Introduction

This package is designed to prepare health professionals to feel competent in giving evidence at judicial hearings for service users under the Mental Health (Compulsory Assessment and Treatment) Act 1992 (the Act).

Background

Service users under the Act can attend court or tribunal reviews at specific times. At Section 16 hearings a service user can contest being under the Act during the compulsory assessment phase. Furthermore, service users routinely appear in judicial reviews prior to a Compulsory Treatment Order (Section 18) or subsequent judicial reviews at 6 months and 12 months while under a Compulsory Treatment Order. In these situations the Act instructs the Judge to consult “with the responsible clinician, and with at least one other health professional involved in the case, and may consult with such other persons as the Judge thinks fit, concerning the patient's condition.” This process also flows over into subsequent reviews undertaken by the Review Tribunal when the person is placed under indefinite status under the Act.

Also, Section 21(1) of the Act states that “the court may, if it is satisfied that it is necessary for the proper disposition of the application, request any person whom it considers qualified to do so to prepare a report on any relevant aspect of the patient's condition”.

In most cases the 'other health professional' in judicial reviews will be the service user’s nurse. Nurses should be prepared to give oral and written evidence at hearings to comply with the requirements of the Act.

Although a set of competencies have not been officially developed to guide the role of giving the second health professional opinion, there are in existence competencies for other statutory roles including that of the Responsible Clinician and the Duly Authorised Officer. A set of competencies has been determined to assist with the role of giving a second health professional opinion. Some are standard practice requirements for nurses; others may be addressed in specific DHB service policies. You may need to check out your own service regarding policies

This is indicated in the set of competencies in Appendix 3.
Educational approach

This package is designed to prepare health professionals to feel competent in giving evidence at judicial hearings for service users under the Mental Health (Compulsory Assessment and Treatment) Act 1992 (the Act). This learning opportunity has been developed on the basis of four educational principles:

1. **Adult learning principles** – that all participants have experience to contribute and enrich the learning experience.
2. **Experiential learning** – that being actively involved in the learning process assists with learning.
3. **Differing learning styles** – people vary in the ways they best learn. Some learn best through observing, some through listening, and others through active engagement. A good learning package should accommodate a variety of learning styles.
4. **Deliberative discussion** – given the experience of health professionals there are a variety of views on topics of interest. There is value in discussing these multiple views to develop greater understanding.

We have developed a package that accommodates all of these principles, with emphasis on the process being fun.

**Pre-reading and preparation for attending:**

Some pre-reading is necessary. Please read this workbook and on reflecting on the reading come to the session with your answers to the following questions.

1. What would you do if you did not agree with the responsible clinicians opinion that someone should be under the Act?

2. You arrive at work and are asked to give a second opinion at a Judicial Review. You have never worked with the person before. What would you do?
3. What are your responsibilities if the client does not want to attend the hearing?

4. If you had to go to the judicial review court and had only looked after the client on that day, what would you say to the Judge?

5. If the client becomes extremely distressed and unable to continue while in the hearing are you able to take the client out of the room?

6. What are your responsibilities to the client after court?
References


Appendix 1: Reading 1
The role of second health professionals under New Zealand mental health legislation

A. J. O’BRIEN1 RGN RPN BA MPhil & A. KAR2 BHB

1Senior Lecturer, Centre for Mental Health Research, Policy and Service Development, The University of Auckland; Clinical Nurse Specialist, Liaison Psychiatry, Auckland Healthcare Services Ltd, and 2Fifth year medical student, School of Medicine, The University of Auckland, Auckland, New Zealand

Correspondence:
A. O’Brien
School of Nursing
The University of Auckland
Private Bag 92019
Auckland 1020
New Zealand
E-mail: a.obrien@auckland.ac.nz


The role of second health professionals under New Zealand mental health legislation

The development of generic statutory roles in mental health care has been the subject of discussion by New Zealand nurses for the past decade. One such role is that of second health professional in judicial reviews of civil commitment. Issues identified by New Zealand nurses have also been raised in England, where it seems that nurses are likely to assume the role of Approved Mental Health Worker under English mental health law. A survey of mental health nurses found that few had received any preparation for the role of second health professional and 45% did not feel adequately prepared for the role. Some of these issues are reflected in a New Zealand inquiry which resulted in the Ministry of Health developing a written report form for second health professionals. However, the form has the potential to reduce the mental health nursing role to a narrow legal role. Statutory roles such as that of second health professional challenge mental health nurses to critically reflect on the conceptual and ethical basis of their practice. While traditional concepts such as therapeutic relationships and advocacy need to be reviewed in light of these changes, nurses need to be vigilant in articulating the moral and clinical basis of their roles. The development of guidelines for second health professional role is suggested as a way of supporting clinical practice in this area.

Key words: advocacy, ethics, mental health legislation, second health professional, statutory role, therapeutic relationship

Introduction

The introduction of the New Zealand Mental Health (Compulsory Assessment and Treatment) Act (New Zealand Government 1992) (the MHA) signalled a clear break between the era of legislation based on a medically determined need for treatment and a more legally determined standard of civil commitment (Bell & Brookbanks 1998). The Act also signalled a move away from an exclusive reliance on medical authority in civil commitment decisions, initiating a number of new statutory roles. Most of these roles are defined in generic terms, meaning that they can be assigned to health professionals from a range of different disciplines. Issues identified by New Zealand nurses have also been raised in England, where it seems that nurses are likely to assume the role of Approved Mental Health Worker under English mental health law. English authors have discussed concerns raised by statutory roles (Hurley & Linsley 2005), and these concerns show similarities to those identified by New Zealand authors. Overall, there is a limited literature addressing these issues.

This paper considers issues raised by one of the statutory roles created in the 1992 Act, that of second health professional in judicial reviews conducted under section 16. Some of these issues have been discussed in a previous publication (Fishwick et al. 2001). In this paper, the nature
of the role of second health professional is outlined, and the issues facing nurses acting in this role are discussed. Recent work in the area of nursing ethics suggests that a relational ethical approach may be useful for nurses in responding to the challenge of statutory roles. Such an approach was foreshadowed by Foster (1998) in suggesting that the role of Duly Authorised Officer provided the opportunity to realize the beneficent moral intent of Act. This paper considers the findings of a recent inquiry which involved a section 16 review (Cull & Robinson 2003), and presents results from a study of nurses’ perceptions of their training needs. The research suggests that any formalized training for the second health professional role needs to conceptualize the role in both clinical and legal terms. Such training needs to emphasize the important role of the review process in safeguarding patients’ rights. It also needs to address how nurses can protect their relationships with service users at the same time as discharging their legal responsibilities. Finally, the paper makes suggestions for the development of a guideline for professionals acting in the role of second health professional.

**Background**

Mental health nurses have traditionally played key roles in the care of service users subject to legal coercion (Clark & Bowers 2000). However, in recent years, as legislation has moved away from a medically defined need for treatment (Grove 1994), nurses’ involvement in formal statutory roles has increased. Proposed changes to English mental health legislation envisage the creation of a generic role of Approved Mental Health Worker (Hurley & Linsley 2005), a move that parallels the development under New Zealand legislation of the role of Duly Authorised Officer (Street & Walsh 1994, 1998, Foster 1998). Development of statutory roles represents a challenge for mental health nurses who have used concepts such as the therapeutic relationship (Peplau 1952/1988) and advocacy (Sines 1994, Willard 1996; Mallik 1997) to characterize their practice. In order to properly discharge responsibilities under legislation, and to meet their commitment to maintaining therapeutic relationships, nurses need a framework for practice in this area which gives weight to both aspects of their role.

**Civil commitment under New Zealand mental health legislation**

Consistent with many other jurisdictions, New Zealand mental health legislation uses a two-part test for civil commitment. The Act requires (section 2) that the proposed patient demonstrates ‘mental disorder’ which is defined as an abnormal state of mind . . . characterised by delusions, or by disorders of mood or perception or volition or cognition, and, in addition, that the person, as a result of mental disorder, poses a serious danger to their own health or safety or that of others; or shows a seriously diminished capacity for self-care. Thus, mental illness is not a sufficient justification for invoking mental health legislation. Furthermore, psychiatric diagnosis is not a necessary requirement.

**Section 16**

The provision of a right to seek a judicial review of a decision to invoke mental health legislation is one of the most important protections available to patients under New Zealand mental health legislation. This provision is consistent with the United Nations’ Principles for the protection of persons with mental illness and the improvement of mental health care (United Nations Office of the Commissioner for Human Rights 1991), which requires that no person shall be held without having available a judicial process of appeal. Section 16 allows a patient subject to compulsory treatment to have their condition reviewed by a judge. This right becomes effective at the time civil commitment is invoked; there is no statutory period for which a patient can be held without the right to seek a review. Reviews are conducted in assigned rooms in inpatient facilities, and constitute a formal sitting of the District or Family Court. In practice, reviews are held on the occasion when a judge is scheduled to visit, which may be several days after the patient makes application. The Act only requires that reviews are held ‘as soon as practicable’ [section 16 (1B) (b)]. The focus of a section 16 review is the ‘patient’s condition’, interpreted in terms of the statutory test of the Act. In considering a case, the judge must hear from the patient’s ‘responsible clinician’ (the clinician in charge of the treatment of the patient) (MHA, section 2) and ‘at least one other health professional’ (MHA, section 16). The latter can be any health professional involved in the patient’s care. In practice, the second health professional is usually a nurse.

Although the intent of the MHA in requiring the judge to listen to the views of another health professional is not spelt out in the legislation, it seems reasonable to assume that what is required is more than simply gaining one additional opinion. Nurses and doctors formulate their views on patients based on a different range of interactions with, and experiences of the patient, albeit that both are informed by a common clinical perspective. Nurses’ views are formed in the context of 24-h care, prolonged contact and interaction with patients in the context of their day-to-day lives. Doc-
tors’ views are formed on the basis of more time-limited clinical interviews, and nurses’ reports of the patient’s communications and behaviour. It is plausible to assume that the intention of the Act is that the court is informed by both perspectives in reaching a decision. In assuming the role of second health professional, it is important that nurses value the nursing perspective that is implicitly required of the role, rather than see the opinion they offer to the court as being simply one more psychiatric opinion.

The Cull and Robinson inquiry

In 2003, an inquiry resulted from an incident in which a patient was discharged from hospital, less than 12 h after his admission, and following a section 16 review which found that he was not mentally disordered (Cull & Robinson 2003). The patient subsequently killed his father, and was found not guilty by reason of insanity. Part of the inquiry focused on the section 16 review, and the role of the second health professional. The inquiry thus provided a rare instance of this process being subject to careful legal scrutiny. The inquiry found that neither the responsible clinician nor the second health professional involved in the section 16 review had adequate time to prepare a report. The review was scheduled for the patient’s first morning as an inpatient, giving the clinicians involved in his care only a few hours to familiarize themselves with his case as well as attending to their other responsibilities. The inquiry also found that either clinician could have asked for the review to be deferred in order to give time for them to prepare their statements to the court.

The inquiry cast light on the second health professional role in a way that was quite new. The second health professional was treated as an integral part of the court process, and the report commented on the need for second health professional to provide ‘meaningful consultation’ (Cull & Robinson 2003, p. 218). Among other recommendations, the report recorded that there needed to be training for the second health professional role, a recommendation that is yet to be implemented. It is apparent in the Cull and Robertson report that the role of second health professional is crucial to the court process. Furthermore, it is apparent that the role involves providing a properly formulated independent clinical opinion.

Research into nurses’ perceptions of their training needs

To establish nurses’ perspectives of their training needs in relation to the section 16 role, a small research study was undertaken. The design involved an anonymous survey of nurses recruited through purposive sampling from an inpatient unit. The survey collected demographic data, data on participants’ experience in section 16 reviews, and data on their preparation for the section 16 role. We asked participants to rate various items in terms of how important they perceived them to be in any training for the section 16 role. Ratings were collected by means of a 5-point Likert scale, in which items were rated from ‘not important at all’ to ‘very important’. Items were developed through literature review and by trialling the questionnaire with a small number of inpatient nurses. Each question provided additional space for open ended questions. Analysis involved the use of descriptive statistics and content analysis of open ended responses. The research was approved by the Ethics Committees of the University of Auckland, and the mental health service provider.

Results

Of the 50 survey forms distributed, 31 were returned giving a response rate of 62%. Respondents were equally divided between those aged under and over 40 years. A summary of the respondents’ range of ages is provided in Table 1. There were slightly more female respondents than male, with females tending to be younger than male. The majority of respondents ($n = 20$) gained registration through hospital training programmes with a smaller number ($n = 11$) gaining registration through comprehensive diploma or degree programmes.

Two-thirds of the participants had six or more years of clinical experience, and over half had been involved in 10 or more section 16 reviews. Participants’ years of clinical experience varied from 1 to 12 years, with one participant having less than 1 year of experience, 11 having between 1 and 5, seven between 6 and 11, and 12 having more than 10 years of experience. Involvement in section 16 reviews varied from one occasion ($n = 1$), between two and five ($n = 8$), between six and 10 ($n = 4$), and more than 10 ($n = 17$).

A summary of nurses’ preparation for the second health professional role and perceptions of being adequately prepared is provided in Table 2. When asked if they had received any preparation for the section 16 role, $77\%$ ($n = 24$) of participants reported that they had received no preparation. For the seven participants who reported having received some preparation, this almost exclusively consisted of ‘discussion of cases’, with one participant indi-

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<td>Age (year)</td>
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cating that he or she had received supervision in the role and another reporting that he or she had used written guidelines. The latter finding is surprising as there are no known written guidelines for this role. Also surprising, in light of participants’ reports of lack of preparation, a little over half the participants \((n = 16)\) reported feeling adequately prepared for the second health professional role. Participants who reported receiving training were almost equally divided between those who reported feeling prepared and those who did not.

In response to a question asking how they gained their knowledge and experience in the second health professional role, 84% \((n = 26)\) of participants identified clinical experience as their source of knowledge, with others nominating ‘making mistakes’, ‘trial and error’ and ‘being thrust into the role’ as sources of knowledge. Most participants (87%, \(n = 27\)) reported that they understood the expectations of the second health professional. Participants were almost equally divided between preferences for training, with 84% \((n = 26)\), 81% \((n = 25)\) and 71% \((n = 22)\), respectively, nominating discussion of cases, written guidelines and training in court process as preferred means of training.

The next section of the survey asked participants to rate a series of eight items in terms of their perceived helpfulness in any training programme. Participants’ responses are summarized in Table 3. Six of the eight items were rated as very important by 75% or more of participants. ‘Criteria for releasing a patient’ was rated as the most helpful of the eight suggested items, with 97% \((n = 30)\) of participants rating that item as very important. The items rated as next most important were ‘Debriefing with the patient following hearing’ \((84\%, n = 26)\), with ‘Formulating oral statements relating to the patient’s clinical condition’ and ‘Criteria for application of the Act’, each rated as very important by 81% \((n = 25)\) of participants. Two other items were rated as very important by the majority of participants. These were: ‘Expectations of a second health professional’ and ‘Maintaining a therapeutic relationship’ which where each rated as very important by 75% \((n = 23)\) of participants. The remaining two items, ‘Debriefing with colleagues following hearing’ and ‘Formulating written statements relating to the patient’s clinical condition’ were rated as very important by 45% \((n = 14)\) and 42% \((n = 13)\) of participants, respectively.

### Discussion

The study is limited by the small sample size, and by being drawn from the staff of a single facility. Hence, the results cannot be generalized to a wider group. The participants provided a balanced group in terms of age and gender, although were disproportionately from hospital-based training programmes. The numbers were too small to allow speculation about whether there were any between group differences in any of the variables measured. The participants represented an experienced group both in terms of their years of clinical practice and their involvement in section 16 reviews. Most had considerable experience in section 16 reviews, although few had any preparation for the role. The preparation that was reported appears to have been informal. In terms of gaining experience, methods such as ‘making mistakes’, ‘trial and error’ and ‘being thrust into the role’ are hardly a sufficient basis for undertaking a formal legal role. In the absence of any further elaboration, it is likely that ‘clinical experience’ also involves such informal learning. A majority of participants reported that they understood the

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<td>Preparation for section 16 role</td>
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<td>Have you received any preparation for the section 16 role?</td>
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<td>Do you feel adequately prepared for the role?</td>
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<td>Perception of being adequately prepared among those who have received training ((n = 24))</td>
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<td>Ratings of suggested training items in terms of helpfulness</td>
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<td>Criteria for making a decision to release</td>
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<td>Debriefing with the patient following hearing</td>
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<td>Criteria for application of the Act</td>
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<td>Formulating oral statements relating to the patient’s clinical condition</td>
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<td>Debriefing with colleagues following hearing</td>
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*For some items there were no responses.*
expectations of the second health professional role, although by a small majority participants reported feeling unprepared for the role. The apparent contradiction between these findings may reflect an understanding of how the role is discharged in practice, with nurses learning expectations through experience, but without formalized preparation to support that learning. Without preparation, it is likely that some aspects of the role will be unclear at best, perhaps even unknown. This was demonstrated in the Cull and Robinson inquiry, where neither health professional was aware that they could ask for the review to be deferred, or present reports written by clinicians at an earlier period (Cull & Robinson 2003).

Most items suggested as possible content for a training programme were rated as ‘very important’ by 75% or more of participants. The items covered legal criteria as well as professional issues such as maintaining therapeutic relationships, and debriefing with the patient, indicating that nurses do not see the second health professional role in exclusively legal terms. The need to understand the criteria of the Act is balanced by a clinical perspective evident in the emphasis given to maintaining therapeutic relationships. The clinical emphasis is also evident in the importance attached to debriefing with the patient following a review. Oral statements were rated as a lot more important than written statements. The relative emphasis on oral statements no doubt reflects the previous experience of this group, as there has been no requirement to date to provide a written opinion. The findings provide a clear indication that training for this role needs to be multifaceted, and should not involve an exclusive emphasis on legal aspects of the role.

Section 16 report form

As this research was undertaken, and in response to the findings of the Cull and Robinson inquiry, the Ministry of Health has produced a written report form for second health professionals (Ministry of Health, unpublished). The judiciary has also formulated a ‘best practice’ guideline which refers to the written report [Applications for review, under section 16 MH (CAT) Act 1992, unpublished]. Although completion of the Ministry of Health form is not a legal obligation, it is likely to be required by Directors of Area Mental Health Services, and by service managers. The form has two sections, the first of which addresses only the relationship of the professional to the patient. The second section addresses the statutory test of the Act, directing the second health professional to record:

Direct observations or information from other sources including family/whanau relevant to mental disorder, e.g.

- ‘abnormal state of mind’
- ‘serious danger to the health and safety’ of the patient or others, and
- ‘serious reduction in the capacity of the patient to take care of himself or herself’. (Ministry of Health, unpublished)

The form does not provide space for the more contextualized comments that would provide a judge with a broader perspective, although the inquisitorial nature of the section 16 is designed to elicit such comments. However, the development of a formal document, in the absence of any guideline that addresses broader aspects of the second health professional role, can be seen as an essentially bureaucratic response to what is a complex clinical and professional issue. It also defines the second health professional role in narrowly legal terms which limit the freedom of professionals to provide a more contextualized report. Importantly, the second health professional report form duplicates the clinical report form completed by the responsible clinician. This latter form specifically requires the responsible clinician to address the two limbs of the Act. The legal construction of what is in most cases a role carried out by nurses raises issues for nurses assuming statutory roles. Addressing the statutory definition of mental disorder is clearly an expectation of second health professionals. However, by directing the report towards the legal definition of mental disorder, the form acknowledges only the legal component of what is a both clinical and legal role.

Need for training

When the MHA first became operational in 1992, nurses noted that one of the key roles within it, that of Duly Authorised Officer, was dependent for its operation on the assessment skills of nurses (Street & Walsh 1994, 1998). It was claimed that the role formalized existing practice (Wilson 1992, cited in Street & Walsh 1994, p. 40), rather than creating an altogether new role. A decade later, there are still no nationally standardized training guidelines for the Duly Authorised Officer (DAO) role, one which is widely assumed by mental health nurses. As with the DAO role, the role of second health professional also assumes that nurses will know how to discharge this responsibility. The finding in the research reported here that 45% of nurses report feeling prepared to act in this role should offer little comfort, especially as 87% also report receiving no training for the role.

Changes in mental health legislation serve important social interests as they seek to embody changing views of mental illness, human rights and due process in civil commitment proceedings. However, these social interests cannot be served when key players in enacting legislation are
expected to assume statutory roles with no training and without the benefit of written guidelines. This situation leads to skills developing through trial and error.

For mental health nurses, there are important questions about the perspective they bring to bear on this role. It is critical that a formal report does not reduce the role of second health professional to one of merely providing a written account that confirms existing medical opinion. Any over reliance on the notion of ‘meeting the statutory test’ stands to push the second health professional role in that direction, depriving the patient of an important source of advocacy, and defeating the intent of the Act to bring a greater range of perspectives to bear in making decisions on civil commitment.

Integrating clinical and legal roles

The development of statutory roles poses a challenge for mental health nurses whose function within mental health legislation has hitherto been less transparent than that required by roles such as second health professional. It may even seem somewhat ironic that professional aspirations have been rewarded with a more explicit involvement in legal processes. Participation in statutory roles requires re-evaluation of how such roles are compatible with traditional concepts such as therapeutic relationships and advocacy. There are a number of possible responses to this problem. One response is to acknowledge that implication in the use of coercive power has always been part of mental health nursing practice, albeit in informal ways. This position has something in common with that of Clark & Bowers (2000) who challenged nurses to take note of variations in application of mental health legislation, pointing out that nurses should not take comfort in some notion of legal objectivity. Bowers and Clark’s challenge takes on even greater significance if nurses are to be the individual agents of coercive legal powers. In the UK, Howell & Norman (2000) have drawn attention to the increasing role mental health professionals are being asked to play in the protection of public safety. Mental health nurses would do well to resist such a role, especially any notion of anticipatory containment (Brookbanks 2002). However, involvement in statutory roles does require nurses to re-examine concepts such as the therapeutic relationship and advocacy, and ask how these can accommodate involvement in legal coercion.

Therapeutic relationships

The literature on therapeutic relationships seldom considers issues of legal coercion, and the limits legal coercion might impose on therapeutic relationships. Within psychi-

Advocacy

The role of advocacy in mental health nursing is potentially problematic in relation to the second health professional role, as patients are represented in court by a legal advocate, their lawyer. As Schwartz (2002) notes, even where a patient is acting autonomously, nurses may be compromised in assuming an advocacy role that commits them to supporting any choice made by a patient. Willard (1996) argues that to be conceptually distinct from beneficence, advocacy needs to represent patients’ autonomous preferences, or risk becoming paternalistic. A further problem with advocacy, identified by Mallik (1997), is that nursing models of advocacy are indeterminate. This problem is accentuated where there is limited support for nurses assuming an advocacy role. Clearly any advocacy role claimed by mental health nurses needs to be carefully considered. But there are important reasons why mental health nurses should retain a place for advocacy within a conceptual framework of mental health nursing. Patients who are subject to legal coercion are at significant risk for loss of human rights, something that is acknowledged in providing
avenues of legal review within mental health legislation. However, there is some research that suggests that patients are not always aware of their rights (Bradley et al. 1995). Furthermore, an audit of clinical case notes in New Zealand found that few files contained evidence of patients being informed of their legal rights (O’Brien et al. 2004). The amount of time nurses spend with hospitalized patients provides an opportunity for nurses to assess patients’ needs and aspirations (Schwartz 2002), and to assist in meeting those needs. In the case of patients under legal restraint, this will at times involve acting paternalistically, which in turn imposes an ethical responsibility on the part of the nurse to reflect carefully, in each case, on the ethical issues involved (O’Brien & Golding 2003). The concept of advocacy can play an important part in perceiving the patient, as a bearer of rights, at the centre of mental health nursing practice. Guidelines such as those suggested below go some way to providing support for nursing practice, but the problematic nature of advocacy remains something to be explored further within the nursing discipline.

**Guidelines for second health professionals**

Section 130 of the MHA makes provision for the Director-General of Health to promulgate guidelines relating to specific roles under the Act. Currently, there are guidelines for Duly Authorised Officers, District Inspectors, Directors of Area Mental Health Services and other roles. The findings of the Cull and Robertson inquiry and the results of the research presented here suggest that it is timely that consideration is given to developing guidelines for the second health professional role. While a guideline would not by itself guarantee good practice, it would provide some clarification for nurses acting in this role, and could provide a basis for training. A guideline would also clarify for patients what they could expect from clinicians acting in the second health professional role. This concern is not unique to nurses. In reviewing issues for psychiatrists in presenting their assessments in section 16 reviews, November (1995) recommended that ‘court training’ could help in preparing psychiatrists for this role.

Areas which could be addressed by guidelines are:

- discussing the potential for conflict between clinical and legal roles;
- clarification of the intent of the second health professional role;
- understanding the statutory test of the Act;
- clarifying the areas of information that may contribute to a second health professional report;
- formulating written statements to the Court;
- formulating verbal statements to the Court;
- explaining to the patient the Court process;
- discussing with the patient, the opinion intended for the Court;
- discussing the Court process and decision with the patient following a hearing.

In addition to training, existing means of developing skills could be utilized to enhance practice in the second health professional role. Group and individual clinical supervision, service user forums, case reviews and interdisciplinary discussions are all practicable means of assisting individuals to develop their clinical practice.

**Conclusion**

Involvement in statutory roles is a relatively recent development in mental health nursing, and one which is likely to increase (Howell & Norman 2000). Literature shows that issues identified by New Zealand nurses have also been experienced by social workers in England, and that similar issues are anticipated by nurses, with the proposed introduction under English legislation of the generic role of Approved Mental Health worker. While it is understandable that nurses may feel that such roles pose a threat to relationships with consumers, there is some evidence to suggest that relationships can be managed in such a way that that possibility is at least minimized, perhaps obviated altogether (Hurley & Linsley 2005). However, the assumption of such roles, which arise out of policy changes reaching beyond the nursing profession, does challenge nurses to reflect on the conceptual and ethical frameworks that inform their practice. In the case of the second health professional role, official intervention has focused on the legal aspect of that role, and minimizes its clinical component. Recent nursing critique of caring, and of traditional models of ethical reasoning may assist nurses to articulate a framework of practice that adequately addresses both the legal and clinical aspects of the second health professional role. There is a need for both training, as recommended by the Cull and Robertson report, and practice guidelines that do justice to the complexity of the role.

**References**


The role of second health professionals


Appendix 2: Meaning of “Mental Disorder”

Reference


This is a teaching resource; please keep this in mind when reading.
Definition of Mental Disorder

2.1 Introduction
Achieving the correct balance in defining mental disorder can be difficult. A definition that is too restrictive may mean that people who do not fit the criteria but need treatment may not receive it, while one that is too wide can lead to people being subject to compulsion who are unlikely to benefit from treatment.

2.2 The definition
While early mental health laws were paternalistic and designed with the protection of others in mind, contemporary legislation now also often includes legal and procedural safeguards designed to ensure adequate protection of the rights of people with mental disorder.

Section 2 Mental Health (Compulsory Assessment and Treatment) Act 1992 defines mental disorder as:
- An abnormal state of mind (whether of a continuous or an intermittent nature), characterised by delusions, or by disorders of mood or perception or volition or cognition, of such a degree that it-
  - (a) Poses a serious danger to the health or safety of that person or of others; or
  - (b) Seriously diminishes the capacity of that person to take care of himself or herself

The definition requires a person to have an abnormal state of mind which, as a result, poses a serious danger to the person’s own health or safety, or that of others. There must be a link between the abnormal state of mind and the personal or public interest. A person cannot be detained solely for his or her own good or because he or she has a propensity to act dangerously. It follows that however unwell a patient may be, he or she should be discharged unless presenting a serious danger to him or herself or the public, or has a seriously diminished capacity for self-care. It also means that if the first limb of the definition is not satisfied than the tests in the second are not relevant.

Reflecting the move away from legislation based on a medical model, the 1992 Act avoids reliance on diagnostic criteria instead setting parameters which establish mental disorder by the “presence or absence of observable symptomological indices”.

2.3 Abnormal state of mind
While it may seem that clarifying what is meant by “abnormal” contributes little to understanding the definition, there are major conceptual and ethical issues underlying the use of the term and an increasing body of writing which suggests that the issue of “normality” – and its use in the mental health context – is likely to assume increasing relevance. The crux of the issue is whether the term should be defined subjectively, that is, by reference to the normal position of the individual concerned, or objectively, by comparing his or her thoughts and behaviour with that of the wider community. An objective approach has been favoured.
While it is logical that anyone making an objective judgment of what is abnormal is likely to rely on what they consider normal as a comparator, it also means that thought which differs significantly from their own is likely to be considered abnormal. For many, an argument that has the attraction of being both pragmatic and supportive of an objective approach is that, if such a standard were not adopted, it would be necessary to assess every patient to decide whether their state was normal for them. As a result, the criteria for compulsory treatment would vary from patient to patient. It could also mean that a person who is persistently psychotic or depressed would not be considered mentally disordered because his or her state of mind was normal for that person.

The Ministry of Health Guidelines, recognising the ambiguities inherent in the term, have recommended that clinicians bear both interpretations in mind when considering an individual’s state of mind and clarify which applies in a particular case.

2.4 Continuous or intermittent

Many mental disorders are, by their nature, episodic with the result that an abnormal state of mind may be either “continuous or . . . intermittent”. Early tribunal decisions suggested that at times patients subject to compulsory orders should not necessarily be discharged simply because the disorder was in abeyance, provided there was sound evidence that the disorder would return.

The present position appears to be that symptoms must not necessarily be present at the time of examination or when the application for a compulsory treatment order is made. Compulsory treatment may be continued, or even initiated, during a period of remission. Thus, in a recent case a patient who had been admitted to hospital 14 times over the previous 22 years following episodes of abusive and delusional behaviour was held to be mentally disordered despite being “largely, if not completely, free of positive symptoms” at the time of examination. In reaching its decision the tribunal took into account the applicant’s longitudinal history and his unique characteristics (his condition was exacerbated by ongoing use of cannabis) together with:

- The rapidity with which he relapsed;
- The seriousness of his symptoms when he relapsed;
- The degree of inevitability or imminence of relapse;
- The seriousness of dangerousness or loss of capacity for self-care when he was unwell; and
- The rapidity with which he recovered when he relapsed.

The Ministry of Health guidelines indicate that compulsory treatment may be appropriate for a person who appears to be free of symptoms in the following circumstances:

- There are repeated or prolonged episodes of illness;
- There are manifestations of violence during periods of illness;
- There is early loss of insight during an episode of illness;
- There is a pattern of being unable to take the necessary steps to halt the illness developing;
- Where changeable insight results in an inability to maintain a consistent decision.

Intervention in these circumstances is justified as good clinical practice since it prevents relapse. Danger itself - let alone its level – is notoriously difficult to predict and establish yet it is central to a determination of mental disorder as it can act as a “strong pointer as to whether there is abnormality, that is whether the first limb applies”. The requirement
that the danger is “serious”, however, is problematic. Although it can be seen as a continual reminder of the potentially draconian results of making a compulsory order (which makes a good argument for its continued retention), its exact meaning creates difficulties both for doctors, who struggle to predict the consequences of certain signs and symptoms, and judges, who have to decide whether the threshold has been reached. In considering whether danger is serious enough to meet the criteria of the Act, the level should tip the scales towards the effect of the possible loss of liberty. In other words, it must be interpreted in a way which balances the objectives of the legislation – which include care for the patient and protection of the community – against the effect of infringing the individual freedoms in the Bill of Rights.

Initially, “serious” was considered to qualify the level of danger arising from an abnormal state of mind by introducing components of imminence and likely consequences, but it is now accepted that imminence is as much about cause and effect as about proximity and deciding the degree of danger should involve an analysis of all the circumstances in a particular case, not just temporal issues. These could include matters such as past behaviour, the person’s acceptance that the behaviour had occurred, the exact nature of the disorder, the success of previous intervention, and the likely maintenance of treatment. Therefore, although imminence was originally considered important in assessing danger its significance has diminished over the period that the Act has been in effect, but it should not be discounted entirely as a factor in determining the level of dangerousness.

Some judges have interpreted “serious” as an indication that patients should only be admitted for assessment if they are so disordered that there is an immediate danger to either their own health or that of some other person. But adopting such a restrictive approach has been criticised as placing members of the public at risk, and a wider interpretation is considered appropriate where the risks appear very high. However, the reluctance at times by clinicians invoke legal provisions that they have to justify before a judge or tribunal, can mean that intervention is delayed until a person appears to have passed a certain threshold.

2.6 Danger to the health or safety of the person
Paragraph (a) of the second limb of the definition requires that a person’s state of mind either poses “a serious danger to the health or safety of that person or of others” or (b) “seriously diminishes the capacity of that person to take care of himself or herself”. Early tribunal decisions tended to emphasise the danger that the patient presented to the health or safety of other rather than the threat to his or her own health or safety perhaps because as para (b) refers to a diminished capacity for self-care, the danger to an individual’s own health and safety appeared to be covered by that limb of the definition so that there seemed little need to rely on the “health and safety” element in para (a).

The phrase “health and safety” is sufficiently comprehensive to encompass not only physical harm, but also emotional and psychological health that could lead to physical harm. At one point it was thought that, given the purpose of the Act, the reference could not logically be to the person’s mental health and something else must have been intended such as danger that was likely to be injurious to other aspects of the patient’s physical integrity or well being. This interpretation was dismissed in subsequent decisions which held that the reference to the health of the patient would, in most cases, mean their physical wellbeing:
In assessing whether an individual’s mental disorder presents a threat to his or her safety, there must be a nexus between the abnormal state of mind and the danger created. The fact that a patient has a propensity to act dangerously in a manner that is not directly related to an existing mental illness – for example, driving recklessly – cannot justify the making of a compulsory treatment order. As to what is meant by health and safety, it is important to note that in this context, too, it has been interpreted to mean more than physical violence. Limiting the phrase so that evidence of physical violence is required is to interpret it too restrictively – a person can pose a danger to the health and safety of others if his or her conduct creates fear and apprehension in the people with whom he or she associates. The reference to “others” is also not limited to those with whom the patient is in direct contact. It could include random members of the public – for example, the risk to the community generally posed by a person suffering from a delusional disorder linked to erotomania – although it is arguable whether threats to clinical staff should be construed as falling within this category.

In analysing the likelihood of danger, the following issues are relevant:

1. Level (that is, the gravity) of the harm should it eventuate;
2. Likelihood of the harm occurring;
3. Proximity of the harm;
4. Frequency of the harm; and
5. The need to balance the nature of the harm against the proposed intervention.

Dangerousness could be determined by scouring these criteria. A relatively low score on one of these factors could be offset by a high score on another.

2.8 Seriously diminished capacity for self-care

Given the difficulties in identifying what constitutes danger to an individual’s own health or safety, it is understandable that there has been a tendency to invoke para (b) of the definition in preference. It is easier to address a patient’s wellbeing. Not only is this less contentious, but it imports an element of concern for their welfare. While this has elements of paternalism about it, these factors should not be discounted if the patient is present at the hearing, for example, and a good therapeutic relationship with a clinician is desirable.

The test for determining a diminished capacity for self-care has been discredited as a combination of subjective and objective elements. For example, it should involve comparing what a person is capable of achieving if functioning normally, with how he or she is functioning in fact. The degree of impairment that is evident should be at a level that puts the individual at risk and compromises his or her ability to take care of him or herself.

2.9 Disorders of mood, perception, volition, or cognition

To be considered mentally disordered a person must suffer from an abnormal state of mind which manifests certain phenomenological consequences, namely delusions, or disorders of mood or perception or volition or cognition. The inclusion of delusions and disorders of mood and perception in the definition is uncontroversial, as the terms have a recognised psychiatric meaning. However, volition and cognition do not have particular significance for psychiatrists, and as a result clinicians and lawyers have found it difficult to agree on how the terms should be interpreted.

2.9.1 Disorders of cognition

The interpretation of “disorder of cognition” led to problems almost as soon as the Act came into force. Some guidance was found in psychiatric texts, which loosely defined cognition as obtaining, organising, and using sensory and perceptual information, but
the definition lacked precision and the courts referred to the dictionary meaning in an attempt to further clarify the term. A dictionary meaning defines cognition as a noun (a thought) and as a verb (the process of thinking). However, if cognition is defined as a thought then the definition of mental disorder could be interpreted very widely, with the result that people whose thoughts are deviant, but not delusional, fall within the Act.

For some years it was thought that a disorder of cognition was limited to the disorganised or illogical thought processes found during psychosis and was typically associated with brain dysfunction arising, for example, from drug-related delirium, head injury, severe depression, or dementia. With such disorders the formal mechanisms of thought – that is, memory, insight, or orientation – are disputed.

2.9.2 Disorders of volition
The inclusion of the term disorders of volition” has been described as “puzzling” and “[its] meaning obscure”. Volition has no generally agreed psychiatric meaning, although it has a specialist connotation in relation to psychoses when it encompasses conditions such as catatonic excitement or withdrawal, depressive stupor, passivity phenomena and command hallucinations, and amotivational syndrome.

However, volition also means “exercise of the will” suggesting that situations involving impulse control have potential to be described as disorders of volition. It can be difficult to decide whether it is appropriate to classify people who, while aware of their actions and potential outcome, act impulsively for a variety of reasons, as mentally disordered.

Applying the term literally could result in the definition “embracing an inordinately vast range of conditions”. Conversely, restricting its use militates against the legislative intent that conditions justifying the description – and requiring compulsory treatment – should fall within the Act. In most cases, whether a person has acted involuntarily because of an irresistible impulse, or simply not resisted acting impulsively, is technically not an issue since it is the result of the behaviour that is important. Practically, therefore, the term may refer to both an irresistible impulse which leads to a loss of free will, and a failure to learn to adjust and control impulsive behaviour – provided that the condition can be described as “abnormal”.

The most contentious use of volition relates to personality disorder. Although personality disorder is discussed in a separate chapter, it is mentioned in this context because people who are said to have a personality disorder are often characterised as such because their behaviour violates social conventions. A compromise position is to view personality disorders as sometimes falling within the definition of mental disorder, but not all people with personality disorders as being mentally disordered. Again, it is necessary to identify the feature of the putative patient’s state of mind, which may be described as abnormal because it constitutes a disorder of perception, volition, or cognition, and establish that the severity endangers the patient or others.

Volition is also closely linked to cognition. For example, an inability to resist sexual impulse may be characterised as a disorder of volition while a failure to understand the consequences of that behaviour could be seen as a disorder of cognition. As a result it has been suggested that mood, perception, volition, and cognition should not be viewed as discrete conditions but rather as strands of a whole, so that while individual components of a disorder may not satisfy the criteria, the totality might.
2.10.1 Section 4(a): personal and/or religious beliefs
Personal and/or religious beliefs do not, of themselves, bring a person within the parameters of the 1992 Act. However, it is important to distinguish between people with idiosyncratic religious convictions and those who act in accordance with a delusional thought structure. Only in the latter case can a person's condition be properly described as an abnormal state of mind, since the thinking is not attributable to any particular personal conviction or faith but the result of delusional thinking.

2.10.2 Section 4 (b): sexual preferences
Inappropriate sexual behaviour and offending do not, by themselves, indicate mental disorder and it would be inappropriate to extend the definition to permit treatment, rather than imprisonment, of a person who has committed such an offence. To do so would be consistent with the argument that a person in mentally disordered simply because of his or her damaging or destructive behaviour.

2.10.3 Section 4 (c): criminal or delinquent behaviour
If disorders of volition are considered to cover some cases of personality disorder and any resulting behaviour is dangerous, then arguably the provisions of s 4 would not apply because a mental disorder could be established. In this case there is always the risk of concluding that 'a person is disordered because he commits crimes and then to conclude that his disorder should at least partially excuse those crimes'

S4 is not a statutory impediment to a finding of mental disorder if delinquent or criminal behaviour is the result of disordered thinking.

2.10.4 Section 4(d): Substance abuse
Section 4(d) will not exclude people who suffer from a mental disorder as a result of prolonged substance abuse from falling within the Act if the criteria for mental disorder are satisfied.

When substance abuse and mental disorder coincide and it is unclear whether the disorder is directly attributable to the substance abuse, the emphasis of the 1992 Act on effects and symptoms (rather than diagnosis) permits a person to be assessed because they appear to be mentally disordered, allowing clinicians to clarify the cause of the disorder.

A person with a dual diagnosis is not disqualified from treatment under the Act, but special management issues may arise. It is possible, for example, that the person could be treated as an outpatient under a community treatment order which stipulates that he or she abstain from using alcohol or drugs as a condition of the order.

2.10.5 Section 4(e): Intellectual disability
The present formulation of the definition of mental disorder, when read together with s4(e), means that it is necessary to establish the existence of a mental disorder to invoke the Act in relation to a person with an intellectual disability. Where a person has an intellectual disability without more, s4(e) excludes the operation of Parts 1 and 2 of the Act.

As with the other exclusionary criteria, s4(e) does not affect the definition of mental disorder where there is a dual diagnosis.
2.11 Head injury
Although it was originally thought that people with head injuries were not covered by the definition this is no longer the case. As the act eschews reliance on specific diagnoses, identifying mental disorder by reference to signs and symptoms, disturbances of mind resulting from head injury can be construed as disorders of cognition, bringing them within the definition. On this reading mental disorder could include organic personality syndrome, organic mood syndrome, and dementia secondary to head injury. However, both from a legal and a therapeutic perspective, it is vital to determine whether the consequent behaviour is attributable to head injury or underlying mental disorder. If the behaviour is principally the result of head injury then significant questions arise about whether a person should be made subject to the Act since people suffering from head injuries have different requirements, including needing intensive neuro-psychological intervention to effectively enable the mind to be ‘recalibrated’.

The Ministry of Health’s guidelines also note that the principal concern relating to people with head injuries is often that care for people with behavioural disturbances is less than satisfactory. While mental health services may be the most appropriate manner of intervention, limited resources and the fact that treatment is often not viable means that this is not a satisfactory long-term solution.

2.12 Conclusion
There is now a considerable body of jurisprudence and academic comment on many aspects of the 1992 Act. There was also a substantial amendment to the legislation in 1999 which clarified difficulties following the introduction of the Act. However, mental health legislation is complex and difficult and despite apparent agreement on many aspects of the legislation the need to reconcile the competing demands of two disciplines such as law and medicine – each with discrete aims and perspectives – means that the interpretation of the legislation will continue to be an issue.
Appendix 3: Competencies

Set one: Communication skills (focus of this learning package)

- Ability to discuss with the service user the court proceedings
- Ability to discuss with the service user the role of the nurse in the court process
- Ability to discuss with the service user the opinion the nurse will be presenting
- Ability to inform the multi-disciplinary team of your opinion
- Ability to debrief with the service user following the hearing
- Ability to debrief with colleagues following the hearing

Set one: Communication skills (assumed to be part of standard clinical practice)

- Ability to consult with, involve and inform family/whanau about the process
- Ability to work with interpreters and cultural advisors

Set two: Administrative skills (assumed to be part of standard clinical practice)

- Ability to complete documentation required
- Ability to ensure copies of documents are sent and filed according to the requirements

Set three: Ethical issues (focus of this learning package)

- Ability to understand the potential conflict between the obligations to provide a professional second opinion verses multi disciplinary team decision making obligations (which require a degree of consensus).
- Ability to understand the potential for conflict between the need to maintain a therapeutic relationship and the potential for the legal role to be perceived as compromising this relationship.
- Ability to understand the potential role conflict if the service user refuses to attend (advocacy verses statutory role).

Set four: Legal knowledge (focus of this learning package objectives)

- Knowledge of court proceedings
- Knowledge of appropriate court behaviour
- Understanding of cross examination process (if applies)
- Understanding of expectations of a second health professional
- Knowledge of definition of mental disorder (section 2).
- Ability to formulate written statements to the Court
- Ability to formulate verbal statements to the Court.
- Knowledge of criteria for making a decision to release
Set five: Clinical knowledge and skills (assumed to be part of standard clinical practice)

- Assessment of presenting mental health features which fulfil the definition
- Assessment of risks that relate to the inability to care for oneself or danger to self or others
- Assessment of why the service user can not be cared for voluntarily
- Assessment of least restrictive alternative
- Knowledge of service user’s treatment plan
- Skills of how to respond if service user becomes distressed during the court process.

Set six: Knowledge of cultural matters relevant to health (assumed to be part of standard clinical role)

- Knowledge of cultural matters that impinge on an understanding of life events and experiences
- Knowledge of the principles of the Treaty of Waitangi and their implications for partnership and sensitivity to cultural identity
Appendix 4: Report writing format
## Report Form for Second Health Professional

### Patient Details:

<table>
<thead>
<tr>
<th>Name of Service user:</th>
<th>Alex Smith</th>
</tr>
</thead>
<tbody>
<tr>
<td>Service user date of birth:</td>
<td>6th August, 1958</td>
</tr>
</tbody>
</table>
| Of: | Puriri Unit.  
Sunshine Mental Health Acute In-patient Service |
| Date of Report: | 12th September, 2009 |

### Demographic background

Age, gender ethnicity, length of time/pathway in the service.

Mr Smith is a 40 year old Pakeha man who resides in Central Auckland with his brother, his brother’s wife and their two children. He was admitted to our acute inpatient service under Section 11 of the Mental Health (Compulsory Assessment and Treatment) Act 1992 for compulsory assessment. He is presently under Section 13 of the aforementioned Act. He was admitted into our intensive care unit but was transferred to the main ward area after 24 hours. He applied on the 11th of September for a Section 16 Judicial Review of his compulsory assessment status.

### Psychiatric history.

Onset, nature and impact (level of functioning, self care, risk to self or others).

Mr Smith has had 4 previous admissions to acute inpatient services over the past 5 years, the last being 18 months ago in April 2007. On three of these admissions he was under the Mental Health (Compulsory Assessment and Treatment) Act and one admission was informal. These admissions have varied in duration from 2 weeks to 5 weeks. All admissions have been in the context of an acute psychotic presentation at which time Mr Smith believes he is a manifestation of a Messiah and that he is gathering together this followers to save the world. At these times Mr Smith has been preoccupied with these beliefs to the extent that he does not engage with his family and does not turn up at work. When discussing these beliefs Mr Smith has a history of becoming agitated when he does not perceive others acknowledge his belief system. This agitation leads to physical threats of violence on others and there is a documented history of one assault against a staff member while residing in an acute inpatient service. In the past Mr Smith has been able to maintain self care in the context of his acute mental health presentation and has never presented as a risk to self.

### Relationship to Service User:

Professional role, nature & extent of relationship and knowledge of service user, including most recent contact with service user.

I am a Registered Nurse and I was assigned as the primary keyworker for Mr Smith on his admission. Of the 8 days since his admission, I have been on duty for six on these days. On each of these shifts I have spend approximately one hour a day in one to one conversation with Mr Smith. I have also attended many of the programmes Mr Smith has been involved in and have observed him interacting in the group and interacting with staff and his peers. During this time I believe I have established a therapeutic rapport with Mr Smith which has enabled me to discuss with him aspects of his mental health presentation and the risk he has recently posed to others.
**Clinical Report:**
Direct observations or information from other sources including family/whanau relevant to mental disorder.

On admission Mr. Smith freely discussed with me his beliefs that he is a Messiah and his that he has come to the world to gather his followers to save it from extinction. He expresses some concern that some of these followers are not staying loyal to the cause. At admission these beliefs were freely stated to all present. Since the initial 48 hours these thoughts have not been as freely volunteered leaving me with the view that they hare resolving since his active engagement in therapy. However when I have spent time alone with Mr. Smith and directed my conversation towards his belief system he becomes excited and volunteers his concerns that some of his followers are not staying true to the “faith”.

I have had telephone contact with Mr. Smith’s brother, who expressed to me a desire for Mr. Smith to stay in the service until his thoughts of being a Messiah have resolved. Hey stated he is not prepared to visit him at this stage as he has threatened him when he has challenged his brother’s beliefs.

**Abnormal state of mind**
A believe that My Smith meets the criteria of “an abnormal sate of mind” in that he currently presents with a thought process characterised by delusions. He believes that he is a Messiah and that he is gathering together this followers to save the world. I believe these delusions are continuous in nature.

Serious reduction in the capacity of the patient to take care of self.
I believe Mr Smith has the capacity to self care.

Serious reduction in the capacity of the patient to take care of self.
I believe Mr Smith does not present with any risk to self.

Serious danger to the health or safety to others
Mr Smith has had one previous admission to inpatient services in which he physically assaulted a staff member by punching him twice in the face in the context of Mr Smith’s perception that the staff member did not agree with his beliefs. Two days proceeding this admission Mr Smith physically pushed a staff member of the Day Centre he was attending who challenged his access to websites Mr Smith believed aided him to track his followers. Although Mr Smiths thoughts about being a Messiah appear to be decreasing they remain present when directly questioned about them. Given the past patterns of assault I think the likelihood of further assault is high until these thoughts of being the Messiah resolve.

**Opinion**

Continuation of or discharge from the Act.
I believe that the compulsory assessment should continue and the issue of risk revisited at the Section 18 Judicial Review to determine the need for a Compulsory Treatment Order

Least restrictive alternative
I believe that this assessment should continue within an inpatient unit. This will allow more detailed observation of mental health status and the link between mental health status and risk to others.

**Signature:**

Joe Bloggs

Date: 12th September, 2009
Appendix 5: Creating your own report writing format

Content of the court report which may be written additional to the “REPORT FORM FOR SECOND HEALTH PROFESSIONAL”

Introduction

Clinician’s name, professional qualifications, and professional nexus i.e. ‘I have been this patient’s nurse for the past ……… since admission to the mental health service’ etc.

A statement of the issue to be considered e.g. application in support of compulsory treatment order under Section 30 of the Mental Health (Compulsory Assessment & Treatment) Act 1992.

Sources of information used for the report (a summary rather than an exhaustive list is usually sufficient in this context).

Background

This summarises the factual information known about the service user. This usually includes history of present admission, diagnosis, past history, current or past danger and inability to care for self. This should be brief given that most of this information will occur in detail in the report by the Responsible Clinician.

Opinion

An opinion is then provided on why you believe the person has a mental disorder and why the Order needs to be made.

You will note that the definition of ‘mental disorder’ under the act requires two standards. First the presence of particular necessary phenomena and secondly that as a consequence of this abnormal mental state, that the person is a serious danger to self and/or others, or is seriously deficient in their ability to self care.

You will further note that this definition avoids any reference to diagnosis. While the background information in a report will often include clinical diagnoses these are neither necessary nor sufficient to establish the presence of a mental disorder.

Conclusion

State ‘support’ or ‘non-support’ for Responsible Clinician’s evidence.
Appendix 6: General take home points

Prior to a court hearing:

A health professional who has worked extensively with the service-user must be allocated to give verbal and written evidence at the hearing.

That health professional must:

• Familiarise him/herself with the service user’s treatment plan and current nursing care.
• Familiarise him/herself with the responsible clinicians report.
• Discuss the hearing with the service user and explain to the service user the role the nurse will take and the aspects of care that will be discussed. Service users’ sense of coercion is reduced when they sense they are involved in fair decision-making processes (i.e that they are given a chance to voice their concerns; that they are listened to; that they are treated with dignity, respect, politeness and concern; and they are given accurate and relevant information about the processes they are involved in) (McKenna, Simpson et al. 2000).
• Inform the multi-disciplinary team of his/her position at the Clinical Review. The second health professional’s opinion should not come as a surprise to colleagues during the hearing.
• Fill out the “Report Form for Second Health Professional”. Discuss the contents of this with those mentioned above.
• File a copy of this Form in the client’s file

At the hearing.

The health professional should:

• Accompany the service user.
• Have the service user’s notes.
• Have a copy of the “Report Form for Second Health Professional” which will be submitted at the hearing.
• Observe an appropriate dress code.
• Identify himself/herself to the Judge.
• Indicate their relationship to the service-user e.g. key worker, length of their involvement, frequency of contact with the person.
• Present an outline of the service-users presentation and the treatment plan.
• Answer the Judges questions.
• Be prepared to be cross-examined by the service-users legal counsel if necessary.
Presenting evidence

Be familiar with the definition of mental disorder in the Act (section 2) and be prepared to comment on it in regards to the service user: -

'Mental disorder' in relation to any person, means an abnormal state of mind (whether of a continuous or an intermittent nature), characterised by delusions, or by disorders of mood, or perception or volition or cognition of such a degree that it:

(a) Poses a serious danger to the health or safety of that person or of others; or
(b) Seriously diminishes the capacity of that person to take care of himself or herself.

Be able to:-

• **Outline features of the service user’s illness** which fulfil the definition
• **Describe the issues** that relate to the inability to care for oneself or danger to self or others
• **Describe why** the service user **can not be cared for voluntarily**
• **Consider** whether the order should be **community or in-patient**
• **Have a clear understanding of the service user’s treatment plan**
• **Have consulted with the/ a Cultural Advisor** for cultural interventions
• **Describe the service user’s day-to-day behaviour, mental status and needs** from a **discipline specific** perspective e.g. mood, behaviour specific symptoms, nutritional state, ability for self-care, sleep patterns, compliance with medication, coping skills etc.

**Following the hearing**

Debrief with the service user concerning what happened at the hearing; the outcome of the hearing; the implication of the outcome; and appeal processes.