, must be given the opportunity to be involved, as far as is practicable, in planning, developing and reviewing their own treatment and care.
5. *Effectiveness, efficiency and equity principle* – those 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.

The principles are intended to inform decisions, not determine them.

Consideration should be given to all the principles in reaching every decision under the Act, but the context will affect the weight given to each principle in making a particular decision.

# Purpose of the Interim Supplementary Guidance

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The MHA 2007 introduced two new roles of approved clinicians (AC) and responsible clinicians (RC) that might be filled by a number of mental health professionals, including chartered psychologists. ACs who are allocated to appropriate patients as RCs, will undertake the majority of the functions previously performed by Responsible Medical Officers (RMOs).

In preparation for this development, the British Psychological Society (BPS) responded to the consultation on the draft revised CoP for the Mental Health Act 1983 in January 2008. In its response the BPS broadly welcomed the main changes to the previous CoP, as well as suggesting further amendments that, in its view, would clarify and thus improve the guidance provided. Unfortunately, these suggestions for developing the code weren't acknowledged. In addition, the final revised CoP differed from the draft version such that guidance that the BPS considered to be helpful to psychologist ACs was not included in the published CoP.

As a result, it was agreed that supplementary guidance to that provided in the revised CoP would be prepared for psychologist ACs concerning aspects of the operation and implementation of the Act that are particularly relevant to the practice of psychologists.

The supplementary guidance provided in this document is "interim" as it is anticipated that both its range and content may change over time as applied psychologists begin to take up the AC and RC roles and test them in practice. The BPS's Mental Health Act Working Party plans to actively monitor the implementation of these extended statutory roles for psychologists through the early implementation field test sites and beyond, to collate information and data collected by psychologists in these roles, and to review and revise the supplementary guidance periodically as required.

The BPS's interim supplementary guidance does not, therefore, supplant the revised CoP which the Act requires ACs to refer to when undertaking duties under the Act. The recommendations provided in the BPS's supplementary guidance are to assist applied psychologist ACs in weighing and reaching clinically defensible decisions in the best interests of patients and relevant others having due regard to the provisions of Act, the CoP, the Reference Guide and other relevant legislation, and the views of the patient, the clinical team and others involved the patient's care.

# Becoming an Approved Clinician

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The MHA 2007 in section 145(1) defines an AC as “A person approved by the appropriate national authority to act as an approved clinician for the purposes of the Mental Health Act 1983.” RCs are ACs who have overall responsibility for an allocated patient’s case and will undertake most of the functions previously performed by RMOs.

## Professional Requirements of Approved Clinicians

The MHA 1983 Approved Clinician (General) Directions 2008 gives directions to Strategic Health Authorities (SHAs) in England under the National Health Service Act 2006.

Schedule 1 of the Directions states that the professional requirements for an AC include “... a chartered psychologist who is listed in the British Psychological Society’s Register of Chartered Psychologists and who holds a relevant practicing certificate issued by that Society” (p.6). Other professional groups eligible to become ACs are: registered medical practitioners, first level mental health and learning disability nurses, registered occupational therapists, and registered social workers.

## Relevant Competencies of Approved Clinicians

Schedule 2 of the Directions (pp.7–8) details the relevant competencies required of ACs. In summary, the competencies are as follows:

1. A comprehensive understanding of the roles, legal responsibilities and key functions of the AC and RC.
2. An applied knowledge of mental health legislation, related codes of practice, policy and guidance, and other relevant legislation, codes, policy and guidance.
3. A demonstrated ability to assess: the presence of mental disorder; the severity of the disorder; whether the disorder warrants compulsory confinement; clinical risks, including risks to the safety of patients and others; and the biological, psychological, cultural and social aspects of a patient’s mental health needs.
4. An understanding of mental health related treatments (physical, psychological and social), different treatment approaches and their applicability to different patients; skills in determining a patient’s capacity to consent to treatment; an ability to formulate, lead and review on treatment for which the clinician is appropriately qualified; and an ability to communicate the aims of treatment to patients, carers and the MDT.
5. A demonstrated ability to develop and manage care plans within the context of the Care Programme Approach (CPA).
6. An ability to lead a multi-disciplinary team effectively; including the ability to assimilate the views of others and to manage and take responsibility for making decisions in complex cases.
7. Contemporary knowledge and understanding of equality issues, including those concerning race, disability, sexual orientation and gender; and an ability to identify, challenge and redress discrimination and inequality in relation to the practice of an AC.

8. The abilities to: communicate effectively at all levels, keep appropriate records, understand and manage the competing requirements of confidentiality and information sharing; to compile and complete statutory documentation and to write reports as required; and to present evidence to courts and tribunals.

## Identification of Potential Candidates for Approval

The Act, CoP and AC Directions do not provide criteria concerning which individuals from the qualifying professions should be nominated for approval as ACs. However, Mental Health Act 2007 New Roles (NIMHE, 2008) provides policy guidance for approving authorities and employers. The guidance indicates that professionals applying for approval as an AC will usually have been nominated by their employer on the basis of having the relevant competencies for the role. The guidance at Annex E (1) is that "... applicants for the AC approval will be very experienced, well-qualified professionals who, given the necessary additional training and development opportunities, should be able to demonstrate the full range of competencies to be approved as an AC" (p.35).

The New Roles guidance also suggests that employers should consider a staged approach to the introduction of non-medical ACs, with the most experienced eligible professionals being identified and supported towards obtaining AC approval in the initial stages to provide supervision and support for succeeding colleagues.

***Recommendations.** The BPS supports this guidance. It is recommended that in general, given the competencies and experience required, consultant psychologists (Agenda for Change bandings 8c and above) are considered by their employers as potential applicants for AC approval. During the early stages of implementation and field-testing of these new statutory roles, experienced senior consultant psychologists should be encouraged and supported by their employers to obtain AC approval in order to provide a supervision network and governance framework for succeeding cohorts.*

## Developing and Demonstrating the Relevant Competencies

The AC Directions do not stipulate how applicants for AC approval can provide evidence of their competencies. Annex E (2) of the New Roles guidance (NIMHE, 2008) provides a framework and examples of how potential ACs can develop and demonstrate evidence of existing competencies to achieve the full range of competencies required for the AC role (pp.37–44). It is acknowledged that AC and RC competencies will build on *existing* professional competencies developed through pre- and post-qualification training and experience.

There is currently no nationally recommended training course for potential ACs to develop their competencies in preparation for application for AC approval. However, in order to demonstrate the full range of AC/RC competencies, psychologists may need to acquire additional skills knowledge and experience through CPD and access to appropriate training. The need for additional training and development will vary for individual psychologists seeking AC approval.<sup>2</sup>

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<sup>2</sup> Preparatory training programmes for psychologist ACs are being piloted through early implementer field test sites and the BPS's MHA Working Party will consider providing additional guidance on preparatory training for potential psychologist AC once these field tests have been completed.

## Initial Training for Approved Clinicians

In addition to demonstrating that they have the required competencies for AC approval, the AC Directions require all applicants to have completed a formal “initial training” course for ACs. This is in addition to any preparatory training towards developing the required competencies that they might have completed. This AC initial training must be completed within the two years prior to seeking approval. AC initial training courses should be approved on a regional basis and the New Roles guidance suggests that these courses are overseen by AC Approval Panels that are the responsibility of SHAs. The guidance is that the initial training should be a two-day attended course with recommended pre-course reading and the suggested standard content of such a course is set out in Annex G (pp.47–48).

## Approval of Approved Clinicians

Once a potential AC is ready to seek AC approval they should compile a ‘portfolio of evidence of required AC competencies.’ This should include the following:

- A summary of the candidate’s skills and experience relevant to the AC role. It is recommended that a matrix such as that set out in Annex E (2) (pp.37–44) of the New Roles guidance (NIMHE, 2008) is used to detail the candidate’s skills and experience relevant to each competency, how these were acquired and the supporting evidence.
- A minimum of two anonymised case reports relating to the candidate’s involvement in the care of a detained patient. These will need to be hypothetical reports appended to a statutory report (e.g. Tribunal or Section renewal report) that demonstrate awareness, understanding and reflection on key areas of AC competence and the principles of the CoP.
- Two testimonies from suitably qualified senior professionals that can validate the candidate’s capacity for the AC role. One referee should be from a different profession from that of the applicant.
- A 360° appraisal that should include (where appropriate) service user/carer feedback as well as the candidate’s immediate line manager/supervisor, and MDT colleagues.

The New Roles guidance suggests that the professional bodies for the eligible professions should consider providing pre-approval scrutiny of candidate’s portfolios of evidence for quality assurance purposes (pp.35–36). The BPS has agreed to establish a pre-approval scrutiny panel for psychologist AC candidates that will use the existing National Assessors framework.<sup>3</sup>

***Recommendation:*** *Psychologist AC candidates should submit their portfolio of evidence of required AC competencies to the BPS for pre-approval scrutiny prior to submission to a formal AC Approval Panel.*

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<sup>3</sup> The detail of how this system will operate is being finalised and additional guidance will be provided once it is available.



Following pre-approval scrutiny of their portfolio of evidence by the Society, and once in receipt of a Society advisory note concerning their skills, training and experience in relation to the required competencies, psychologist AC candidates should then submit their portfolio of evidence and Society advisory note to the AC Approval Panel established by their SHA, along with the following materials:

- Documentary evidence of professional qualification.
- Documentary evidence of current registration with the appropriate registration body.
- Evidence of completion of AC initial training within the last two years.
- Confirmation from the employer of their support for the applicant, and agreement to provide information to the Approval Panel on competency issues.
- Declaration by the applicant of agreement to comply with the conditions of approval required by the AC Directions.

## **Allocation of Responsible Clinicians**

The CoP indicates that hospital managers should have local protocols in place for the allocation of RCs to patients to ensure that the RC is the AC with the most appropriate expertise to meet that particular patient's main assessment and treatment needs (chapter 14.3, p.107). The selection of the appropriate responsible clinician should be based on the individual needs of the patient concerned. The CoP specifies that where psychological therapies are central to the patient's treatment, it may be appropriate for a professional with particular expertise in this area to act as the RC (chapter 14.5, pp.107–108). This is consistent with the effectiveness, efficiency and equity principle of the CoP.

The local protocols should also provide for regular reviews of the appropriateness of the allocated RC. For example, when a patient moves from an in-patient to a community setting under supervised community treatment (SCT), any required changes in RC will need to be managed carefully. Local protocols should also give guidance on cover arrangements for when a patient's RC is not available.

***Recommendation:** Before accepting AC or RC responsibilities, psychologists should, with the support of their line manager/professional lead, ensure that agreed protocols are in place to guide: (a) the allocation of patients to RCs with the most appropriate expertise to meet the needs of patients; (b) regular reviews and transfer of patients to the most appropriate RC as they move through the rehabilitation pathway; and (c) cover arrangements for when a patient's RC is not available.*

# The Appropriate Medical Treatment Test

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For the purpose of the Act as amended by the MHA 2007, medical treatment for mental disorder means medical treatment which is for the purpose of alleviating, or preventing a worsening of, a mental disorder or one or more of its symptoms or manifestations. Medical treatment includes “nursing, psychological intervention and specialist mental health habilitation, rehabilitation and care” (CoP, chapter 6.2, p.54). Such treatment must have the purpose of alleviating or preventing a worsening of the disorder or its symptoms or manifestations, even though it cannot be shown in advance that the treatment is likely to have an effect for a particular patient. Thus, appropriate medical treatment need not be likely to achieve those purposes – “Purpose is not the same as likelihood” (CoP, chapter 6.4, p.54).

The purpose of the appropriate medical treatment test is to ensure that patients are not detained for treatment, or subject to SCT, unless they are actually to be offered appropriate medical treatment for their mental disorder. Thus, the MHA 2007 requires that appropriate medical treatment must be available to a detained patient. The patient’s refusal to accept treatment can no longer be an obstacle to detention, so long as appropriate treatment is available.

This has particular relevance for psychological therapies. The CoP at chapter 6.19 states: “In particular, psychological therapies and other forms of medical treatments which, to be effective, require the patient’s co-operation are not automatically inappropriate simply because a patient does not currently wish to engage with them. Such treatments can potentially remain available as long as it continues to be clinically suitable to offer them and they would be provided if the patient agreed to engage” (p.58).

***Recommendation.** Whilst the availability test of appropriate medical treatment applies to psychological interventions in the same way as for other forms of treatment, it is important for psychologist ACs and RCs to avoid placing undue pressure on patients to participate in such treatment. There is an inevitable power differential in favour of the clinician. Thus, every attempt should be made to emphasise patient involvement and choice and to avoid coercion in a manner consistent with the CoP respect and participation principles.*

The scenario below illustrates the prospect of a psychologically-informed therapeutic milieu overseen by a psychologist acting as approved clinician, set in a forensic facility which has an emphasis on specialist mental health habilitation, rehabilitation and care.

## Applying the Principles to The Appropriate Medical Treatment Test

Following discharge from hospital under SCT, Joe lapses into substance misuse and an associated mental disorder re-emerges. He has a history of assault when psychotic. On recall to hospital, there is no specific medical intervention, as he is medication compliant. He is not willing to engage in any other specific treatment programme. The questions arise as to whether:

1. He should be transferred to the care of a psychologist AC/RC, and;
2. If care in a forensic habilitation unit, run jointly by psychology and nursing personnel, would constitute appropriate medical treatment.

The following CoP guiding principles help to inform such a decision.

### **Purpose principle**

- Would admission to the unit benefit Joe?
- Would it reduce risk to the public?
- Does this unit offer
  - specialist care,
  - under the supervision of an AC,
  - in a safe and secure therapeutic environment, and
  - a structured regime?
- Is there any specific benefit in changing Joe's RC?

### **Least restrictive alternative principle**

- Is the habilitation unit the least restrictive option?
- Will admission to this unit best facilitate a safer, more enduring care pathway?

### **Respect principle**

- What are Joe's views
  - about this unit, and
  - on a change in RC?

### **Participation principle**

- Will Joe be more able, in the habilitation setting, to take part in his future discharge pathway and in particular the risk-needs assessment that will inform any future CTO conditions?
- Will Joe be better able to consider direct treatment options for his substance misuse within this unit that is consistent with a motivational cycle of change model?

### **Effectiveness, efficiency and equity principle**

- Will the use of the available resources, expertise and clinical leadership in the habilitation unit provide the most effective, efficient and fair means of managing Joe's risk to himself and others?

## Conflicts of Interest (or *Competing Duties of Care*)

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Chapter 7 of the CoP sets out the circumstances in which potential conflicts of interest may prevent AMHPs from making an application for a patient's detention or guardianship and doctors from making a recommendation supporting the application. The potential conflicts of interest dealt with in the CoP involve financial, business, professional and personal issues.

For psychologists there can be potential conflicts of interest, or what we prefer to term 'competing duties of care' between the roles of RC (including the duty to detain or otherwise compel participation in treatment) and that of psychological therapist (including, principally, the duty to establish freely-given consent wherever possible to enhance the efficacy of the therapeutic intervention). The CoP at chapter 23 (Medical treatment under the Act) states that permission given by a patient to a particular treatment "under any undue or unfair pressure" is not consent (23.31, p,188). Good outcomes for psychological therapies are associated with positive therapeutic alliances and good working relationships between therapists and patients. The potential for even perceived abuse of power and the inherent power differential between an RC and a patient subject to a MHA section runs a risk of rupturing this relationship or it becoming coercive.

***Recommendation.** RCs trained to provide psychological treatments must remain aware of and give full consideration to any potential competing duties of care between the RC and psychological therapist roles when providing psychological treatments to patients over whom they have compulsory powers.*

The main issues to be considered by RCs when addressing potential competing duties of care in this context include:

1. Psychological treatments (apart from indirect interventions delivered by proxies such as paid staff and carers) are more likely to be effective when valid consent is obtained.

***Recommendation.** RCs acting as psychological therapists should utilise all reasonable and ethical attempts to obtain valid consent from patients before proceeding with psychological treatment. The CoP at chapter 23.31–23.36 (pp.188–189) provides guidance on obtaining consent.*

2. The Act permits psychological treatment to be given without consent and the CoP provides guidance on how to proceed with treatment in these circumstances (chapter 23.37–23.41, pp.190–191). There may be circumstances, especially when significant risks to others or self have been identified, when it is considered to be necessary for an RC to proceed with providing psychological treatment without consent.

***Recommendations.** In circumstances in which an RC is considering providing psychological treatment without the patient's consent then there should be, where practicable, prior discussion with the MDT involved in the patient's treatment and care about the risks involved; and careful consideration should be given to the availability and merits of another suitably qualified member of the team providing the psychological treatment required with the RC remaining in overall charge of the patient's care.*

3. There may be situations where it is judged that valid consent cannot be clearly obtained, or where it would appear another available practitioner would be more likely to achieve a more effective outcome (perhaps due to the power differential between patient and RC).

***Recommendation.** In such situations the RC is advised to refer on to other members of the treatment team who are able to provide the psychological treatment needed, while the RC remains in charge of overall care.*

The following practice-based examples illustrate these issues.

### **Scenario 1: Responsible Clinician Undertaking Psychological Intervention**

Joe was admitted to hospital under section for a third time with a medic RC in charge of his care. Like his previous admissions, Joe had entered hospital in a manic state and, following an increase in sedating medication, he recovered to a baseline state within a week. It was noted that in the period leading up to hospitalisation Joe had been compliant in taking his medication as prescribed consistently. He asked to work with a psychologist to formulate his relapse signature and develop a relapse prevention plan. Joe was subsequently assigned a consultant clinical psychologist as RC. He was aware that the RC had responsibility for his section and his discharge, but nonetheless he was happy to consent to psychological intervention which would hopefully reduce the likelihood of a future relapse and re-admission.

### **Scenario 2: Responsible Clinician Delegating Psychological Intervention**

Helen was admitted to hospital under a MHA section following an escalating pattern of self-harming behaviours, including alcohol and drug misuse, and deliberate self-harm through cutting and overdosing on tablets. As she was not deemed to be clinically depressed, rather to be experiencing difficulties related to an emotionally-unstable personality in the context of childhood sexual abuse, she was assigned to a consultant psychologist RC as it appeared that a psychological approach would be advantageous to her recovery. Helen was angry about remaining under section even though she recognised that she posed a risk to herself. She appeared unwilling to explore her past or review her current coping strategies with her psychologist RC. She agreed, however, to meet with one of the nurses on the ward who had been trained and received supervision in relevant psychological interventions. Helen began weekly sessions with the nurse, and she understood and accepted that her progress in these sessions would be discussed within care planning sessions with her psychologist RC.

# Safe and Therapeutic Responses to Disturbed Behaviour

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Chapter 15 of the CoP provides guidance for the safe and therapeutic management of patients detained in hospital under the Act whose behaviour may present immediate risks to themselves or others. NICE (2005) guidance on the short-term management of disturbed and violent behaviour complements the guidance provided in the CoP.

The CoP is clear that central to a hospital's policy on the management of disturbed behaviour is "... the establishment of a culture which focuses on early recognition, prevention and de-escalation of potential aggression, using techniques that minimise the risks of its occurrence" (15.7, p.113).

***Recommendation.** RCs working with patients who may present with disturbed or violent behaviour should, through effective clinical and organisational leadership, aim to establish an ethos in the MDT and service that emphasises early recognition, prevention and de-escalation of such behaviour.*

The CoP provides guidance on general measures that can be helpful in promoting a positive therapeutic milieu in clinical environments (15.15, pp.115–116). An important component of a positive culture is the promotion of attitudes in the clinical team that negate negative and stigmatising views about patients' characteristics, previous behaviour, cultural background and diagnoses that can interfere with accurate assessments and formulations of current risks, needs and potentially beneficial interventions.

***Recommendation.** RCs should consider the training and professional support needs of the MDT as an essential component of the management of patients who present risks in this regard. Specialist training for staff in the clinical team, as well as continuity and stability in the team, are important in the development of the skills, confidence and professional attitudes required for the effective management of patients who display disturbed and violent behaviour.*

Chapter 15.3 of the CoP states that all patients admitted to hospital under the Act should be assessed in relation to the immediate and potential risks they present to themselves and to others. General factors that can contribute to the risk of disturbed behaviour occurring are listed at 15.5 (p.113). These and any other relevant factors that could contribute to the risk of disturbed or violent behaviour occurring should be included in a risk assessment that informs an individual care plan for each patient. Care plans should contain clear contingency plans for managing any disturbed or violent behaviour that might occur.

***Recommendations.** Risk assessment and management are central to the successful care and treatment of people who present risks to themselves and others. RCs should utilise systematic and robust risk assessment procedures that are evidence based and the purpose of which is to prevent disturbed or violent behaviour (cf. with attempting to predict its occurrence). Risk assessments should take into account current clinical/dynamic factors that will influence the potential risks that are present, as well as historical/static risk factors, including the patient's previous behaviour. Assessments of a patient's behaviour and the potential risks they present should also take into consideration the environmental context in which it occurs. The risk assessment process should include a range of views and perspectives so that clinically defensible judgements about the risks presented can be reached. As well as the views of clinical team members, paid carers and family members, wherever possible patients should also be engaged in the process and informed of the*



*outcomes so that a collaborative approach is taken that is consistent with the CoP participation and respect principles.*

*Individual care plans that set out agreed measures for the management and treatment of disturbed and violent behaviour are essential in developing a preventative and proportionate approach to the risks presented by patients that can reduce the frequency and/or severity of future behaviour.*

*The involvement of patients as far as is practicable in the development of their care plans will also result in improved outcomes through increased collaboration and understanding between the patient and the clinical team.*

Chapter 25 of the CoP focuses on the short-term management of disturbed and violent behaviour including physical restraint, rapid tranquilisation, and seclusion, in addition to the use of “de-escalation techniques” (15.6, p.113). The implementation of these techniques should be guided by local policies that reflect the needs of the particular types of patients that the service works with. The guidance indicates that these reactive management approaches should be planned, embedded in a preventative culture, and must never be used in a punitive manner. A hierarchy of management interventions is also indicated, with rapid tranquilisation being used only if de-escalation and other strategies have failed to calm a patient; physical restraint and seclusion used only as “a last resort” (15.23, p.118 and 15.45, p.123 respectively); and the use of mechanical restraint should be “exceptional” (15.31, p.120). The CoP does not, however, refer to or discuss longer-term proactive therapeutic interventions that might be helpful in reducing the frequency and/or severity of disturbed and violent behaviour.

***Recommendations.*** *In addition to the short-term reactive management of potentially disturbed and/or violent behaviour, RCs should explore with the MDT, the patient and carers as appropriate the potential benefits of planned and proactive therapeutic interventions aimed at reducing the frequency and/or severity of such behaviours. These options might include behavioural interventions based on applied behavioural analysis principles or intensive psychotherapeutic treatments (e.g. individual cognitive-behavioural anger treatment) that have been shown to be effective in reducing the rate and effects of challenging and aggressive behaviours. Interventions of this kind would potentially be helpful in engaging patients and developing therapeutic relationships which are inherently protective and would help to reduce risks. Consideration of such approaches is also consistent with CoP purpose, least restriction, participation, and effectiveness, efficiency and equity guiding principles.*

# Supervised Community Treatment

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The CoP states at chapter 25 that the purpose of supervised community treatment (SCT) is “... to allow suitable patients to be safely treated in the community rather than in hospital, and to provide a way to help prevent relapse and any harm – to the patient or to others – that this might cause.” (25.2, p.220). SCT is intended to promote the patient’s recovery and stability by providing a framework for their management in the community. It gives the RC the power to recall the patient to hospital for treatment if required.

SCT is an option for those patients detained in hospital under Section 3 of the Act, or those who are unrestricted Part 3 patients. Only those patients who meet the criteria set out in the Act can be considered for SCT (see CoP 25.5, pp.220–221). It is important for AC/RCs to note that one of these criteria is the “appropriate medical treatment test” discussed earlier in this guidance. This means that patients cannot be made subject to SCT unless they are actually to be offered appropriate medical treatment (which could include psychological treatment) for their mental disorder.

The CoP is clear that while patients do not need to consent formally to SCT, in practice they do need to be involved in decisions about the treatment to be provided in the community and to be prepared to co-operate with it (25.14, p.222). Thus, it is important that patients are consulted early when considering the possibility of SCT and are involved in the preparation of a care plan, in line with CPA, that will underpin their SCT.

## Conditions Attached to Community Treatment Orders

SCT is enacted through Community Treatment Orders (CTO), which will include conditions with which the patient is required to comply while subject to SCT. With the agreement of an AMHP, RCs may set conditions that they consider are necessary to ensure the patient receives appropriate medical treatment, prevents risk of harm to the patient, or protects others. Any conditions applied to the CTO must be set out clearly and precisely so that the patient is able to understand readily what is expected of them. The CoP indicates that for SCT to be successful, it is important that “... the patient agrees to keep to the conditions, or to try to do so, and that patients have access to the help they need to be able to comply” (25.35, p.227).

RCs may, with the agreement of an AMHP, set treatment conditions, including a requirement for psychological treatment, as part of a CTO.

***Recommendations.** If an RC is considering setting a condition of treatment, including psychological treatment, as part of a CTO, then this should be discussed as early as possible in the planning process with the patient so that their views and likely motivation to co-operate can be taken into account. It is also important that there is full discussion with the MDT involved in the patient’s care, and in particular those clinicians who will be responsible for the delivery of any compulsory treatment as a condition of a CTO, before an order is made. This approach is underlined in ‘SCT: A guide for practitioners’ (NIMHE, 2008) which tells us that it’s the RC’s responsibility to “consult with the patient and all interested parties” (p.14) when considering SCT. The guide also says that RCs need to ask the question: “Have all the appropriate professionals involved in the provision of care to the patient been consulted?” (p. 8); and subsequently, “Once agreement is reached with all of the care team and the patient, then the CTO is made ...” (p.19).*



## Psychological Treatment as a Condition of CTOs

On occasions, a psychologist who is not the RC for a particular patient may be asked to provide treatment for that patient as part of SCT. Some, if not all, patients can engage successfully (at least initially) in psychological treatment set as a condition of a CTO. In some circumstances such compulsion may better serve the patient's interests than attempting to offer the treatment on a voluntary basis, especially if the patient has in the past, to their detriment, regularly declined to take part in or has actively disengaged from treatment. However, it may be the case, especially where patients can expect little or no choice of psychologist, that agreeing to treatment as a condition of SCT could have a lasting negative impact on future therapeutic engagement with the individual psychologist involved, if not with psychological services generally.

***Recommendations.** Psychologists should generally start from the presumption that the proposed psychological intervention would have more effect if it is offered as a choice to the patient as part of the care plan and is not made a condition of the CTO. This may be the preferred approach if, for instance, there are indications that the patient will engage with the psychological treatment voluntarily and/or where the intervention is not deemed essential to prevent risk of harm to the patient or others. Psychologists have a responsibility to use their clinical judgment in deciding, on a case-by-case basis, and following discussion with MDT colleagues, whether the treatment/intervention they are being asked to provide as a condition of SCT is appropriate in meeting the patient's clinical needs and/or reducing a significant risk of harm to the patient or others.*

## Monitoring SCT Patients

What is required of a patient on SCT in order to keep to any conditions set as part of their CTO should be clearly set out in the care plan and understood by the patient, the care co-ordinator and others involved in supporting the patient.

The CoP requires the RC to take appropriate action if a patient subject to SCT withdraws consent to, or begins to object to treatment that they have previously agreed to and is a condition of their CTO (25.39, p.228). In such circumstances the RC is directed to consider with the patient (and others as appropriate) the reasons for this change and what actions should follow. The RC should consider alternative treatment that is available that would allow the SCT to continue safely and which the patient would accept. If, however, the patient refuses treatment that is considered to be crucial in reducing significant risk of harm to the patient or others, then an urgent review of the situation must be undertaken and the option of recalling the patient to hospital can be considered.

***Recommendations.** In circumstances where an SCT patient withdraws consent to, or begins to object to psychological treatment that is a condition of the CTO then the RC will need to consider, with the patient and other members of the care team, the reasons for this and whether alternative treatments are available that are acceptable to the patient. If the patient or others are thought to be at significant risk of harm as a result of the patient's withdrawal from treatment (or the lack of availability of a suitable alternative), then an urgent review will be required and recall to hospital will be an option. RCs will need to be clear from the outset with the patient, the care co-ordinator and others involved in supporting the patient, what constitutes a breakdown in therapy (and thus non-compliance with CTO conditions) as opposed to routine difficulties that might be anticipated*

*in adherence to all aspects of psychological treatment over time (e.g. completion of homework tasks in cognitive-behavioural interventions). Such difficulties should be clinically reviewed with the patient and MDT colleagues and their meaning explored with regard to any increased risks before remedial action is considered.*

## **Consultation and Agreement to Provide Psychological Treatment as a Condition of CTOs**

In the same way as a psychologist RC would be expected to consult with MDT colleagues and others who have been identified as providing treatment to a patient as a condition of SCT, psychologists (who are not acting as RC) should expect to be consulted before a CTO is agreed that involves them in delivering psychological treatment to a patient as a condition of an order.

***Recommendations.** If a situation arises in which a psychologist is designated by an RC to provide psychological treatment to a patient as a condition of a CTO without having been consulted as part of any MDT and/or care planning discussions beforehand, then the psychologist should decline to become involved in delivering treatment to the patient concerned and inform their line manager and local Hospital Managers that the appropriate procedures as set out in the CoP and other operational and good practice guidance have not been followed. The issue should then be resolved as quickly as possible, and in the best interests of the patient, with reference to local protocols that have been developed with the involvement of relevant professional heads of psychological services.*

# People with Learning Disabilities

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The 2007 amendment of the Mental Health Act 1983 removes the “mental impairment” and “severe mental” impairment categories of mental disorder and introduces the term “learning disability”.

In the revised Act, learning disability is defined as “a state of arrested development of the mind which includes significant impairment of intelligence and social functioning” (chapter 1.2 (3), p.2).

The presence of a learning disability alone is *not* sufficient for a person to be detained for treatment or subject to guardianship under the Act. As set out in chapter 34 of the revised CoP, an application for detention for treatment, SCT or reception into guardianship on the basis of learning disability (without another concurrent mental disorder) can be made only if “abnormally aggressive behaviour” and/or “seriously irresponsible conduct” is present (34.6, p.308).

## Assessment of Learning Disability

The CoP states that the identification of an individual with learning disability is “a matter for clinical judgement, guided by current clinical practice” (34.4, p.307). The CoP offers guidance on the characteristics a patient should exhibit for this judgement to be reached. The following three factors constitute the definition of learning disability for the purposes of the Act.

- i. *Significant Impairment of Intelligence.* The CoP advises that the judgement about the presence of this factor must be made using “reliable and careful assessment” (34.4, p.308), but warns it is not defined rigidly using an arbitrary cut-off point of an IQ of 70.
- ii. *Significant Impairment of Social Functioning.* It is suggested in the CoP that recent and reliable observations, made by a number of people who know the person, are helpful in assessing the nature and extent of their social competence. The CoP also advises that social functioning assessment tools can be helpful in this regard.
- iii. *Arrested or Incomplete Development of Mind.* According to the CoP this involves “... a significant impairment of the normal process of maturation of intellectual and social development that occurs during childhood and adolescence” (34.4, p.307). Intellectual impairment caused as a result of accident, illness or injury following completion of normal maturation processes are not included in the definition of learning disability in the Act.

The BPS supports the definition of learning disability introduced into the amended Act, and in particular the inclusion of a developmental criterion, as it is closer to the general understanding of the three core criteria for learning disability, and is consistent with the BPS’s recommended definition (BPS, 2000).

However, the CoP goes onto to say “It may be appropriate to identify learning disability in someone with an IQ somewhat higher than 70 if their social functioning is severely impaired.” It also suggests that “A person with a low IQ may be correctly diagnosed as having a learning disability even if their social functioning is relatively good” (34.5, p.308).

**Recommendations.** *Whilst the BPS agrees with the importance of assessing people holistically, and in not applying IQ scores inflexibly or using overly strict cut-off criteria, its professional guidelines recommend that assessment of a person’s level of intellectual functioning is obtained using an individually administered test that is recognised as being reliable, valid and properly standardised – taking into account the person’s age, language, cultural and social background (BPS, 2000). The most commonly used measure of general intellectual functioning for the adult population is the Wechsler Adult Intelligence Scale – III (WAIS-III; Wechsler, 1999) which is based on a normal distribution of general intelligence. By convention, a significant impairment of intelligence has become defined as a score of more than two standard deviations below the mean on a test such as the WAIS-III.*

*Further, it is recommended that individual IQ scores should be reported with explicit confidence limits that indicate the likely extent of the measurement error for scores derived from particular tests. For the WAIS-III the confidence limits vary with age group, but across all age groups included in the test standardisation study, the 95 per cent confidence interval for Full Scale IQ scores is  $\pm 4.5$  points (WAIS-III, 1997, pp.53–56). Thus, psychologists should be very cautious and should exercise clinical judgement in identifying a learning disability in anybody whose measured IQ falls outside the upper 95 per cent confidence limit for their age group, irrespective of their level of social functioning. This is in keeping with the requirement for significant impairments of both intellectual and adaptive/social functioning to coexist in order for a learning disability to be identified (BPS, 2000, p.11).*

The BPS supports the guidance in the CoP to incorporate reliable and recent observations from multiple sources in determining impairment of social functioning. The CoP does not define social functioning, but BPS guidelines suggest that for a person to have a significant impairment<sup>4</sup> of adaptive and/or social functioning, a person “... requires significant assistance to provide for his/her own survival (eating and drinking needs and to keep himself/herself clean, warm and clothed), and/or with his/her social/community adaptation (e.g. social problem solving, and social reasoning)” (BPS, 2000, p.6).

**Recommendation.** *Although there is not yet a gold standard measure, the BPS recommends as good practice the use of a formal assessment of adaptive/social functioning. At least one assessment should be completed, preferably by more than one informant and on more than one occasion. Assessments of adaptive/social functioning must be made with reference to a person’s age, gender, socio-cultural background and environment.*

The identification of a significant impairment of social functioning within the meaning of the Act will require informed clinical judgement. However, psychologists should be very cautious in identifying a learning disability in anybody who, on the basis of a systematic assessment, does not appear to have a significant impairment of adaptive/social functioning, irrespective of their level of intellectual functioning. This is in keeping with the requirement for significant impairments of both intellectual and adaptive/social functioning to coexist in order for a learning disability to be identified (BPS, 2000, p.11).

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<sup>4</sup> A significant impairment of adaptive/social functioning is indicated by a person having “Intermittent” or “Limited” support needs (BPS, 2000, p.10).

## Assessment of Abnormally Aggressive and Seriously Irresponsible Behaviour

For the purposes of detention for treatment (rather than assessment), SCT or reception into guardianship under the Act, a learning disability can only be considered as a mental disorder if it is associated with “abnormally aggressive or seriously irresponsible conduct.” This is described as the “learning disability qualification” in the *Reference Guide to the MHA 1983* (Department of Health, 2008b, chapter 1.14, p.19).

The terms abnormally aggressive and seriously irresponsible behaviour are not defined in the Act. The CoP, however, provides some guidance. The following factors should be considered in assessing whether a person’s conduct amounts to abnormally aggressive or seriously irresponsible behaviour:

- How persistent and severe the observed behaviour has been;
- Whether, and to what degree, the behaviour has actually (or might have) resulted in harm to the patient or the patient’s interests, or in harm or distress to other people, or actual damage to property, and;
- If the behaviour has not been observed recently, how likely is it to recur?

In judging whether abnormally aggressive behaviour has taken place consideration should also be given to the following:

- How common similar behaviour is in the population generally, and;
- Whether it has occurred without a specific trigger or seems to be out of proportion to the circumstances that triggered it.

In considering whether a patient is exhibiting seriously irresponsible behaviour the following additional factor should be considered:

- The extent to which the observed behaviour suggests a disregard or an inadequate regard for its serious or dangerous consequences.

Outside of emergency situations, the CoP asserts that it is not good practice to “diagnose” a patient who has a learning disability as meeting either the abnormally aggressive or seriously irresponsible behaviour conditions without “an assessment by a consultant psychiatrist in learning disabilities and a formal psychological assessment” (34.4, p.310), and ideally this should be part of an assessment by a multi-disciplinary team with experience in learning disabilities (34.11, p.310). The CoP also suggests that such aggressive or irresponsible behaviour that results from a person’s difficulties in communication indicates that treatment under the Act would not be appropriate (34.10, p.310).

The learning disability qualification aims to limit the extent to which people can be detained for treatment, subject to SCT or received into guardianship. Taking the factors listed above into account, the identification of abnormally aggressive and seriously irresponsible behaviour requires observational assessment and clinical judgement. The following recommendations are based on previous guidance provided by the BPS (BPS, 2000).



**Recommendations.** *It is recommended that abnormally aggressive and seriously irresponsible behaviour should be observed directly, ideally by at least two reliable informants, and that there should be good quality recordings and descriptions of this conduct in behavioural terms (including date, time, setting, frequency, severity, duration, antecedents/triggers and consequences/effects).*

*For behaviour to be considered abnormally aggressive it needs to be judged to be outside of the usual range for people in the population generally. However, the CoP indicates that such behaviour (and seriously irresponsible conduct also) should be discounted if it stems from communication difficulties. This suggests that caution should be exercised in making these judgements in people with moderate/severe and profound levels of learning disability.*

*Understanding the context in which abnormally aggressive behaviour occurs, including antecedents and specific triggers, and the proportionality of the response given the circumstances, will be helpful in establishing this 'normality' criterion. Similarly, awareness of the situation and setting factors will be of assistance in judging whether seriously irresponsible behaviour indicates a disregard or an inadequate regard for its seriousness or consequences.*

*If abnormally aggressive or seriously irresponsible behaviour has not been observed recently then a judgment is required about how likely it is to recur. The CoP does not provide guidance on how this judgment is made. However, it is clearly important to be able to state that such conduct is likely/unlikely to recur, or has in effect ceased as a result of treatment and/or remission, as a person with learning disability could no longer be considered to have a mental disorder for the purposes of the Act.*

*It is recommended that a structured and systematic risk assessment should be carried out to both inform and support judgements made about likely recurrence or cessation of aggressive or irresponsible behaviour that also draws on clinical experience of similar cases and presentations. Where possible, the risk assessment process should involve and take into account the views of people (professionals and others) who know the patient well, as well as information from records. In order to demonstrate that decisions concerning the risks presented by individuals have been made in a clinically defensible manner, the risk assessment process, and the steps within it, should be recorded carefully to ensure transparency.*

*In considering the cessation or significant reduction in the frequency of aggressive or irresponsible conduct, one factor that should be taken into account is the effect(s) of the patient's current place of detention or treatment/management programme. It is suggested that judgments about the likely recurrence or cessation of such behaviour are made in relation to at least two scenarios: (a) the patient's current situation and care plan; and (b) a general community living situation in which the patient would be receiving routine levels of support.*

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# Glossary

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AC	Approved Clinician
“the Act”	Mental Health Act 1983
AMHP	Approved Mental Health Professional
BPS	British Psychological Society
CoP	Code of Practice 2008
CPD	Continuing Professional Development
CPA	Care Programme Approach
CTO	Community Treatment Order
MCA 2005	Mental Capacity Act 2005
MHA 2007	Mental Health Act 2007
MDT	Multi-Disciplinary Team
NICE	National Institute for Health and Clinical Excellence
NIMHE	National Institute for Mental Health in England
PCT	Primary Care Trust
RC	Responsible Clinician
RMO	Responsible Medical Officer
SHA	Strategic Health Authority
SCT	Supervised Community Treatment
Tribunal	Mental Health Review Tribunal



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