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Date: 22 January 2018

Dear Member

REGULATION COMMITTEE MENTAL HEALTH GUARDIANSHIP SUB-COMMITTEE - FRIDAY, 19 JANUARY 2018

I am now able to enclose, the following appendices to the report to the Regulation Committee Mental Health Guardianship Sub-Committee that were unavailable when the agenda was printed.

Agenda Item No
4 **Section 7 Mental Health Guardianship Workshop** **(Pages 3 - 32)**

Presentation Slides
Case Study

Yours sincerely

Benjamin Watts
General Counsel

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James

James is a white British male who is aged 46. He is the younger of two children. His parents divorced when he was young and it wasn't until he was in his early 30s that he had contact with his father 3 times a year. More recently, he has reverted back to not having any contact with him. He has always maintained close contact with his mother and currently stays with her for the weekend every 3 weeks.

As a young child James repeatedly absconded from home and in an attempt to prevent this his mother insisted at times that he wore pyjamas.

Although he initially attended a mainstream school he was later transferred to a school for children with a learning disability and then special residential schools for children with complex needs.

James left school at the age of 12 and was accommodated by various foster parents as his behaviour became more difficult to manage. During this time James reports that another child with learning disabilities sexually abused him.

From the age of 16 through to his early 20s he carried out various criminal acts, which included: fraud, assault, criminal damage, arson and exposing himself to young children in public places.

As a result James was admitted to the unit for people with intellectual disability and forensic or challenging behaviour at the Bethlem hospital, London for 2 years.

Although James was initially subject to S.25A of the MHA (a Supervised Discharge Order) this was later thought to be inappropriate partly, as he was accepting of his treatment and because it was psychological and social rather than pharmacological. Instead, an application for Guardianship was made as a least restrictive alternative (2005).

Forensic reports by the Consultant Psychiatrist who had known James since the time of his index offence (1998) up to this point, stated that James becomes sexually aroused by both fire and young children. She also pointed out that the risk of him repeating offences these offences has remained unchanged as he appears to be resistant to treatment.

As part of James' Guardianship he was required to reside at a residential home for people with a learning disability and challenging behaviour, to give access to professionals involved with his care and to attend for treatment. In 2010 his treatment included attending a sex offender treatment group but despite this he continues to pose a threat.

Since then James has resided at a number of different specialist residential homes and has remained subject to Guardianship. His focus on young

children has continued and over the years he has made various attempts to make contact with some. He has also been made subject to a Deprivation of Liberty Safeguard in order to ensure that he can be closely supervised whilst outside of the home.

In 2006 he married another resident who also has learning disabilities but this was a volatile and abusive relationship, which often broke down and finally resulted in them divorcing 2017.

Given the risks that James poses to others and the degree to which he is vulnerable, the use of Guardianship has enabled him to live a far more independent life than would otherwise be possible.

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Kent County Council Workshop for Regulation Committee Mental Health Guardianship Sub-Committee

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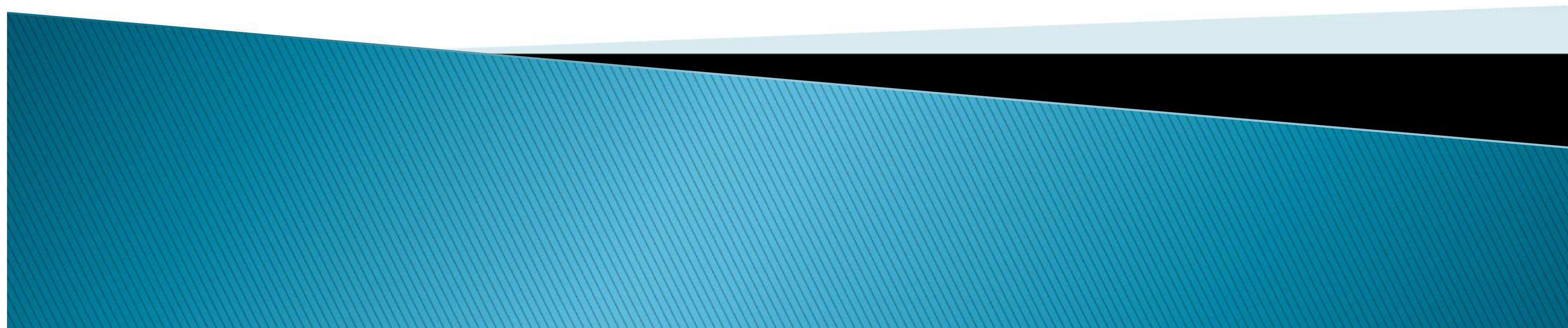

Topics to be covered

- Short history
- Legal criteria and procedure
- Legal effect of guardianship- powers of the guardian and the rights of the patient (often termed ‘safeguards’)
- MHA Code of Practice guidance
- Current estimated statistics
- Case study
- Any final questions

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www.edgetraining.org.uk

Trainer

Christine Hutchison- Director of Edge Training & Consultancy Ltd

- Social worker and previously Approved Mental Health Professional for 18 years
- Mental Health Tribunal Specialist Lay Member
- Previously a Mental Health Act Commissioner for the Care Quality Commission
- Lecturer for Bournemouth University for over 10 years
- Co-author of Focus on Social Work Law- Mental Health, Pub Palgrave 2016.

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Mental Health Law-introduction

"People's understanding of how the mind works, together with their views on mental capacity, free will, determinism and social responsibility, combine to influence how they think the law should operate in this field".
(Rob Brown- The AMHPs guide to Mental Health Law 4th edition 2016.)

For example, look at the terminology used in the past few centuries:

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Date and relevant law	Language
1713 & 1744 Vagrancy Act	Allowed detention of Lunaticks or mad persons
1886 - Idiots Act	Separated out idiots and imbeciles
1913 - Mental Deficiency Act	Idiots, Imbeciles, Feeble minded and Moral Defectives all in one Act.
1959 - Mental Health Act	mental illness, severe subnormality, subnormality or psychopathic disorder.
1983 - Mental Health Act	mental illness, severe mental impairment, mental impairment, psychopathic disorder
2005- Mental Capacity Act	Impairment of or disturbance in functioning of the mind or brain
2007-Mental Health Act	**Mental disorder is any disorder or disability of the mind**

Any disorder or disability of the mind includes:

- Dementia
- Mental illnesses such as Bipolar Disorder or Schizophrenia
- Personality disorder
- Learning disabilities- 'a state of arrested or incomplete development of mind which includes significant impairment of intelligence and social functioning' (Section 1)

But drug or alcohol dependence alone is NOT a mental disorder for the purposes of MHA

The main function of the MHA

- is to “receive, care and treat mentally disordered patients” (section 1)
- provides a number of routes for providing care or treatment to people with a mental disorder within the community as well as within hospital settings.
- The mental disorder must be of a nature or degree to warrant the use of the MHA. In addition, it must be in the interests of the patients health or safety or in some instances to protect others.
- When patients are subject to the MHA, certain ‘safeguards’ apply such as their right to appeal.

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Guidance on use of the MHA

- The MHA has an accompanying Code of Practice which is legal guidance

- Local authorities have to “have regard” to this guidance and show they have applied its principles (see programme for details)

- Chapter 30 of the MHA Code details guidance on the implementation and use of guardianship

Mental Health Act 1983 Code of Practice on Purpose of Guardianship (30.2 & 30.4)

…to enable patients to receive care outside of hospital where it cannot be provided without the use of compulsory powers. Such care may or may not include specialist medical treatment for mental disorder.

Guardianship therefore provides an authoritative framework for working with a patient, with a minimum of constraint, to achieve as independent a life as possible within the community. Where it is used, it should be part of the patients overall care plan.

Guardianship procedure

- Possible through a Civil route (section 7) or via the courts (section 37- very rare)
- S7 requires 2 medical recommendations + an application by an AMHP or Nearest Relative. The AMHP can make an application to the LSSA if there is no objection from the nearest relative and they consider it necessary that the patient be placed on guardianship.
- A care plan should accompany the application setting out which powers are required and why.

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Guardianship procedure

- The application needs to be accepted by the local authority before it takes effect. The local authority does not have to accept an application. Where it does, KCC appoint an AMHP to act as the guardian.
- They must appoint an RC (Responsible Clinician) to determine whether the criteria for renewal are met.
- A private guardian must appoint a doctor as the patients ‘nominated medical attendant’.

Grounds for guardianship

- Patient must be at least 16 years old
- Suffering from a mental disorder of a nature or degree which warrants his reception into guardianship; and
- it is necessary in the interests of the welfare of the patient or for the protection of other persons that the patient should be so received
- If the mental disorder is “learning disability” it must be associated with abnormally aggressive or seriously irresponsible conduct.

Abnormally aggressive or seriously irresponsible

- Re F (2000) 17 yr old's desire to return home to possible exposure to chronic neglect and sexual exploitation was not enough. Need a clear opinion based on reliable evidence that conduce would result in significant risk to patient or others.
- Newham LBC v BS & S (2003) Lack of road sense and tendency on her art to rush into the road without looking was not enough to satisfy the test
- GC v Kingswood Centre (2008) ruled that rushing into road by man with OCD and sense of invincibility was "seriously irresponsible".

Powers under guardianship

Power of guardian to require the patient to

- reside in a particular place
- attend places for medical treatment, occupation, education or training
- allow access by doctor, AMHP or other specified staff

To be taken into custody and conveyed to a place of residence and to return patient to where patient has absconded (s18(6)

The power to require a patient to live in a particular place and take or return them there may be used for example to discourage the patient from:

- Living somewhere the guardian considers unsuitable
- Breaking off contact with services
- Leaving the area before proper arrangements can be made, and
- Sleeping rough

(But it may not be used to deprive them of their liberty)

(MHA Code of Practice para 30.30)

When is guardianship appropriate?

It is most likely appropriate where

- The patient is thought to be likely to respond well to the authority and attention of a guardian and so be more willing to comply with necessary treatment and care for their mental disorder and
- There is a particular need for someone to have authority to decide where the patient should live or insist that doctors, AMHPs or other people be given access to the patient

(MHA Code para 30.9)

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When is guardianship appropriate?(2)

In most cases it should be possible for patients who need care, but do not need to be in hospital, to receive that care without being subject to the control of guardianship. In a minority of cases, the powers which may be exercised by the guardian and the structure imposed by guardianship, may assist relatives, friends and professionals to help a mentally disordered person manage in the community.

(MHA Ref guide para 28.3)

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- Andrew has a diagnosis of schizophrenia.
- He has a history of leaving his supported living accommodation in the Midlands and going to the seaside in Sussex by train to watch boats. In the past he has been missing for several days at a time and he is vulnerable to exploitation (financial and sexual)
- He has benefited in the past from structured supported employment schemes and the authority of his social worker who refers him to such schemes.
- Andrews mother is very concerned by his vulnerability and lack of structure and wants to know whether there is anything more that could be done to protect him
- He has been known to 'hit out' at staff and strangers when very distressed.
- Would the powers of guardianship be suitable in this scenario?

- Andrew has a diagnosis of schizophrenia.
- He has a history of leaving his supported living accommodation and stopping his medication. In the past he has been missing for several days at a time and has put himself and others at risk as a result of deteriorating mental state
- He requires prompt admission to hospital to restart his medication once he becomes unwell and
- Andrews mother is very concerned by the risks of his mental state deteriorating and wants to know whether there is anything more that could be done to protect him (and others).
- He has been known to 'hit out' at staff and strangers when very distressed

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Safeguards for guardianship patients

- Time limited- lasts up to 6 months, renewable for a further 6 months and then yearly.
- Requirement of LSSA to provide information to patient and NR on their rights
- Right to apply to the Mental Health Tribunal
- LSSA procedure for review, renewal and discharge
- Access to an Independent Mental Health Advocate
- The nearest relative can object/discharge s7 (no blocking power)
- Displacement only via County Court
- Care Quality Commission oversee use of MHA & Code

Who can discharge a guardianship patient?

- The responsible clinician (RC)
- Nearest relative (only for s7 guardianship cases)
- Mental Health Tribunal
- The Local Social Services Authority (via a panel- see handouts for further details on process)

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Case law

The majority of relevant case law on guardianship deals with whether a guardianship is necessary where an incapacitated patient is also subject to a deprivation of liberty authorisation (DoLS)

- Guardianship on its own does not authorise a deprivation of liberty (NL v Hampshire County Council 2014).
- “The MCA deals with the person’s best interests, whereas the MHA deals with the protection of the patient and the public” (NM v Kent CC 2015)
- A DoLS and guardianship can sit alongside each other but guardianship continues to be necessary to require residence and powers to return for the protection of others (YCC & ZZ (2012)

Guardianship under the Mental Health Act, 1983

England 2015-16 National Statistics

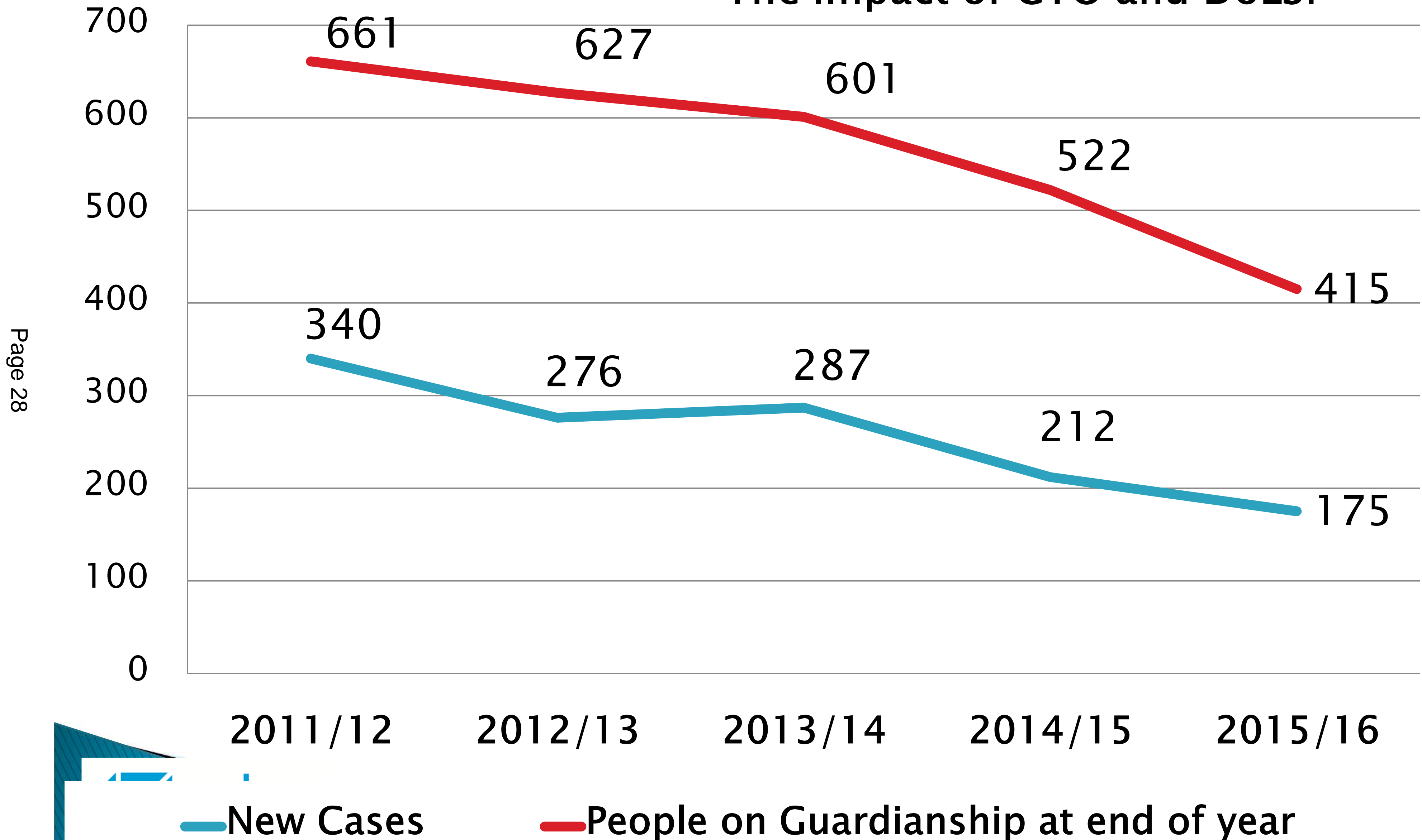
Published 4 August 2016

No statistics for Guardianship published for the period 2016/17. The figures (for no real reason) are now going to be published biennially. If the previous historic trends continue the use of Guardianship would be expected to show further decline.

175 new Guardianship cases in England for the year 2015-16

A long term decline in both the number of new guardianship cases and the number of people subject to guardianship.

On 31st March 2015 there were **415 people subject to Guardianship.** A 50% reduction over the last decade.


Guardianship – continued decline.
The impact of CTO and DoLS?
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212
175
2011/12
2012/13
2013/14
2014/15
2015/16
New Cases
People on Guardianship at end of year

Guardianship under the Mental Health Act, 1983

England 2015-16 National Statistics

Published 4 August 2016

This report contains information on the use of Guardianship under Section 7 and 37 of the Mental Health Act 1983 during the reporting period 1 April 2015 to 31 March 2016, as well as the yearly time series since 2003-04.

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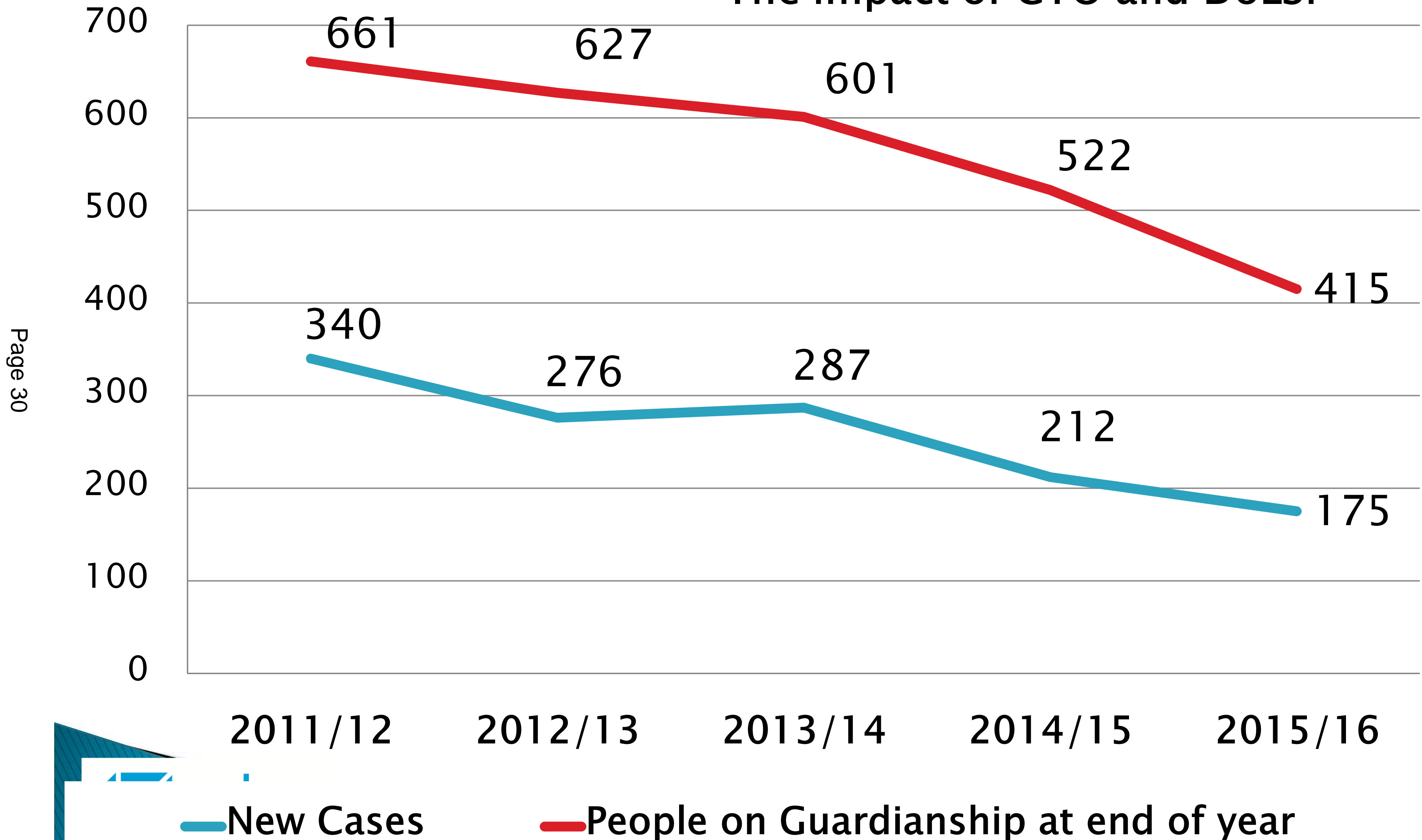
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New Cases
People on Guardianship at end of year

Continuing Guardianships at 31.03.16 for 12 English LAs.

Local authority	Total	Population	Per 100,000
Herefordshire	15	186,087	8.06
Plymouth	10	258,026	3.88
Cumbria	15	499,900	3.00
Gloucestershire	15	597,000	2.51
Cornwall	10	537,914	1.86
Lewisham	5	281,556	1.78
Barnet	5	369,088	1.35
Birmingham	10	1,085,417	0.92
Hampshire	10	1,344,610	0.74
Hertfordshire	5	1,129,100	0.44
Bexley	0	234,271	0.00
Surrey	0	1,132,390	0.00
Totals from sample	**100**	**7,655,359**	**1.31**
Total England	**415**	**54,316,600**	**0.76**

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