DRAFT ILLUSTRATIVE CODE OF PRACTICE

Addendum

Note on Principles following amendments to the Bill in the House of Lords

Chapter 1 of the draft illustrative Code of Practice sets out a list of guiding principles to which decision makers should have regard in respect of a patient.

During the course of the Bill's passage through the House of Lords the Government laid an amendment to place in legislation a requirement for the Code of Practice to include a statement of principles and for the statement of principles to ensure that particular matters are addressed. A copy of the Government amendment is printed below.

In light of the Government amendment, the principles as presented in the draft illustrative Code of Practice Chapter 1 will be revised. We will be drafting a revised set of principles which will be published for comment as part of the consultation on the Code.

The draft illustrative Code of Practice has not been revised to reflect other amendments made to the Bill during its passage through the House of Lords.

April 2007

The fundamental principles

After section 118(2) of the 1983 Act (code of practice) insert –

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

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

(a) respect for patients' past and present wishes and feelings,

(b) minimising restrictions on liberty,

(c) involvement of patients in planning, developing and delivering care and treatment appropriate to them,

(d) avoidance of unlawful discrimination.

(e) effectiveness of treatment,

(f) views of carers and other interested parties,

(g) patient wellbeing and safety, and

(h) public safety.

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

(a) the efficient use of resources, and

(b) the equitable distribution of services.

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

This version of the draft illustrative Code of Practice is as published when the Bill was introduced into Parliament on 17 November 2006. It has **not** been updated to reflect any changes made to the Bill during its passage through the House of Lords.

COVERING DOCUMENT FOR REVISED CODE OF PRACTICE AND MEMORANDUM

INTRODUCTION

1. These documents set out, in draft, how the current Mental Health Act 1983 Code of Practice and Memorandum, would be likely to change in the light of the Mental Health Bill, were the current style and structure retained. A draft chapter on the Bournewood provisions, which will be incorporated into the Mental Capacity Act Code of practice, will be available shortly.

2. We are publishing these drafts now in order to help people understand the effect of the Bill and to inform the debate as the Bill passes through Parliament. We would welcome comments on these documents, however they not been produced for formal consultation. There will be a formal consultation on both the style and content of these documents once the Bill has been passed (Parliament willing).

3. The draft Code of Practice has been prepared by the Department of Health as guidance for England. The Welsh Assembly Government, on behalf of Welsh Ministers, will prepare a Code of Practice for Wales, which will be available in the Summer of 2007.

WHAT IS THE MENTAL HEALTH ACT CODE OF PRACTICE?

4. The Code of Practice gives guidance to statutory bodies and professionals on how the Mental Health Act should be applied. In accordance with case law practitioners should have a cogent reason if they depart from the guidance in the Code. The Code is also a useful source of information to patients and their representatives.

5. The revisions in this draft version of the Code focus on two areas:

    a. to guide professionals and others on how the changes to the 1983 Act should be carried into practice;
    b. to update the Code to reflect changes in case law, policy and practice since the last edition of the Code (which was published in 1999)

6. For this early draft, we have used the framework of the current Code and have added amendments (in green). For example in the chapter on guiding principles, the new draft material has been inserted into the existing chapter, and appears in green.

WHAT IS THE MENTAL HEALTH ACT MEMORANDUM?

9. The Memorandum describes the main provisions of the Act and is for the guidance of all those who work with the Act. As with the Code of Practice, we have used the existing framework of the memorandum and have added amendments in green

NEXT STEPS

10 DH officials will continue developing the material for the Code or Practice and Memorandum and the Bournewood chapter for the Mental Capacity Act Code in discussion with stakeholders as the Bill goes through Parliament.

11 Following introduction of the Bill, we will be engaging with stakeholders, including in a series of workshops and consultation events to develop further the draft material and as part of the wider review of style and format of the Code of Practice and Memorandum

Draft timetable for consultation

12 A revised timetable will be made as soon as possible following the Bill receiving Royal Assent. The timetable will outline the process for formal consultation on the draft illustrative Code of Practice. Prior to the formal consultation, we would be very interested to receive any comments on the draft illustrative Code of Practice.

13 To conclude, this is draft material and there will be opportunities throughout the development of the Code and memorandum to make further comments

14. If you would like a copy of either of these draft documents (code or memorandum) without the crossed out parts please email.

15. Please send your comments to MHBillCodeofPractice@dh.gsi.gov.uk

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DRAFT ILLUSTRATIVE CODE OF PRACTICE

Department of Health ~~and Welsh Office~~

CODE OF PRACTICE
Mental Health Act 1983

~~Published March 1999,~~ pursuant to Section 118 of the Act

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FOREWORD

People with mental health problems deserve good care and support. They are often vulnerable, may have difficulty in expressing their needs and, in some cases, my not recognise that they need help. These patients, carers, and the general public, should be able to rely on health and social services which provide effective care and treatment.

At the moment, the legal framework that managers, doctors, nurses social workers and the police must follow is set by the Mental Health Act 1983. The Code of Practice gives guidance on how the Act should be applied. It should be used by everyone who works with people with mental health problems, whether or not they are patients formally detained under the Act. The Act is increasingly out of date and we are consulting extensively before changing the law to replace it with a more modern and dependable system, but in the meantime, the Code should be followed until the new legislation comes into force.

The revised Code updates and amends the previous version to take account of recent case law and changes in practice and terminology since it was last revised in 1993.

For patients and their carers what matters is their own experience of services and the way the law is applied in their case. This revised Code puts a new emphasis on the patient as an individual – from the guiding principles in the first chapter, through assessment for admission, consent to treatment, discharge and after-care. It is also essential that the different agencies that deal with people with mental health problems work together.

The Code provides essential referenced guidance for those who apply the Act. Patients and their carers are entitled to expect professionals to use it.

Frank Dobson Alun Michael

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To be amended

Mental Health Act 1983

Code of Practice

INTRODUCTION

Introduction

1. This revised Code of Practice has been prepared in accordance with section 118 of the Mental Health Act 1983 (the Act) by the Secretary of State for Health ~~and the Secretary of State for Wales~~, after consulting such bodies as appeared to her ~~them~~ to be concerned, and laid before Parliament. The Code will come into force ~~on 1 April 1999~~.

The Act does not impose a legal duty to comply with the Code but ~~as it is a statutory document~~ the people to whom it is addressed should not depart from the guidance contained in it without cogent reasons. Failure to follow it could be referred to in evidence in legal proceedings.

2. The Code provides guidance to registered medical practitioners, approved clinicians, managers and staff of hospitals ~~and mental nursing homes~~ and ~~approved social workers (ASWs)~~ approved mental health practitioners (AMHPs) (who have defined responsibilities under the provisions of the Act), on how they should proceed when undertaking duties under the Act. It should also be considered by others working in health and social services (including the independent and voluntary sectors), and by the police.

3. The Code makes a number of references to the Memorandum on Parts I to VI, VIII and X of the Act ~~(revised 1998)~~ which gives a detailed description of ~~some~~ most of the Act's provisions. Authorities, Trusts and other service providers are responsible for seeking their own legal advice on any matters of doubt.

4. The Secretary~~ies~~ of State is ~~are~~ required to keep the operation of the Code under review. The Mental Health Act Commission will be monitoring experience of using the Code and will take this into account in drawing up proposals for any necessary further modification in due course. The Commission also publishes from time to time Practice Notes containing advice on particular points which have been drawn to its attention. ~~A list of the current Practice Notes is given at Annex A.~~

5. Finally a note on presentation. It is hoped that the Code will be helpful not only to those for whom the Act requires it to be written but also to patients, their families, friends and others who support them. It has been drafted as far as possible with this aim in mind. Throughout the Code the Mental Health Act 1983 is referred to as "the Act". Where there is reference to sections of other Acts, the relevant Act is clearly indicated.

~~6. In accordance with the requirements of the Welsh Language Act, this publication is available in the Welsh Language. Details can be obtained from~~

~~Robert Booth or Dominic Worsey~~

~~PCH4 Welsh Office, Health and Social Work Service~~

~~Cathays Park Cardiff CF1 3NQ~~

Chapter 1 – Guiding principles

1.1 ~~The detailed guidance in the Code needs to be read in the light of the following broad principles, that people to whom the Act applies (including those being assessed for possible admission) should:~~ The individual principles set out below should be understood as working together to provide for balanced decision-making, which is consistent with the need to prevent harm and the wider policy and legislative framework ~~set out in chapter 2 of this code.~~

1.1a The status of the principles is the same as the status of the code as a whole. Thus, a decision maker having regard to the guidance in this code in respect of a patient (including those being assessed for possible admission) should do so with regard to the following principles

Participation principle

- care and treatment should be provided in such a way as to promote patients' participation, self determination and personal responsibility to the greatest practicable degree.

Respect for patients principle

- patients should be treated with respect for their qualities as unique individuals, including their wishes and feelings, so far as they are known

Non discrimination principle

- patients should not be discriminated against, either directly or indirectly, on the grounds of age, gender, sexual orientation, race, colour, language, religion or national, ethnic or social origin.

Respect for others principle

- carers, family members and other interested parties should be treated with respect and, where appropriate and practicable, involved in decision-making processes.

Transparency principle

- decisions by professionals and statutory bodies should be made in a transparent way

Communication principle

- the communication needs of patients, parents, carers and others involved in decisions should be understood and met as far as is practicable

Perspectives principle

- decisions on the use of compulsory powers should be taking into consideration all available perspectives, particularly those of the patient, any carer(s), and other involved professionals.

Assessment of risk principle

- decisions should be informed by an assessment of risk

Maximum benefit principle

- When providing treatment and care to patients all reasonable effort should be made to maximise the clinical benefit to the patient

Minimum restriction principle

- restrictions imposed on a patient subject to compulsory powers should be kept to the

minimum necessary

- ~~receive recognition for their basic human rights under the European Convention of Human Rights (ECHR);~~
- ~~be given respect for their qualities, abilities and diverse backgrounds as individuals and be assured that account will be taken of their age, gender, sexual orientation, social, ethnic, cultural and religious background, but that general assumptions will not be made on the basis of any one of these characteristics;~~
- ~~have their needs taken fully into account, though it is recognised that, within available resources, it may not always be practicable to meet them in full;~~
- ~~be given any necessary treatment or care in the least controlled and segregated facilities compatible with ensuring their own health or safety or the safety of other people;~~
- ~~be treated and cared for in such a way as to promote to the greatest practicable degree their self determination and personal responsibility, consistent with their own needs and wishes;~~
- ~~be discharged from detention or other powers provided by the Act as soon as it is clear that their application is no longer justified.~~

The Care Programme Approach ~~and Care Management~~

The ~~delivery of all mental health services is framed within the~~ Care Programme Approach (CPA) ~~set out in Circular HC(90)23/LASSL(90)11 and in the Welsh Office Mental Illness Strategy (WHC(95)40).~~ ~~p~~provides a framework for effective mental health care for all patients receiving care from secondary mental health services in all settings, including hospital, community and prison. The policy is set out in *Effective Care Co-ordination in Mental Health Services: Modernising the Care Programme Approach (1999)* ~~The CPA provides the framework for all patients, both in hospital and in the community, and Health Authorities, Trusts and Social Services Authorities are responsible for ensuring that the Act is always be applied within this context.~~

The key elements of the CPA are:

- systematic arrangements for assessing ~~people's health and social care needs~~ and managing the health and social needs of people accepted into specialist mental health services;
- the formulation of a care plan which identifies the health and social care required from a variety of providers ~~addresses those needs~~;
- the appointment of a ~~key worker~~ care co-ordinator to keep in close touch with the patient and monitor and co-ordinate care;
- regular reviews and ~~if need be~~ where necessary, agreed changes to the care plan.

Similarly Local Social Services Authorities also have a responsibility to undertake assessment of individuals social care needs and design care plans in accordance with care management procedures. These two systems should as far as possible be integrated.

CPA policy guidance stresses the importance of close working between health and social care services and the need to involve service users and their carers in the assessment and planning of their support and care.

The CPA framework applies to all service users and patients served by secondary mental health services, whether they are formally detained under the Mental Health Act or not.

Communicating with patients

1.3 The Communication Principle (see 1.1) requires ~~As a general principle, it is the responsibility of~~ staff to ensure that effective communication takes place between themselves and

patients. All those involved in the assessment, treatment and care of patients should ensure that everything reasonably possible is done to overcome any barriers to communication that may exist.

1.4 ~~Local and Health Authorities and Trusts~~ Local social services authorities (LSSA's), relevant NHS bodies and hospital managers should ensure that A~~SW~~ AMHPs, doctors, nurses and others receive sufficient guidance in the use of interpreters and assistive communication technologies and should make arrangements for there to be an easily accessible pool of trained interpreters. LSSA's and Trusts should consider co-operating in making this provision.

1.5 Barriers to communication may be caused by any one of a number of reasons, e.g. the patient's first language is not English or he or she may not read and write in English, he or she may have difficulty understanding technical terms and jargon or maintaining attention for extended periods of time; he or she may have a hearing or visual impairment and have difficulty reading. There may also be barriers to communication associated with the person's mental disorder, for example, the patient may lack mental capacity.

1.6 Staff need to ~~be aware of~~ assess and identify how communication difficulties affect each patient individually so that they can address the needs of patients in ways that best suit them. This will require patience and sensitivity. Specialist help should always be made available to staff as required, either from within the hospital itself, or from the local social services authority or a voluntary organisation. The patient's relatives or friends should not normally be used as an intermediary or interpreter. When the need arises, staff should make every attempt to identify appropriate interpreters considering ~~who match~~ the patient's ~~in~~ gender, religion, dialect, and ~~as closely as possible in~~ age. Professional advocates engaged by patients can be invaluable in helping patients to understand the questions and information being presented to them and in helping the patients to communicate their views to staff.

1.7 It will at times be necessary to convey the same information on a number of different occasions or in different formats and ~~frequently~~ regularly check that the patient has fully understood it. Information given to a patient who is unwell may need to be repeated when they have improved.

~~Confidentiality~~ (see sections on Confidentiality and Victims at Chapter 33A)

~~1.8 Managers and staff in all Trusts, Authorities, Mental Nursing Homes independent hospitals, Social Service Departments and other organisations which provide services for patients should be familiar with the DH Guidance on confidentiality (The Protection and Use of Patient Information, Department of Health 1996, HSG(96)18). Ordinarily, information about a patient should not be disclosed without the patient's consent. Occasionally it may be necessary to pass on particular information to professionals or others in the public interest, for instance where personal health or safety is at risk (see chapter ? information sharing)[this should be referenced to section on Information Sharing]. Any such disclosure should be in accordance with the principles set out in the Guidance (*see also Building Bridges (para 1.5), Department of Health, February 1996, and guidance on the power to disclosure information under section 115 of the Crime and Disorder Act, Home Office, 1998).*~~

~~Victims~~

~~1.9 Where a patient detained under Part III of the Act is both competent and willing to agree to the disclosure of specified information about his or her care, this should be encouraged to enable victims and victims' families to be informed about progress. It can be important to a patient's rehabilitation that victims understand what has been achieved in terms of modifying offending behaviour. Disclosure of such information also serves to reduce the danger of harmful confrontations after a discharge of which victims were unaware. Without prejudice to a patient's right to confidentiality, care teams should be ready to discuss with him or her the benefits of enabling some information to be given by professionals to victims, within the spirit of the Victim's~~

~~Charter (Home Office, 1996). The patient's agreement to do so must be freely given and he or she will need to understand the implications of agreeing to information being given to the victim (s). Care must be taken not to exert any pressure on the patients or this may bring into question the validity of the consent.~~

Information

1.10 The Hospital Managers have a statutory duty to give information to detained patients, and to their nearest relatives, unless the patient objects. A definition of the nearest relative under the Act is given at section 26. The Department of Health publishes leaflets about the information which should be given to detained patients.

1.11 All patients, including those subject to guardianship or Supervised Community Treatment (SCT) should be given full information, both verbally and in writing, to help them understand why they are in hospital, ~~or~~ subject to guardianship, or Supervised Community Treatment, and the care and treatment they will be given. Informal hospital patients should be told they may leave at any time (although this does not prevent them being asked to keep ward staff informed of their intended movements.)

1.12 Information should be clearly displayed on ward notice boards and in reception areas. All patients should be given admission booklets, information about the Mental Health Act Commission and complaints leaflets for the Hospital, Trust and local Social Services Department. More details on the giving of information is in Chapter 14.

1.13 Authorities and Trusts should keep records of the ethnicity of all patients admitted under the Act. The Department of Health's *A practical guide to ethnic monitoring in the NHS and social care* ~~NHS Executive's Information Management Group guidance *Collecting ethnic group data for admitted patient care – implementation guidance and training material*~~ *(Department of Health 2005 ~~1994~~)* should be followed. The Department of Health's standard ethnicity codes should be used, namely:

A. White

- British,
- Irish
- Any other White background

B. Mixed

- White and Black Caribbean
- White and Black African
- White and Asian
- Any other mixed background

C. Asian or Asian British

- Indian
- Pakistani
- Bangladeshi
- Any other Asian background

D Black or Black British

- Caribbean
- African
- Any other Black Background

E. Other ethnic Groups

- Chinese
- Any Other Ethnic Group

F. Not stated

~~0 White~~

~~1 Black Caribbean~~

~~2 Black African~~

~~3 Black other~~

~~4 Indian~~

~~5 Pakistani~~

~~6 Bangladesh~~

~~7 Chinese~~

~~8 Any other~~

~~9 Not given~~

and should establish a system to monitor admissions by race and sex

Chapter 1A – Professional roles

1A.1 This chapter is about key professional roles within the Act – the approved clinician, the responsible clinician, the section 12 doctor and the approved mental health professional (AMHP).

Approved Clinician

1A.2 Section 145(1) defines an approved clinician as a person approved by the appropriate national authority to act as an approved clinician for the purposes of the Act. The power to approve is delegated. To act as a patient's responsible clinician, a professional must first be approved as an 'approved clinician'. The approved clinician in charge of a particular episode or type of treatment, who may or may not be the responsible clinician, also has functions under part 4 of the Act (see paragraph 15.2).

1A.3 Directions from the Secretary of State set out minimum requirements for approval as an AMHP in England, but the body to whom approval is delegated has discretion to set additional requirements over and above the minimum.

1A.4 Approved clinician training is concerned with the functions that responsible clinicians are required to perform under the Act. It is not intended to equip a person with the competence to carry out the professional duties of a member of another profession. The training will include teaching on issues relating to social exclusion, race equality and gender.

Responsible clinician

1A.5 A patient's responsible clinician is defined at sections 34, 64 and 79 as the approved clinician with overall responsibility for the patient's case. Once approved as **an approved clinician**, a person may become a patient's **responsible clinician**. All patients subject to detention or Supervised Community Treatment have a responsible clinician.

1A.6 It is for the hospital to decide who should be a patient's responsible clinician. The decision should be based on the individual needs of that patient. When a patient is first admitted to hospital, it may not be immediately clear who is the most appropriate person to be their responsible clinician. It may, in some circumstances, be appropriate to appoint a responsible clinician whilst the patient's needs are being assessed and then, as soon as possible, to make a decision about whether there is a more appropriate person to take on the role in the longer term. Local arrangements should ensure that all patients have a responsible clinician and that it is clear who the responsible clinician is for each patient at any given time, on a 24 hour basis.

1A.7 The responsible clinician has a duty to keep a patient's case under constant review. In particular, the Responsible Clinician should at regular intervals assess whether the patient still meets the criteria for detention or liability to recall.

Section 12 doctor

1A.8 One of the medical recommendations required for admission of a patient under the Act must be given by a registered medical practitioner approved under s12 of the Act. To be approved under s12, a doctor must have special experience in the treatment or diagnosis of mental disorder. Approval of s12 doctors is delegated from the Secretary of State

Approved mental health professional

1A.9 Section 114 defines an approved mental health professional as a person approved to act in that role by a local social services authority (LSSA). Once approved by an English LSSA, an AMHP can act on behalf of any English LSSA, similarly, an AMHP approved by a Welsh LSSA can act on behalf of any Welsh LSSA. Approval lasts for 5 years.

1A.10 The Act does not require an AMHP to be employed by the LSSA that they are acting on behalf of. For example, a LSSA may wish to enter into arrangements with a NHS Trust to provide the AMHP service on their behalf. It is for the LSSA to decide how they provide an AMHP service

for their area. If they decide to enter into arrangements with another body to provide AMHP's, they should ensure suitable provisions will be in place for the AMHPs' supervision, refresher training, health and safety, discipline, legal indemnity and access to legal advice. However an LSSA chooses to provide the AMHP service for their area, they retain the duty to arrange for an AMHP to consider the case of a patient within their area where they have reason to believe that an application to hospital or guardianship needs to be made with respect to the patient (see paragraph 2.37 below).

1A.11 Directions set out minimum requirements for the approval of a person as an AMHP. LSSAs have discretion to set additional requirements over and above the minimum.

1A.12 The training required of a person before they can be approved as an AMHP is designed to enable individuals taking on the role to bring a social care perspective to act independently and assess whether all the conditions for compulsion are met, or whether the patient's needs can be met without compulsion. The training will include teaching on issues relating to social exclusion, race equality and gender.

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Chapter 1B – Mental Disorder

1B.1 `Mental disorder is defined as "any disorder or disability of the mind". It is for the relevant professionals to determine whether a patient has a disorder or disability of the mind.

1B.2 Clinically recognised conditions falling within this definition could include:

- organic mental disorders such as dementia, and including personality and behavioural changes due to brain injury and damage
- mental and behavioural disorders due to psychoactive substance use, schizophrenia and other delusional disorders
- affective disorders, such as depression and bi-polar disorder (manic depression)
- neurotic, stress related and somatoform disorders, such as anxiety, phobic disorders, obsessive compulsive disorders, post-traumatic stress disorder and hypochondriacal disorders
- eating disorders, non-organic sleep disorders and non-organic sexual disorders
- personality disorders
- learning disabilities (but see below)
- autistic spectrum disorders (including Asperger's syndrome)
- behavioural and emotional disorders of children and adolescents

Learning disability

1B.3 Learning disability, which the Act defines as a "state of arrested or incomplete development of mind which includes significant impairment of intelligence and social functioning" falls within the definition of mental disorder. However, for the purposes of detention or guardianship under sections 3, 8, 35, 36, 37, 38, 45A, 47, 48 and 51(5) a learning disability is only treated as a mental disorder if it is associated with `abnormally aggressive or seriously irresponsible' conduct on the part of the person concerned.

1B.4 For the purposes of this "learning disability qualification", abnormally aggressive behaviour means observed actions which are outside the normal range of aggressive behaviour and seriously irresponsible conduct means behaviour which shows little or no regard for its consequences. These behaviours must cause actual damage and/or real distress occurring recently or persistently or with excessive severity. See Chapter 30.

Exclusions from the definitions of mental disorder

1B.5 Disordered beliefs are sometimes symptoms of clinically recognised mental disorders, but in the absence of such a disorder no-one may be considered to be mentally disordered solely because of their political or cultural beliefs, values or opinions. A person's sexual orientation does not, by itself, indicate the presence or absence of mental disorder; nor does involvement, or likely involvement, in illegal, anti-social or "immoral" behaviour. Beliefs, behaviours or actions which do not result from a disorder or disability of the mind are not a basis for determining that any of the conditions is met, even if they appear unusual or cause other people alarm or distress.

1B.6 Mental disorder does not include disorders or disabilities of the brain, unless (and only to the extent that) they also give rise to a disability or disorder of the mind.

1B.7 Section 1(3) of the Act states, "dependence on alcohol or drugs is not considered to be a

mental disorder for the purposes of [the definition of mental disorder in the Act.]" This means that there are no grounds for detaining a person in hospital (or using other compulsory measures) because of alcohol or drug dependence alone. Drugs for these purposes should be taken to include psychoactive substances such as opiates, psychostimulants and some solvents. But it is recognized that alcohol or drug dependence may be accompanied by or associated with another mental disorder which does fall within the Act's definition. It is therefore possible to detain a person who is dependent on alcohol or drugs if he or she is suffering from a mental disorder, whether or not it arises from or is suspected to arise from alcohol or drug dependence or from the withdrawal of alcohol or a drug, provided of course all the other relevant criteria are met.

1B.8 The Act does not exclude other mental disorders relating to the use of alcohol or drugs. Some such disorders, for example uncomplicated acute intoxication, may only rarely justify the use of powers under the Act, whilst others, for example withdrawal state with delirium or associated psychotic disorder may justify use more often, provided the other criteria are met. Prolonged abuse of drugs or alcohol may cause damage to the brain and associated organic mental disorder, which can also justify use of powers under the Act.

1B.9 Nor does the Act prohibit compulsory treatment for alcohol or drug dependence where that treatment is part of the treatment of another mental disorder from which the patient suffers

Chapter 2 – Assessment and examination prior to application for admission or guardianship

General

2.1 This chapter is about the roles and responsibilities of ~~ASWs~~ AMHPs and doctors when making assessments of the needs of a person with mental health problems, where the assessment may lead to an application for admission to hospital under the Act.

2.2 An individual should only be compulsorily admitted if the statutory criteria are met and other relevant factors have been considered as set out in para 2.6 below. A decision not to apply for admission under the Act should be supported, where necessary, by an alternative framework of care and/ or treatment. The decision should also be clearly recorded in the patient's ~~medical~~ notes.

2.3 Doctors and ~~ASWs~~ AMHPs undertaking assessments need to apply professional judgment, and reach decisions, independently of each other but in a framework of co- operation and mutual support. Good working relationships require knowledge and understanding by the members of each profession of the other's distinct role and responsibilities. Unless there are good reasons for undertaking separate assessments, assessments should be carried out jointly by the ~~ASW~~ AMHP and doctor(s). It is essential that at least one of the doctors undertaking the medical assessment discusses the patient with the applicant (~~ASW~~ AMHP or nearest relative) and desirable for both of them to do this.

2.3(a) The legislation requires that where practicable one of the recommending doctors should have previous acquaintance with the patient. When setting up an assessment, consideration should be given to whether there should be one assessor who is not familiar with the patient.The most appropriate AMHP to assess the patient should also be considered, taking into account all the circumstances of the case. If an AMHP feels that if would be difficult to make an impartial assessment of the patient another AMHP should be asked to undertake the assessment.

2.4 Everyone involved in assessment should be alert to the need to provide support for colleagues, especially where there is a risk of the patient causing physical harm. Staff should be aware of circumstances where the police should be called to provide assistance, and how to use that assistance to minimise the risk of violence.

The objective of assessment under the Act

2.5 All those assessing for possible admission under the Act should ensure that:

- they take all relevant factors into account;
- they consider appropriate alternatives to compulsory admission;
- they comply with the legal requirements of the Act.

The factors to be taken into account at assessment

2.6 ~~A patient may be compulsorily admitted under the Act where this is necessary~~: An application for admission may not be made in respect of patient except (in summary)

- ~~in the interests of~~ for his or her own health, or
- ~~in the interests of~~ for his or her own safety, or
- for the protection of other people.

(the way these concepts are phrased varies slightly between sections 2 and 3).

Only one of the above grounds needs to be satisfied (*in addition to those relating to the patient's mental disorder*).

~~However, a patient may only be admitted for treatment under section 3 if appropriate the treatment (see chapter 2A) can be provided for the patient and it cannot be provided unless he or she is detained under the section~~. There is no obligation on anyone to make an application for admission or guardianship just because the statutory criteria are met. In judging whether compulsory admission is appropriate, those concerned should consider not only the statutory criteria but should also take account of:

- the guiding principles in Chapter 1, ~~in particular; the participation principle, including the patient's present and past wishes and view of his or her own needs; the perspectives principle, including what may be known about the patient by his or her nearest relative, any other relatives or friends, carers and professionals involved, assessing in particular how reliable that information is; and the assessment of risk principle considering the need for the patient and others to be protected~~
- the patient's wishes and view of his or her own needs
- the patient's social and family circumstances and cultural background
- the nature of the ~~illness/ behaviour~~ mental disorder and its course;
- ~~what may be known about the patient by his or her nearest relative, any other relatives or friends, carers and professionals involved, assessing in particular how reliable this information is;~~
- other forms of care or treatment including, where relevant, consideration of whether the patient would be willing to accept medical treatment in hospital informally or as an out- patient and of whether guardianship would be appropriate (see chapter 13);
- the needs of the patient's family and carers and ~~or~~ others with whom he or she lives; ~~the need for others to be protected from the patient;~~
- the burden on those close to the patient of a decision to admit or not to admit under the Act.

Ordinarily only then should the applicant (in consultation with other professionals) judge whether the criteria stipulated in any of the admission sections are satisfied, and take the decision accordingly. In certain circumstances the urgency of the situation may curtail detailed consideration of all these factors.

~~Informal admission~~ [A replacement 'Informal Admission' is drafted at 2.10a]

2.7 ~~Where admission to hospital is considered necessary and the patient is willing to be admitted informally this should in general be arranged. Admission powers should only be exercised in the last resort. Indeed, an application under section 3 may not be made if there are others safe and effective ways in which the necessary treatment may be provided.~~

~~Informal admission to hospital is usually appropriate when a mentally capable patient consents to admission. But not if detention is necessary because of the danger the patient presents to him or herself or others. Compulsory admission should be considered where a mentally capable patient's current medical state, together with reliable evidence of past experience, indicates a strong likelihood that he or she will have a change of mind about informal admission prior to actually being admitted to hospital, with a resulting risk to their health or safety or to the safety of other~~ people.

2.8 ~~is mentally incapable of consent, but does not object to entering hospital and receiving care or treatment, admission should be informal [R v Bournewood Community and Mental Health~~

~~NHS Trust ex parte L [1998] 3 ALL ER 289]; 9see paras 15.9- 15.10 for assessment of capacity and 15.18- 15.22 for the treatment of mentally incapacitated patients)~~ ~~The decision to admit a mentally incapacitated patient informally should be made by the doctor in charge of the patient's treatment in accordance with what is in the patient's best interests and is justifiable on the basis of the common law doctrine of necessity (see para 15.21). If a patient lacks capacity at the time of an assessment or review, it is particularly important that both clinical and social care requirements are considered, and that account is taken of the patient's ascertainable wishes and feelings and the views of their immediate relatives and carers on what would be in their best interests.~~

Protection of others

2.9 In considering the protection of others (see sections 2(2)(b) and 3(2)(c)) it is essential to assess both the nature and the likelihood of the potential risk arising from the patient's mental disorder ~~and the level of risk others are entitled to be protected from,~~ taking into account:

- reliability of evidence including any relevant details of the patient's clinical history and past behaviour including contact with other agencies and (where relevant) criminal convictions;
- the degree of risk and its nature. A risk of physical harm, or serious persistent psychological harm, to others is an indicator of the need for compulsory admission;
- the willingness and ability to cope with and manage the risk, by those with whom the patient lives and those who provide care and support to the patient, and whether there are alternative options available for managing the risk.

The health of the patient

2.10 A patient may be admitted under sections 2 or 3 solely in the interests of his or her own health or safety even if there is no risk to other people. Those assessing the patient must consider:

- any evidence suggesting that the patient's mental health will deteriorate if he or she does not receive treatment;
- the reliability of such evidence which may include the known history of the individual's mental disorder;
- the views of the patient and of any relatives, carers or close friends, especially those living with the patient, about the likely course of the ~~illness~~ disorder and the possibility of it improving;
- the impact that any future deterioration or lack of improvement would have on relatives, carers or close friends, especially those living with the patient, including an assessment of their ability and willingness to cope;
- whether there are other methods of coping with the expected deterioration or lack of improvement.

Informal admission – patients with capacity to consent

2.10a Where admission to hospital is considered necessary, compulsory admission powers should only be exercised if there are no effective alternatives available. Indeed, an application under section 3 may not be made if there are other safe and effective ways in which the necessary treatment may be provided.

2.10b Informal admission to hospital is usually appropriate when a ~~mentally capable~~ patient who has the capacity to do so consents to admission. But this is not a hard and fast rule. There

may be circumstances where compulsory admission is justified despite the patient's stated willingness to be admitted voluntarily, especially ~~but not~~ if detention is necessary because of the danger the patient presents to him or herself or others. Compulsory admission should be considered where ~~a mentally capable~~ such a patient's current medical state, together with reliable evidence of past experience, indicates a strong likelihood that he or she will have a change of mind about informal admission either prior to or after admission ~~actually being admitted to hospital~~, with a resulting risk to their health or safety or to the safety of other people.

Patients who lack capacity to consent to treatment or admission

2.10bb This section should be read alongside the guidance on consent in chapter 15 and the Mental Capacity Act in chapter 16A

2.10c Where patients aged 16 or over do not have the capacity to consent to admission and/or to the treatment that is expected to be required, AMHPs and medical practitioners will need to consider whether the patient could instead safely and effectively be treated by relying on the provisions of the Mental Capacity Act 2005 (MCA) including an authorisation under the Bournewood safeguards for people who need to be deprived of their liberty in order to be cared for in their own best interests. Throughout this section references to the MCA include Bournewood, unless otherwise stated.

2.10d Compulsory admission under the Mental Health Act for such people should be required only when there are reasons to think that relying on the MCA is either not possible or inadequate for some reason. That is a judgement for the professionals concerned. There is no obligation to ask the Court of Protection for a ruling that the MCA should not be relied on before using the MHA.

2.10e Where AMHPs and doctors are satisfied that a patient can safely and effectively be assessed or treated by relying on the MCA, it should not be necessary to consider using either section 2 or section 3 the MHA. In particular, if a patient can be safely and effectively dealt with under the MCA, it is likely to be difficult to demonstrate that the criteria for detaining them under section 3 are met.

2.10f But circumstances which might indicate the need to consider detention under the MHA instead of the use of the MCA include:

- it is not possible safely or effectively to provide appropriate care or treatment in a way which does not amount to deprivation of the person's liberty, and the person is ineligible for an authorisation under the Bournewood procedures. This is particularly likely to apply where the person objects to being admitted to hospital for treatment for mental disorder regime (see box 1 and chapter 16A.14ff for more detail);
- the person needs treatment which cannot lawfully be provided under the MCA - for example because the person has made a valid and applicable advance decision to refuse a necessary element of the treatment (chapter 8);
- a degree of restraint needs to be used which is justified by the risk to other people but which exceptionally cannot be said to be proportionate to the risk to the patient personally (as required by section 6, 11 or 20 of the MCA);
- necessary assessment or treatment cannot be safely or effectively delivered without a power to treat the patient compulsorily, eg because a patient's lack of capacity to consent is thought to likely to be only short lived or their capacity is likely to fluctuate and the

patient is not expected to co-operate when they have capacity. This may be particularly relevant to patients suffering acute psychotic, manic or depressive episodes;

- a patient who lacks capacity to make decisions on some elements of the care and treatment they need, nonetheless has capacity to refuse a vital element – eg admission to hospital – and has done so;
- there is some other risk that the person might otherwise not receive the necessary treatment and either the person or others might potentially suffer harm as a result
- the patient is being considered for detention under Part 3 of the Act in connection with criminal proceedings.

People ineligible for Bournewood authorisations

A person is ineligible to be detained under the Bournewood procedure if

(a) the proposed authorisation is for detention in hospital for the purpose of being treated wholly or partly for mental disorder, and

(i) the patient meets the criteria for admission to hospital under section 2 or 3 of the MHA;

(ii) there is no attorney or deputy able and willing to consent to the admission and treatment in question; and

(iii) the patient objects to being admitted or treated for mental disorder (having regard not only to what (if anything) the patient is currently saying but also to the patient's past and present behaviour, wishes, feelings, views, beliefs and values so far as they are reasonably ascertainable.)

(b) the person is detained in hospital under sections 2, 3, 4. 35, 36, 37, 38, 44, 45A, 47, 48 or 51 of the MHA (or their equivalent)

(c) the person is liable to be detained under one of those sections but is not in fact detained (eg because they are on leave of absence or are a conditionally discharged restricted patient), or is subject to SCT but

(i) the authorisation would conflict with an obligation imposed on the patient under the MHA (eg a condition of leave of absence), or

(ii) the authorisation would be for the purpose of detaining the patient in hospital wholly or partly for medical treatment for mental disorder.

(d) the person is subject to guardianship and the authorisation would conflict with an obligation placed on the person (eg about where to live) by the guardian or a condition of the community treatment order.

2.10g Compulsory admission under the MHA is never, however, an option where

- the patient's mental disorder does not justify detention in hospital
- the patient needs treatment only for a physical disorder (unless it is a symptom or consequence of a mental disorder and so would in fact be part of treatment for that mental disorder).

So there will from time to time be cases where a person cannot be treated either under the MHA or the MCA, even if the treatment is for mental disorder.

Box 2 Summary of how the Mental Capacity Act 2005 (MCA) will feature in decisions about whether to make an application for detention under the MHA

Has the patient got capacity to make their own decisions about their care and treatment for mental disorder and admission to hospital?

If yes, MCA is irrelevant. But if not, the MCA is relevant. In some cases, the answer will be partly yes and partly no (eg where a patient has capacity to decide to attend for occupational therapy, but not to consent to medication.)

If the patient does lack capacity to make the necessary decisions, is there a viable alternative to admission to hospital?

If the person lacks capacity to make all the necessary decisions themselves, this will inevitably involve considering whether sufficient and appropriate care and treatment could be provided without admission to hospital by relying on the MCA (or a combination of the MCA and the patient's own consent)

If hospital admission is necessary, should the patient be detained?

If the person cannot consent to admission or to the treatment they will need once admitted, decision-makers will have to consider whether informal admission under the MCA would be adequate. It will not be if the patient's treatment and care will result in them being deprived of their liberty.

If the patient is to be deprived of their liberty, the Bournewood authorisation to be used

If satisfied that the person needs to be admitted and detained in hospital for assessment or treatment for mental disorder, decision-makers will need to consider whether the person is eligible for the Bournewood safeguards.

If the person objects to being admitted to hospital or treated for mental disorder, they will normally not be eligible. (See 16A.14 for further guidance).

Nor will they be eligible if they are on leave of absence, supervised community treatment or conditional discharge under the MHA and the proposed treatment in hospital is for mental disorder. In other words Bournewood cannot be used a substitute for recall to hospital under the MHA.

If they are not eligible, an application for admission under the MHA may be appropriate.

Even if they are eligible, decision-makers will need to consider whether there are reason why it would nonetheless not be sufficient to rely on a Bournewood authorisation, but appropriate to make an MHA application instead.

See chapter 31 for special considerations in relation to children and young people under 18.

Individual professional responsibility – the Approved ~~Social Worker~~ Mental Health Professional

2.11 It is important to emphasise that an ~~ASW~~ AMHP assessing a patient for possible admission under the Act has overall responsibility for co- ordinating the process of assessment and, where he or she decides to make an application, for implementing that decision. The ~~ASW~~ AMHP must, at the start of the assessment, identify him or herself to the person, members of the family or friends present and the other professionals involved in the assessment. They should explain in clear terms the ~~ASW's~~ AMHP's own role and the purpose of the visit, and ensure that the other professionals have explained their roles. ~~ASWs~~ AMHPs should carry with them at all times documents identifying them as ~~ASWs~~ AMHPs and identifying which local social services authority they are acting on behalf of.

2.11(a) the AMHP is acting on behalf of a local social services authority but should exercise their own judgement based on social and medical evidence when deciding whether to apply for a patient to be brought under the statutory powers of the Act.

2.11 (b) Except in exceptional circumstance the AMHP and the doctors making the assessment should not be in a line management relationship.

2.12 The ~~ASW~~ AMHP must interview the patient in a `suitable manner', taking account of the guiding principles in Chapter 1:

a. It is not desirable for a patient to be interviewed through a closed door or window except where there is serious risk to other people. Where there is no immediate risk of physical danger to the patient or to others, powers in the Act to secure access (section 135) should be used.

b. Where the patient is subject to the effects of sedative medication, or the short- term effects of drugs or alcohol, the ~~ASW~~ AMHP should consult with the doctor(s) and, unless it is not possible because of the patient's disturbed behaviour and the urgency of the case, either wait until, or arrange to return when, the effects have abated before interviewing the patient. If it is not realistic, or the risk indicates that it would not be appropriate to wait, the assessment will have to be based on whatever information the ~~ASW~~ AMHP can obtain from all reliable sources. This should be made clear in the ~~ASW's~~ AMHP's report.

2.13 The patient should ordinarily be given the opportunity of speaking to the ~~ASW~~ AMHP alone but if the ~~ASW~~ AMHP has reason to fear physical harm, he or she should insist that another professional be present. If the patient wants or needs another person (for example a ~~friend~~ familiar person or an independent advocate) to be present during the assessment and any subsequent action that may be taken, then ordinarily the ~~ASW~~ AMHP should assist in securing that person's attendance unless the urgency of the case or some other reason makes it inappropriate to do so. ~~Deaf or hearing impaired patients~~ Patients may feel more safe or confident with a friend or other person they know well in attendance. Equally, an advocate can help reassure patients. ~~Who is also deaf or hearing impaired.~~

2.14 The ~~ASW~~ AMHP must attempt to identify the patient's nearest relative as defined in section 26 of the Act (*see paragraph: currently 62- 63 of the Memorandum)*. It is important to remember that the nearest relative for the purposes of the Act may not be the same person as the patient's "next of kin", and also that the identity of the nearest relative ~~is liable to~~ may change with the passage of time, for example if the patient enters into a marriage or civil partnership. The ~~ASW~~ AMHP must then ensure that the statutory obligations with respect to the nearest relative set out in section 11 of the Act are fulfilled. In addition, the ~~ASW~~ AMHP should where possible:

a. ascertain the nearest relative's views about both the patient's needs and the relative's own

needs in relation to the patient;

b. inform the nearest relative of the reasons for considering an application for admission under the Act and the effects of making such an application.

2.14a The AMHP should confirm with the patient the identity of their nearest relative as soon as is practical. If the patient appears to have no nearest relative under the Act, the AMHP should inform the patient as soon as is practical.

2.14b When informing the patient of the identity of the person who is their nearest relative, the AMHP should advise the patient of their rights to apply for the displacement of their nearest relative in the circumstances described in section 29. If this is not practicable at the time, the information should be given as soon as it becomes practicable.

2.14c Where the patient appears to have no nearest relative, the AMHP should advise the patient of their right to apply to the county court for the appointment of a person of his choice to act as his NR. (See chapter 33B)

Applications under section 2

2.14d A person can be detained in hospital for assessment under section 2. A person can only be detained for assessment under section 2 if the following criteria apply:

- the person has to be suffering from a mental disorder of a nature or degree which warrants their detention in hospital for assessment (or for assessment followed by treatment) for at least a limited period; and
- the person should be so detained in the interests of their own health or safety or with a view to the protection of others.

2.15 It is a statutory requirement to take such steps as are practicable to inform the nearest relative about an application for admission under section 2, and of their power of discharge (section 11(3)). If the ~~ASW~~ AMHP has been unable to inform the nearest relative before the patient's admission, he or she should notify the hospital as soon as this has been done.

Applications under section 3

2.15a A person can also be detained in hospital for treatment section 3. A person can only be detained for treatment under section 3 if the following criteria apply:

- the person has to be suffering from a mental disorder of a nature or degree which ~~warrants their detention in hospital for assessment (or for assessment followed by treatment) for at least a limited period~~ which makes it appropriate for him to receive medical treatment in hospital and
- it is necessary for the health or safety of the person or for the protection of other persons that he should receive such treatment and it cannot be provided under the person is detained under this section ~~The person should be so detained in the interests of their own health or safety or with a view to the protection of others~~; and
- appropriate medical treatment is available ~~for them~~ (see chapter 2A).

2.16 Consultation by the ~~ASW~~ AMHP with the nearest relative about possible application for admission under section 3 or reception into guardianship, is a statutory requirement unless it is not reasonably practicable or would involve unreasonable delay (section 11(4)). Circumstances in which the nearest relative need not be informed or consulted include those where the ~~ASW~~

AMHP cannot obtain sufficient information to establish the identity or location of the nearest relative or where to do so would require an excessive amount of investigation. (*R (on the application of E) v Bristol City Council* [2005] EWHC 74 (Admin))

2.16(a) Practicability includes the appropriateness of informing or consulting the nearest relative. Consultation or notification should therefore not take place where it would pose a risk to the wellbeing of the patient. Consulting and notifying the nearest relative is a significant patient safeguard; invoking impracticality due to the risk posed to the patient by such consultation or notification should not be done lightly. However, consultation should not take place where it would lead to an infringement of the patient's rights to respect for their privacy which could not be justified by the benefit of that involvement. The AMHP should consider not consulting where the patient strongly objects to the consultation and/or where the AMHP considers the potential impact of consultation on the patient to be detrimental. Detrimental impact will include where the patient is assessed as being likely to suffer emotional distress, deterioration in his/her mental health, physical harm or financial/ other exploitation.

2.16(b) Consultation must not be avoided purely because it is thought that the nearest relative might object to the application.

2.16(c) If the ~~ASW~~ AMHP has been unable to consult the nearest relative before making an application for admission for treatment (section 3) for reasons other than the unsuitability of the nearest relative he or she should persist in seeking to contact the nearest relative so as to inform the latter of his or her powers to discharge the patient under section 23. The ~~ASW~~ AMHP should inform the hospital as soon as this has been done.

2.16d The local social services should provide a protocol on the recording of decisions and their reasons not to consult with or notify nearest relatives when AMHPs decide it is impracticable in the circumstances to do so.

Delegation of nearest relative's functions

2.17 If the nearest relative would find it difficult to undertake the functions defined in the Act, or is reluctant for any reason to do this, regulation 14 [Mental Health (Hospital, Guardianship and Consent to Treatment) Regulations 1983] allows him or her to delegate those functions to another person. ~~ASWs~~ AMHPs should consider proposing this in appropriate cases.

2.18 If the nearest relative objects to an application being made for admission for treatment or reception into guardianship it cannot proceed at that time. If, because of the urgency of the case, and the risks of not taking forward the application immediately, it is thought necessary to proceed with the application, the ~~ASW~~ AMHP will then need to consider applying to the county court for the nearest relative's `displacement' (section 29) (see chapter 33A), ~~and local authorities must provide proper assistance, especially legal assistance, in such cases. It is desirable for social services authorities to provide clear practical guidance on the procedures, and this should be discussed with the relevant county courts.~~

Displacement of the nearest relative

2.18a If the patient believes their existing nearest relative is unsuitable to act as such, they can apply to the county court for the displacement of the nearest relative (s29). (see chapter 33A)

2.19 In so far as the urgency of the case allows, an ~~ASW~~ AMHP who is the applicant for the admission of a patient to hospital should consult with other relevant relatives, carers or friends and should take their views into account.

2.20 The ~~ASW~~ AMHP should consult wherever possible with others who have been involved with the patient's care in the statutory, voluntary or independent services. Patients may be known to other service providers who do not specialise in mental health services. ~~Deaf patients may be~~

~~known to one of the specialist hospital units for mental health and deafness.~~

2.21 Having decided whether or not to make an application for admission the ~~ASW~~ AMHP should tell (with reasons):

- the patient;
- the patient's nearest relative (whenever practicable);
- the doctor(s) involved in the assessment;
- the ~~key worker~~ care co-ordinator if the patient is on CPA;
- the patient's GP, if he or she was not involved in the assessment.

When an application for admission is to be made the ~~ASW~~ AMHP should plan how the patient is to be conveyed to hospital and take steps to make the necessary arrangements (see Chapter 11).

Individual professional responsibility – the doctor

2.22 The doctor should:

a. decide whether the patient is suffering from mental disorder within the meaning of the Act (section 1) and assess its seriousness and the need for further assessment and/ or medical treatment in hospital;

b. consider the factors set out in para 2.6, and discuss them with the applicant and the other doctor involved;

c. specifically address the legal criteria for admission under the Act and, if satisfied that they are met, provide a recommendation setting out those aspects of the patient's symptoms and behaviour on which that conclusion is based;

d. ensure that, where there is to be an application for admission, a hospital bed will be available.

Medical examination

2.23 A proper medical examination requires:

- direct personal examination of the patient's mental state;
- consideration of all available relevant ~~medical~~ clinical information including that in the possession of others, professional or non- professional;
- that the guiding principles in Chapter 1 are taken into account.

2.24 If direct physical access to the patient is not immediately possible, and it is not desirable to postpone the examination in order to negotiate access, consideration should be given to applying for a warrant allowing ~~calling~~ the police ~~in order~~ to exercise ~~their lawful~~ power of entry ~~in the Act~~ (section 135).

2.25 It may not always be practicable for the patient to be examined by both doctors at the same time; but they should always discuss the patient with each other.

2.26 It is desirable for both doctors to discuss the patient with the applicant. It is essential for at least one of them to do so (see para 2.3).

Joint medical recommendations

2.27 Joint medical recommendations forms (3 and 10) should only be used where the patient has been jointly examined by two doctors. It is desirable that they are completed and signed by

both doctors at the same time.

2.28 In all other circumstances separate recommendation forms should be used (forms 4 and 11).

The second medical recommendation

2.29 Unless there are exceptional circumstances, the second medical recommendation should be provided by a doctor with previous acquaintance with the patient. Ideally, this should be a doctor who knows the patient personally in his or her professional capacity, but it is sufficient for the doctor to have had some previous knowledge of the patient's case. This should be the case even when the `approved' doctor (who is, for example, a hospital based consultant) already knows the patient. Where this is not possible (for example the patient is not registered with a GP) it is desirable for the second medical recommendation to be provided by an `approved' doctor (see paras 2.41 and 2.42).

2.30 Where ~~a Trust~~ an NHS body manages two or more hospitals which are in different places and have different names one of the two doctors making the medical recommendation may be on the staff of one hospital and the second doctor may be on the staff of one of the other hospitals.

A decision not to apply for admission

2.31 Most compulsory admissions require prompt action to be taken. It should be remembered that the ~~ASW~~ AMHP has up to 14 days from having personally seen the patient to complete an application for admission under sections 2 or 3. The duly completed application and the medical recommendations provide the ~~ASW~~ AMHP with the authority to convey and, in the case of an application for admission under section 2 or 3, such authority lasts for 14 days from the date when the patient was last examined by a doctor with a view to making a recommendation for his or her admission. Where a decision not to apply for a patient's compulsory admission is taken, the ~~ASW~~ AMHP must decide how to implement those actions (if any) which his or her assessment indicates are necessary to meet the needs of the patient including, for example, referral to ~~other~~ social workers or services within the social services department or a referral to health care. It is particularly important that any ~~keyworker~~ care coordinator concerned with the patient's care be fully involved in the taking of such decisions. The professionals must ensure that they, the patient and (with the patient's consent except where section 13(4) applies) the patient's nearest relative and any other closely connected relatives, carers or friends have a clear understanding of any alternative arrangements. Such arrangements and any plans for reviewing them must be recorded in writing and copies made available to all those who need them (subject to the patient's right to confidentiality).

2.32 The AMHP ~~The ASW~~ must discuss with the patient's nearest relative the reasons for not making an application and should advise the nearest relative of his or her right to do this. If the nearest relative wishes to pursue this the ~~ASW~~ AMHP should suggest that he or she consult with the doctors. Where the ~~ASW~~ AMHP has carried out an assessment at the request of the nearest relative (section 13(4)) the reasons for not applying for the patient's admission must be given to the nearest relative in writing. Such a letter should contain, as far as possible, sufficient details to enable the nearest relative to understand the decision whilst at the same time preserving the patient's right to confidentiality.

Particular practice issues – disagreements

2.33 Sometimes there will be differences of opinion between assessing professionals. There is nothing wrong with disagreements: handled properly these offer an opportunity to safeguard the interests of the patient by widening the discussion on the best way of meeting his or her needs. Doctors and ~~ASWs~~ AMHPs should be ready to consult colleagues (especially ~~keyworkers~~ care

co-ordinators and other community care staff involved with the patient's care), while retaining for themselves the final responsibility. Where disagreements do occur, professionals should ensure that they discuss these with each other.

2.34 Where there is an unresolved dispute about an application for admission, it is essential that the professionals do not abandon the patient and the family. Rather, they should explore and agree an alternative plan, if necessary on a temporary basis, and ensure that the family is kept informed. Such a plan should include a risk assessment and the arrangements for reviewing it should be recorded in writing and copies made available to all those who need it (subject to the patient's right to confidentiality).

The choice of applicant for admission

2.35 The ~~ASW~~ AMHP is usually the right applicant, bearing in mind professional training, knowledge of the legislation and of local resources, together with the potential adverse effect that an application by the nearest relative might have on the latter's relationship with the patient. The doctor should therefore advise the nearest relative that it is preferable for an ~~ASW~~ AMHP to make an assessment of the need for a patient to be admitted under the Act, and for the ~~ASW~~ AMHP to make the application. When reasonably practicable the doctor should, however, advise the nearest relative of the rights set out in section 13(4) (see para 2.38) and of his or her right to make an application.

2.36 The doctor should never advise the nearest relative to make an application in order to avoid involving an ~~ASW~~ AMHP in an assessment.

Agency responsibilities the Local Authority

2.37 Section 13(1) and (4) place a duty on a local social services authority to arrange for an AMHP to consider the case of a patient within their area where they have reason to believe that an application to hospital or guardianship needs to be made with respect to the patient. Where a patient is detained under section 2, the local social services authority that arranged for an AMHP to consider the patient's case for admission under that section remains responsible for arranging for an AMHP to consider the patient's case if they have reason to believe that an application to hospital or guardianship is needed under section 3. These duties do not prevent any other local authority from arranging for an AMHP to consider a patient's case for admission if that is more appropriate. Given these duties, local authorities must provide a 24-hour AMHP service to ensure that a nearest relative ~~should~~ is not put in the position of having to make an application for admission under the Act because it is not possible for an ~~ASW~~ AMHP to attend for assessment. ~~Subject to resources, local authorities should provide a 24 hour ASW service to ensure that this does not happen.~~

Section 13(4).

2.38 Local authorities are required, if requested by a nearest relative, to arrange for an AMHP to make an assessment and:

a. should have explicit policies on how to respond to repeated requests for assessment where the condition of a patient has not changed significantly;

b. should give guidance to ~~ASWs~~ AMHPs as to whether nearest relative requests can be accepted by way of GPs or other professions. (Such requests should certainly be accepted provided the GP or other professional has been so authorised by the nearest relative.)

Emergencies out of hours etc

2.39 Arrangements should be made to ensure that information about applications is passed to professional colleagues who are next on duty, for example where an application for admission is

not immediately necessary but might be in the future. For example, the necessary arrangements could then be made for an ~~ASW~~ AMHP to attend the next day.

Agency responsibilities – the Strategic **Health Authority**

Doctors approved under section 12

2.40 The Secretary of State has delegated to [Strategic Health Authorities] the task of approving medical practitioners under section 12(2).

2.41 Strategic Health Authorities should:

a. take active steps to encourage sufficient doctors, including GPs and those working in the Health Care Service for Prisoners, to apply for approval;

b. seek to ensure a 24 hour on- call rota of approved doctors sufficient to cover the area;

c. maintain a regularly updated list of approved doctors which indicates how each approved doctor can be contacted and the hours that he or she is available;

d. ensure that the up- to- date list of approved doctors and details of the 24 hour on- call rota are circulated to all concerned parties including GPs, mental health centres and social services.

2.42 ~~Authorities and~~ Trusts should consider including in the job description for new consultant psychiatrists with a responsibility for providing a catchment area service obligations to become approved under section 12 of the Act, to keep such approval up- to- date and to participate in the 24 hour on- call approved doctors' rota.

~~Health Authorities/~~ Trusts/ Local Authorities

2.43 Good practice requires that ~~Health Authorities~~, Trusts and local social services authorities should co- operate in ensuring that regular meetings take place between professionals involved in mental health assessments in order to promote understanding, and to provide a forum for clarification of their respective roles and responsibilities. Professionals should also keep in mind the interface with the criminal justice agencies, including the probation service and the police.

Chapter 2A Appropriate Treatment Test

2A.1 The appropriate treatment test requires a professional decision on whether an appropriate package of treatment for mental disorder is to be made available for the individual being considered for compulsion (or continued compulsion). It is not needed to determine the detention of a patient for assessment under section 2.

2A.2 In relation to detention under section 3 (and the relevant provisions of Part ~~3~~ III), the purpose of the appropriate treatment test is to ensure that no one is detained (or remains detained) unless they are actually to be offered medical treatment (within the definition of medical treatment at Section 145(1) of the Act) which is appropriate, taking into account the nature and degree of their mental disorder and all their particular circumstances, including cultural, ethnic and religious considerations. The test guarantees that detention will be clinically appropriate – not simply preventive detention without the offer of medical treatment.

2A.3 Where ~~it~~ the appropriate treatment test forms part of the criteria for detention, it follows that the medical treatment in question is treatment for mental disorder in hospital. The test encompasses the question of whether proposed medical treatment is clinically appropriate for the nature and degree of the patient's mental disorder and all other factors relating to the patient's circumstances which need to be weighed in the balance including, for example:

- age-appropriate accommodation;
- whether the treatment is available locally;
- its implications for the patient's family and social relationships~~,~~;
- the patient's gender, culture and ethnicity;
- any other health problems they are experiencing.

2A.4. Available treatment need not be the most appropriate treatment that could ideally be made available. But the treatment to be offered must be an appropriate response to the patient's situation. Medical treatment can only be considered appropriate if it is intended to address the mental disorder(s) from which the patient is suffering and which (alone or in combination) form the basis of the decision to detain (or continue to detain) the patient. "Intended to address" means that the purpose of the medical treatment is to alleviate, prevent deterioration in or otherwise manage the disorder itself, its symptoms or manifestations or the behaviours arising from it.

2A.5. Where appropriate treatment is available no one should be excluded from detention, or discharged, solely because it cannot be shown that it is likely to produce any particular benefit or outcome~~.~~. What is appropriate will vary greatly between patients but, given the wide definition of medical treatment in the Act, for some patients decision-makers may conclude that care under the clinical supervision of an approved clinician in a safe and secure therapeutic environment with a structured regime may be sufficient to constitute appropriate medical treatment in the light of the nature and degree of their mental disorder and their other circumstances..

2A.6 A patient's attitude towards proposed treatment is a factor to be taken into account when determining whether the appropriate treatment test is met. But psychological therapies and other treatments which require the patient's co-operation to be effective are not inappropriate simply because a patient does not wish to engage with them. They will remain available so long as it continues to be clinically appropriate to offer them and they would be provided if the patient agreed to engage. Similarly, the fact that a patient indicates an unwillingness to co-operate with treatment generally, or a specific aspect of treatment, does not, of itself, make such treatment inappropriate.

2A.7 The reason for which a patient is detained is also relevant to whether the appropriate treatment test is met. So, for example, where a patient is detained under section 3 because medical treatment is necessary in the interests of his own health or safety or with a view to the protection of others, medical treatment would not be considered appropriate unless, at least in part, it was intended to pursue that aim.

2A.8 However, the treatment that is actually given to a patient can focus on more than the reasons for the patient's detention. For example, patients who have been detained for the protection of others may be given a package of treatment which may also aim to protect their own mental health. Nor does the test tie the decision maker to the particular package envisaged at the point of detention, which may be replaced by either a modified or a wholly different approach to treatment that may be more appropriate.

2A.9 It is not necessary for decision-makers to be satisfied that appropriate treatment will be available for every aspect of the patient's condition, nor for the whole course of the patient's treatment. What is appropriate may change over time, as the patient's condition changes or clinicians obtain a greater understanding of the patient's case. But decision-makers must satisfy themselves that some medical treatment is available which is appropriate, given the patient's condition and circumstances as they are currently understood. If they are not personally able to provide or secure appropriate services, they must have evidence that there is a suitable service provider willing to accept the patient.

Chapter 3 – Part III of the Act – patients concerned with criminal proceedings

Assessment prior to possible admission

General

3.1 People subject to criminal proceedings have the same right to psychiatric assessment and treatment as other citizens. Any person who is in police or prison custody, who is in need of medical treatment for mental disorder which can only be satisfactorily given in a hospital ~~(or mental nursing home)~~ as defined by the Act, should be admitted to such a hospital. If criminal proceedings are discontinued it may be appropriate for the police to alert the relevant local social services ~~department~~ authority to allow them to consider whether an application under Part II of the Act would be appropriate.

3.2 All professionals involved in the operation of Part III of the Act should remember:

a. that mentally disordered people in police or prison custody may be very vulnerable. The risk of suicide or other self-destructive behaviour should be of special concern;

b. that a prison health care centre is not a hospital within the meaning of the Act. ~~Comprehensive treatment facilities are rarely available, and~~ the provisions of Part IV of the Act do not apply and treatment cannot be given there without the patient's consent.

Individual professional responsibilities

3.3 All professionals concerned with the operation of Part III of the Act should be familiar with:

- the guiding principles
- the relevant provisions of the Act *[see paras 141- 211 of the Memorandum];*
- ~~Home Office and Department of Health guidance relating to mentally disordered offenders including Home Office Circular 12/ 95;~~
- their own professional responsibilities and those of other disciplines and authorities and agencies;
- available facilities and services.

Agency responsibilities

3.4 ~~Health Authorities~~ PCTs should:

a. be able to provide in response to a request from a court under section 39 of the Act, or other proper requests, up- to- date and full information on the range of facilities that would be available for a potential patient from their area, including secure facilities [*see para 173 of the Memorandum]* ;

b. appoint a named person to respond to requests for information.

3.5 Section 39A ~~which was introduced under sections 27 of the Criminal Justice Act 1991~~ requires a local social services authority to inform the court if requested, if it or any other person is willing to receive the offender into guardianship and how the guardian's powers would be exercised.

3.6 Local authorities should appoint a named person to respond to requests from the courts about mental health services provided in the community including guardianship.

Assessment by a doctor

3.7 A doctor who is asked to provide an opinion in relation to a possible admission under Part

lll of the Act should:

a. identify him or herself to the person being assessed, explain who has requested the report and the limits of confidentiality in relation to the report, including that the data and the opinion could be relevant not only to medical disposal by the Court but also to the imposition of a punitive sentence, or to its length (see para 3.12);

b. request relevant pre- sentence reports, the Inmate Medical Record, if there is one, previous psychiatric reports as well as relevant documentation regarding the alleged offence. If any of this information is not available, the doctor's report should say so clearly.

The report should, where possible, be prepared by a doctor who has previously treated the patient. The doctor, or one of them if two doctors are preparing reports, should have access to a bed or take responsibility for referring the case to another doctor who does (see para 3.18).

3.8 The doctor should where possible identify and access other independent sources of information about the person's previous history (including convictions), including information from GP records, previous psychiatric treatment and patterns of behaviour.

3.9 Assessment for admission of the patient is the responsibility of the doctor but other members of the clinical team who would be involved with the person's care and treatment should also be consulted. A ~~nursing~~ multi disciplinary assessment should usually be undertaken if admission to hospital is likely to be recommended. The doctor should also contact the person who is preparing a pre- sentence report, especially if psychiatric treatment is recommended as a condition of a probation order.

3.10 In cases where the doctor cannot state with confidence at the time of sentencing whether admission to hospital will be beneficial, he or she should consider recommending an interim hospital order under section 38 of the Act. This order provides for the person to be admitted to hospital for up to 12 weeks (which may be extended for further periods of up to 28 days to a maximum total period of 12 months) so that the court can reach a conclusion on the most appropriate and effective disposals ~~that recommendations as to treatability and the appropriateness of continuing treatment in hospital can be fully informed~~.

Reports to the court

3.11 The weight of the clinical opinion is particularly important in helping courts to determine the sentence to be passed. In particular they will help to inform the decision whether to divert the offender from punishment by way of a hospital order, or whether a prison sentence is necessary to protect others. In the case of patients subject to criminal proceedings the doctor's report should set out clearly:

a. the data on which the report is based;

b. how this relates to the opinion given;

c. where relevant, how the opinion may relate to any medical condition defence or other trial issue;

d. factors relating to presence of mental disorder that may affect the risk that the patient poses to him or herself, or to others, including risk of re- offending; and

e. if admission to hospital is recommended, what, if any, special treatment or security is required and how this would be addressed. The report should not comment on guilt or innocence.

3.12 When sentencing mentally disordered offenders the court is bound by the requirement in section 4 157 of the Criminal Justice Act ~~1991~~ 2003 to consider any information before it which relates to the patient's mental condition. Except where the offence is one for which ~~the law~~

~~requires~~ a life sentence is mandatory the court must before passing sentence consider the effect of a custodial sentence on the offender's mental disorder and on the treatment which may be available for it.

~~3.13 A medical report will be of crucial importance in determining whether or not a sentence of life imprisonment should be imposed where this is not mandatory~~.

3.14 In a report submitted to the court it may be appropriate to include recommendations on the disposal of the case including any need for a further report in the event of conviction. In making recommendations for disposal the doctor should consider the longer term, as well as immediate, consequences. Factors to be taken into account include:

a. whether the court may wish to make a hospital order subject to special restrictions *[see paras 162- 164 of the Memorandum];*

b. whether, for restricted patients, the order should designate admission to a named unit within the hospital.

3.15 The power of the courts to order admission to a named unit was introduced by the Crime (Sentences) Act 1997 to enable the court or the Home Secretary to specify a level of security in which the patient needs to be detained. A named hospital unit can be any part of a hospital which is treated as a separate unit. It will be for the court to define what is meant in each case where it makes use of the power. Admission to a named unit will mean the Home Secretary's consent will be required for any leave or transfer from the named unit, whether the transfer is to another part of the same hospital or to another hospital.

3.16 The need to consider the longer term implications of a recommended disposal is particularly important ~~following the introduction of powers under section 45A of the Act (introduced under the Crime (Sentences) Act 1997). This provides a new option, if the offender is diagnosed as suffering from psychopathic mental disorder within the meaning of section 1 of the Act (with or without an additional category of mental disorder), for the court to attach a hospital direction and limitation direction to a prison sentence~~. where either a hospital order under section 37 or a prison sentence with a hospital direction under section 45A is available to the Court the ~~choice~~ decision rests with the court. The making of a hospital direction and a limitation direction will mean that from the start of his or her sentence the offender will be managed in hospital as if he or she was a transferred prisoner (under section 47 and 49). Thereafter the responsible ~~medical officer (rmo)~~ clinician will have the option of seeking the patient's transfer to prison at any time before his or her release date if no further treatment is ~~likely to be beneficial~~ necessary or likely to be effective.

3.17 It is a matter for the discretion of the court whether to make a hospital order subject to restrictions. A hospital direction must always be accompanied by a limitation direction which applies restrictions. It is also for the courts to decide whether to name a hospital unit.

Availability of places

3.18 If the doctor has concluded that the person needs treatment in hospital but is not able to identify a suitable facility where the person could be admitted immediately, he or she should consider seeking advice from the NHS forensic mental health service or learning disability services for the person's home area. Once advice has been sought, written details of the type of provision required should be sent to the responsible ~~Health Authority~~ PCT together with relevant supporting information which the ~~authority~~ PCT will need in order to discharge their responsibilities.

Requests for ~~ASW~~ AMHP assessment

3.19 When an ~~ASW~~ AMHP is requested to undertake an assessment in prison or court with a

view to making an application for admission under section 2 or section 3 or guardianship, he or she must be given as much notice as possible, and time and facilities to interview the prisoner. The ~~ASW~~ AMHP should be given access to the pre- sentence report and any other relevant records and reports.

Transfer of prisoners to hospital

3.20 The need for in- patient treatment for a prisoner should be identified and acted upon quickly and contact made immediately with the responsible PCT by Prison Health Care professionals. Reference should be made Prison Service Instruction 3/2006 for guidance on effective process. ~~between the prison doctor and the hospital doctor. The Home Office Mental Health Unit should be informed as soon as the statutory requirements for transfer are in place so that consideration can be given to issuing a direction under the Home Secretary's powers. Supporting reports should take account of the guidance on reports to the courts in paras 3.11 and 3.14 above.~~

~~3.21 The transfer of a prisoner to hospital under the Act should take place as soon as possible after the need has been identified. A transfer close to the expected date of release may be seen by the prisoner as being primarily intended to extend detention and result in an unco-operative attitude towards treatment.~~

Chapter 4 Private practice and Conflicts of interest ~~the provision of medical recommendations~~

4.1 The Act restricts the provision of medical recommendations by certain categories of doctor in private practice. Thus:

a. where an individual is to be admitted to an independent hospital ~~mental nursing home~~ or as a private patient to an NHS hospital, neither medical recommendation can be provided by a doctor on the staff of the hospital ~~or mental nursing home~~ (section 12(3));

b. no medical recommendation can be provided by a doctor who receives, or has an interest in the receipt of, any payment made on account of the maintenance of the patient (section 12(5)(d)).

4.2 It is the personal responsibility of any doctor providing a medical recommendation to ensure that he or she is complying with these legal requirements; if in doubt legal advice must be sought.

4.3 It is undesirable for a doctor to provide a recommendation where he or she will receive payment from the patient (or a relative or friend or an insurance company) for medical services to be provided after he or she has been admitted to an independent hospital or as a private patient to an NHS hospital.

4.4 If there could be any suspicion (however unjustified) that a doctor providing a medical recommendation is doing so for pecuniary advantage, then arrangements should be made for another doctor to make the recommendation.

4.5 Where the patient is currently receiving treatment from a doctor that doctor, if practicable and appropriate, should be consulted by the doctor(s) providing the medical recommendation.

4.5a The responsible clinician and the AMHP responsible for making the decision as to whether to place a patient on Community Treatment Order, or any decision to recall them should not have any financial interest in the outcome of the decision.

4.5b Neither the responsible clinician nor AMHP who are responsible for making the decision to place a patient on a CTO or a decision to recall them should be a relative of the patient or of each other.

4.5c It is undesirable for either of the doctors making the medical recommendations or the AMHP making the application to act in any case where it appears to them that, by virtue of any personal, business or financial relationship with the patient, any member of the patient's family or other examiner, they could reasonably be seen to be subject to a conflict of interest which would impair their ability to act in an impartial way.

Chapter 5. Section 2 or section 3?

The choice

5.1 Which admission section should be used? Professional judgment must be applied to the criteria in each section and only when this has been done can a decision be reached as to which, if either, section applies. Detention under section 3 can last for any period of time, and need not last its full course.

5.2 **Section 2 pointers:**

a. the diagnosis and prognosis of a patient's condition is unclear;

b. a need to carry out an in- patient assessment in order to formulate a treatment plan;

c. a judgment is needed as to whether the patient will accept treatment on a voluntary basis following admission;

d. a judgment has to be made as to whether a particular treatment proposal, which can only be administered to the patient under Part IV of the Act, is likely to be effective;

e. the condition of a patient who has already been assessed, and who has been previously admitted compulsorily under the Act, is judged to have changed since the previous admission and further assessment is needed;

f. the patient has not previously been admitted to hospital either compulsorily or informally and has not been in regular contact with the specialist ~~psychiatric~~ mental health services.

5.3 **Section 3 pointers:**

a. the patient is considered to need compulsory admission for the treatment of a mental disorder which is already known to his clinical team, and has been assessed in the recent past by that team. In these circumstances it may be right to use section 3 even where the patient has not previously been admitted as an in- patient;

b. the patient is detained under section 2 and assessment indicates a need for treatment under the Act for a period beyond the 28 day detention under section 2. In such circumstances an application for detention under section 3 should be made at the earliest opportunity and should not be delayed until the end of section 2 detention. The change in detention status from section 2 to section 3 will not deprive the patient of a Mental Health Review Tribunal hearing if the change takes place after a valid application has been made to the Tribunal but before that application has been heard. The patient's rights to apply for a Tribunal under section 66(1)(b) in the first period of detention after his change of status are unaffected.

5.4 Decisions should not be influenced by the possibility that:

a. a proposed treatment to be administered under the Act will last less than 28 days;

b. a patient detained under section 2 will get quicker access to a Mental Health Review Tribunal than one detained under section 3;

c. ~~after- care under supervision or~~ a community treatment order will only be available if the patient has been admitted under section 3 ~~(See Chapter 27).~~ The use of section 3 must be justified by the patient's need to be admitted for treatment under the terms of that section, not considerations about what is to happen after his or her eventual discharge;

d. a patient's nearest relative objects to admission under section 3.

5.5 If the nearest relative unreasonably objects to admission under section 3 an application should be made to the county court under section 29 of the Act for the functions of the nearest relative to be transferred to ~~the local social services authority or~~ another person. A section 2

application cannot be made if the patient is already in hospital following admission under that section (see the judgment in R v Wilson ex parte W [1996] COD 42). The section 29 application should be made as soon as it is clear that the patient will need to be detained under section 3 and that the nearest relative unreasonably objects to this or is likely to do so. (see chapter 33A)

5.5a The county court may extend a section 2 beyond 28 days until the section 29 application is heard. An extension by the county court of the section 2 does not preclude the patient from being discharged. The court should be notified as soon as practicable and the section 29 application withdrawn where this occurs.

In such cases, the hospital managers should always consider, especially if the patient did not make an application to the MHRT during the first 14 days of detention, or their detention under section 2 has been extended for a significant period, requesting the Secretary of State to refer to patient's case to the Mental Health Review Tribunal (see chapter 23A]

Chapter 6. Admission for assessment in an emergency (section 4)

(Para 24 of the Memorandum)

General

6.1 Application for admission for assessment under section 4 should be made only when:

a. the criteria for admission for assessment are met (see para 5.2); and

b. the matter is of urgent necessity and there is not enough time to get a second medical recommendation.

6.2 Section 4 should be used only in a genuine emergency, never for administrative convenience. 'Second doctors' should be available to assist with assessments prior to admission.

Admission

6.3 An emergency arises where those involved cannot cope with the mental state or behaviour of the patient. To be satisfied that an emergency has arisen, there must be evidence of:

- an immediate and significant risk of mental or physical harm to the patient or to others; and/ or – the danger of serious harm to property; and/ or – the need for physical restraint of the patient.

6.4 Patients should not be admitted under section 4 rather than section 2 because it is more convenient for the second doctor to examine the patient in, rather than outside, hospital. Those assessing an individual's need must be able to secure the attendance within a reasonable time of a second doctor and in particular an approved doctor.

6.5 If the ~~ASW~~ AMHP is considering an application for admission and no second doctor is available, he or she should discuss the case with the doctor providing the first recommendation and seek to resolve the problem. If this is not possible he or she should have access to an officer in the local social services authority who is sufficiently senior to take up the matter with the ~~Health Authority~~ relevant NHS body ~~or Trust~~. The Local Authority of whose behalf the AMHP is acting. ~~ASW's AMHP's local authority~~ should make it clear that the ~~ASW~~ AMHP in these circumstances is under an obligation to report the matter in this way.

6.6 Hospital Managers should monitor the use of section 4 and seek to ensure the second doctors are available to visit a patient within a reasonable time after being so requested.

6.7 If a patient is admitted under section 4 an appropriate second doctor should examine him or her as soon as possible after admission, to decide whether the patient should be detained under section 2 (or Section 3)

Chapter 7 Part III of the Act – patients admitted from prison etc ~~or remand centre~~

Admission

7.1 The following documents should be sent from the prison etc – to the hospital at the time of transfer:

- an up- to- date medical report including details of medication
- a report from Prison Health Care staff covering the patient's day- to- day care and management including risk factors
- any relevant pre- sentence reports prepared by the probation service. It is important that all information is made available to the patient's ~~rmo~~ responsible clinician and other professional staff concerned.

Restricted patients

7.2 When a person is transferred from prison to hospital under sections 47 or 48 as a restricted patient, it is the responsibility of the Hospital Managers and the ~~rmo~~ responsible clinician to ensure that the patient has received, and as far as possible, understood the letter from the Home Office explaining the roles of Hospital Managers and ~~rmo~~ responsible clinicians in relation to restricted patients, and patient leaflets 18 and 20.

Patients on remand/subject to an interim hospital order

For patients detained under sections 35, 36, 37 and 38 it is the court's responsibility to organise appropriate transport from the court to the receiving hospital.

Return to court (moved from chapter 29.6)

7.2 (a) All professionals concerned with ensuring the return to court of a patient on remand or under an interim hospital order should be familiar with the contents of paras 31- 33 of Home Office circular number 71/ 1984 on the implementation of sections 35, 36, 38 and 40(3) of the Mental Health Act. When a patient has been admitted on remand or subject to an interim hospital order, it is the responsibility of the hospital to return the patient to court as required. The court should give adequate notice of the hearing. The hospital should liaise with the courts in plenty of time to confirm the arrangements for escorting the patient to and from hospital. The hospital will be responsible for providing a suitable escort for the patient when travelling from the hospital to the court and should plan for the provision of necessary staff to do this. The assistance of the police may be requested if necessary. Once on the court premises, the patient will come under the supervision of the police or prison officers there.

Chapter 8 ~~Doctor's~~ ~~h~~ Holding power (section 5(2))

(Paras 25- 27 of the Memorandum)

8.1 Good practice depends upon:

xa. Application of the guiding principles

a. the professionals involved in implementing the holding power (and in particular the doctor or approved clinician invoking it) correctly understanding the power and its purpose;

b. the NHS bodies and local social services authority making necessary arrangements and agreeing performance standards to ensure that when the power is used, the patient is assessed as quickly as possible for possible admission under the Act by an ~~ASW~~ AMHP and doctors; and

c. the Hospital Managers monitoring the use of the power.

Nature of the power

8.2 The power, which authorises the detention of the patient for up to 72 hours, can be used only where the doctor, or approved clinician, in charge of the treatment of an informal in- patient, or that doctor's, or approved clinician's, nominated deputy, concludes that an application for admission under one of the relevant sections of the Act is appropriate. For this purpose, informal in- patients include those being treated for physical disorders who need treatment for a mental disorder. The period of detention commences at the moment the doctor's or approved clinician's ~~doctor's~~ report (form 12) is delivered to the Hospital Managers, or someone authorised to receive such a report on their behalf.

8.3 Detention under section 5(2) will end immediately, where: a. an assessment for admission under section 2 or 3 is made and a decision is taken not to make an application for detention under section 2 or 3; b. the doctor decides that no assessment for possible detention under section 2 or 3 needs to be carried out. The patient should be informed that he or she is no longer detained under the ~~doctor's/approved clinician's~~ holding power. The decision, the reasons for it, and its time should be recorded preferably on a form prepared for the purpose. The power cannot be renewed, but circumstances may arise where, subsequent to its use and the patient's reversion to informal status, its use can be considered again.

8.4 An informal in- patient, is one who ~~has willingly, or not unwillingly, entered and stayed in hospital and~~ is receiving in-patient care or treatment without being subject to the use of compulsory powers under the Act. For these purposes, it includes patients who are in hospital by virtue of a Bournewood authorisation under the Mental Capacity Act 2005. The section cannot be used for an out- patient attending a hospital's accident and emergency department. Admission procedures should not be implemented with the sole intention of then using the power in section 5(2).

8.5 Where a report under section 5(2) is provided in relation to a patient under the care of a ~~consultant~~ professional other than a psychiatrist, the doctor or approved clinician invoking the power should make immediate contact with a psychiatrist.

8.6 Where a patient is receiving treatment for a physical disorder and a mental disorder for the purposes of section 5(2) the consultant psychiatrist or approved clinician should be considered to be ~~is the doctor~~ in charge of the treatment.

Information

8.7 Where a patient is detained under section 5(2), the Hospital Managers must ensure that the requirements of section 132 to give information are fulfilled. See Chapter 14.

Treatment

8.8 Part IV of the Act does not apply to a patient detained under section 5(2). In the absence of the patient's consent, treatment can only be given to such a patient ~~with consent, or where a~~ if the patient aged 16 or over lacks the capacity to consent and the treatment is administered in accordance with the Mental Capacity Act 2005. ~~under the common law~~. See 31.7-31.12 for further information on consent to medical treatment for children and young people aged under 18.

The doctor's / approved clinician's role

8.9 Section 5(2) should only be used, if at the time it is not possible or safe to use section 2, 3 or 4. Section 5(2) is not an admission section under the Act.

8.10 The patient's doctor or approved clinician, or their nominated deputy, should only use the power immediately after having personally examined the patient. The doctor / approved clinician should not complete a section 5(2) form and leave it on the ward with instruction for others to submit it to the Hospital Managers if, in their view, the patient is about to leave.

Hospital Managers' responsibilities

8.11 The patient may only be detained when the doctor's or approved clinician's section 5(2) once the Hospital Managers , or someone authorised to receive it on their behalf, have been furnished with the report. ~~report has been delivered to the Hospital Managers~~, ~~or somebody authorised to receive it on their behalf.~~ It is therefore important that there is no delay in delivering the report to the Hospital Managers and that sufficient staff are authorised to enable reports to be received at any time. The doctor / approved clinician or nominated deputy must always be aware of who the authorised person is.

Assessment for admission while a patient is 'held' under section 5(2)

8.12 All the normal procedures apply, including the use of either section 2 or section 3 if compulsory admission is thought necessary.

Nominated deputies – section 5(3)

8.13 The registered medical practitioner, or approved clinician, in charge of an in- patient's treatment may nominate a deputy to exercise section 5(2) powers during his or her absence from the hospital. That deputy will then act on his or her own responsibility and should be suitably experienced.

8.14 Some safeguards:

a. Where the nominated deputy is a junior doctor, the nominating doctor / approved clinician must be satisfied that the deputy has received sufficient guidance and training to carry out the function satisfactorily.

b. Wherever possible the nominated deputy must contact the nominating doctor / approved clinician or another consultant or approved clinician, where the nominated deputy is not a consultant or approved clinician, before using section 5(2). The nominated deputy should have easy access to the nominating doctor / approved clinician or the consultant psychiatrist / approved clinician on call.

c. To nominate a deputy, a ~~Only approved clinicians or~~ registered medical practitioner~~s~~ ~~who are~~ who is not an approved clinician must be a consultant psychiatrist~~s should nominate deputies~~.

d. The nominated deputy should report the use of section 5(2) to the nominator as soon as possible.

e. All relevant staff should know who is the nominated deputy for a particular patient.

8.15 It is unlawful for one nominated deputy to nominate another.

8.15(a) Only one deputy may be authorised at any time.

8.16 It is usual practice outside normal working hours for the nominated deputy to be the junior doctor on call for the admission wards. Where this occurs the nominating doctor or approved clinician is responsible for ensuring that all the doctors liable to be on duty are competent to act as the nominated deputy and that they are adequately trained, and that an individual doctor has been nominated for every duty period.

Transfer to other hospitals

8.17 It is not possible for patients detained under section 5(2) to be transferred to another hospital under section 19 (because they are not detained by virtue of an application made under Part II of the Act). Guidance on the implications of this, and on the circumstances in which such patients may be lawfully transferred, is given in the Mental Health Act Commission's Practice Note 3 (March 1994).

Chapter 9 Nurse's holding power (section 5(4))

(Paras 28- 29 of the Memorandum)

The power

9.1 A psychiatric emergency requires the urgent attendance of a doctor or approved clinician. In practice, a doctor or approved clinician may not be immediately available. This chapter sets out the circumstances in which a nurse of the "prescribed class'' [Defined in the relevant orders as "a nurse registered in Part 3 (first level nurses trained in the nursing of persons suffering from mental illness) or Part 5 (first level nurses trained in the nursing of persons suffering from mental handicap) or Part 14 (nurses qualified following a course of preparation in learning disabled nursing)" of the professional register established under section 10 of the Nurses, Midwives and Health Visitors Act 1997] may lawfully prevent an informal in- patient, receiving medical treatment for mental disorder, from leaving the hospital. The holding power may only be applied for up to 6 hours or until a doctor or approved clinician with the power to use section 5(2) in respect of the patient arrives, whichever is the earlier, and can only be used when the patient is still on the hospital premises. The holding power cannot be renewed. It is the personal decision of the nurse who cannot be instructed to exercise this power by anyone else. Part IV of the Act does not apply to patients detained under section 5(4)

Assessment before implementation

9.2 Before using the power the nurse should assess:

a. the likely arrival time of the doctor or approved clinician as against the likely intention of the patient to leave. Most patients who express a wish to leave hospital can be persuaded to wait until a doctor or approved clinician arrives to discuss it further. Where this is not possible the nurse must try to predict the impact of any delay upon the patient;

b. the consequences of a patient leaving hospital immediately – the harm that might occur to the patient or others – taking into account:

- the patient's expressed intentions including the likelihood of the patient committing self harm or suicide;
- any evidence of disordered thinking; - the patient's current behaviour and in particular any changes in usual behaviour: - the likelihood of the patient behaving in a violent manner; - any recently received messages from relatives or friends; - any recent disturbances on the ward; - any relevant involvement of other patients.

c. the patient's known unpredictability and any other relevant information from other members of the multi- disciplinary team.

Acute emergencies

9.3 Normally assessment should precede action but in extreme circumstances it may be necessary to invoke the power without carrying out the proper assessment. The suddenness of the patient's determination to leave and the urgency with which the patient attempts to do so should alert the nurse to potentially serious consequences if the patient is successful in leaving.

Reports

9.4 The nurse entitled to use the power does so by completing form 13. This must be delivered to the Hospital Managers, or to an officer appointed by them, as soon as possible after completion. It is essential that:

a. the reasons for invoking the power are entered in the patient's nursing and medical notes;

b. a local incident report form is sent to the Hospital Managers;

c. details of any patients who remain subject to the power at the time of a shift change are given to staff coming on duty.

9.5 At the time the power elapses the nurse of the prescribed class who is responsible for the patient at that time must complete form 16.

Use of restraint

9.6 A nurse invoking section 5(4) is entitled to use the minimum force necessary to prevent the patient from leaving hospital. The general principles that should be applied when the use of restraint has to be considered are set out in paras 18.6 and 18.8.

Management responsibilities

9.7 The use of section 5(4) is an emergency measure and the doctor or approved clinician with the power to use section 5(2) in respect of the patient should treat it as such and arrive as soon as possible. The doctor or approved clinician should not wait six hours before attending simply because this is the maximum time allowed. If the doctor or approved clinician has not arrived within four hours, the duty consultant should be contacted and should attend. Where no doctor or approved clinician has attended within six hours an oral report (suitably recorded) should be made immediately to the responsible senior manager, and a written report should be submitted to that manager and the Hospital Managers on the next working day. The responsible senior manager should nominate a suitable person to supervise the patient's leaving.

9.8 The holding power lapses upon the arrival of the doctor or approved clinician. The six hour holding period counts as part of the 72 hour holding period if the doctor or approved clinician decides to report under section 5(2).

9.9 A suitably qualified, experienced and competent nurse should be on all wards where there is a possibility of section 5(4) being invoked, particularly acute admission wards, and wards where there are acutely disturbed patients, or patients requiring intensive nursing care.

9.10 While it is desirable that a nurse who invokes the power should be qualified in the speciality relevant to the patient's mental disorder the legislation does not require this. Where a nurse may have to apply the power to patients from outside his or her specialist field it is good practice for employers to arrange suitable post- basic education and training, especially in the use of section 5(4). Close working between nurses in different specialities is also important.

Chapter 10 The police power to remove to a place of safety (section 136)

(para 317 of the Memorandum)

Good practice

10.1 This depends on:

xa. application of the guiding principles

a. the local social services authority, ~~Health Authority, Trust~~ hospitals and the Chief Constable establishing a clear policy for use of the power and identifying appropriate facilities for the safe containment and rapid assessment of the person removed;

b. all professionals involved in its implementation understanding the power and its purpose, and the person's other rights and following the local policy concerning implementation.

The local policy

10.2 The purpose of removing a person to a place of safety (as defined in section 135(6)) under section 136(2) is to enable him or her to be examined by a doctor and interviewed by an ~~ASW~~ AMHP and for any necessary arrangements for his care and treatment to be made. The local policy should ensure that these assessments are conducted effectively and quickly.

10.3 The policy should define the responsibilities of:

a. PCTs to provide or secure facilities for safe containment of persons requiring assessment and facilities to ensure their swift assessment

b. ~~medical~~ health and local social services authority in providing prompt assessment and, where appropriate, admission to hospital for treatment

c. the police service in providing attendance where patient's health or safety or the protection of others so require.

d. the. police officers, doctors and ~~ASWs~~ AMHPs for the satisfactory returning to the community of a person assessed under section 136 who is not admitted to hospital or immediately placed in accommodation.

~~a. police officers to remain in attendance where the patient's health or safety or the protection of others so require, when the patient is taken to a place of safety other than a police station;~~

10.4 The policy should include provisions for the use of the section to be monitored so that:

a. a check can be made of how and in what circumstances it is being used, including its use in relation to black and minority ethic communities ~~ethnic minorities~~;

b. the parties to the policy can consider any changes in the mental health services that might result in the reduction of its use.

The place of safety

10.5 The identification of preferred places of safety is a matter for local agreement. However, as a general rule it is preferable for a person thought to be suffering from mental disorder to be detained in a hospital ~~rather than a police station~~ and every effort should be made to ensure that a police station is used only where it is necessary to provide short term containment where a patient is too violent for the available hospital setting. ~~if no suitable alternative place of safety is immediately available~~. Regard should be had to any impact different types of place of safety may have on the person held and hence on the outcome of an assessment. It should also be borne in

mind when determining the preferred place of safety that once the person has been removed to a particular place of safety, they cannot be transferred to a different place of safety.

Good practice points

10.6 Where an individual is removed to a place of safety by the police under section 136 it is recommended that:

a. where he or she is to be taken to a hospital as a place of safety immediate contact is made by the police with both the hospital and the local social services ~~department~~ authority;

b. where the police station is to be used as a place of safety immediate contact is made with the local social services authority and the appropriate doctor

The local policy for the implementation of section 136 should ensure that police officers know whom to contact. It should also be borne in mind that a person who is removed to a place of safety may already be subject to supervised community treatment (SCT), or conditional discharge or may be on leave of absence and that their recall to hospital may need to be considered. The patient's clinical supervisor (where known) should be contacted as soon as possible

Record keeping

10.7 A record of the person's time of arrival must be made immediately he or she reaches the place of safety. As soon as detention under section 136 ends the individual must be so advised by those who are detaining him or her. The managers of the place of safety should devise and use a form for recording the end of the person's detention under this section (similar to the form used for section 5(4)).

10.8 Section 136 is not an emergency admission section. It enables an individual who falls within its criteria to be detained for the purposes of an assessment by a doctor and ~~ASW~~ AMHP, and for any necessary arrangements for his or her treatment and care to be made. When these have been completed within the 72 hour detention period, the authority to detain the patient ceases.

a. Ordinarily, neither a hospital nor the police should discharge an individual detained under section 136 before the end of the 72 hour period without assessments having been made by a doctor and ~~ASW~~ AMHP within that period. Where the doctor, having examined the individual, concludes that he or she is not mentally disordered within the meaning of the Act then the individual can no longer be detained under the section and should be immediately discharged from detention.

b. Where a hospital is used as a place of safety it may be better for the patient not to be formally admitted although he or she may have to be cared for on a ward. Where such a policy is adopted it is essential to remember that the patient must be examined by a doctor in the same way as if formally admitted.

c. Where a police station is used as a place of safety speedy assessment is desirable to ensure that the person spends no longer than necessary in police custody but is either returned to the community or admitted to hospital.

Information about rights

10.9 Where an individual has been removed to a place of safety by the police under section 136:

a. the person removed is entitled to have another person, of his or her choice, informed of the removal and his or her whereabouts (section 56 of the Police and Criminal Evidence Act 1984);

b. when the person removed is in police detention (that is, a police station is being used as a place of safety) he or she has a right of access to legal advice (section 58 of the Police and Criminal Evidence Act 1984);

c. where detention is in a place of safety other than a police station access to legal advice should be facilitated whenever it is requested.

It is important to recognise that although the Act uses the term "remove", it is deemed to be an "arrest" for the purposes of the Police and Criminal Evidence Act 1984.

10.10 Where the hospital is used as a place of safety the Hospital Managers must ensure that the provisions of section 132 (giving of information) are complied with.

10.11 Where the police station is a place of safety, although section 132 does not apply, the local policy should require that the same information is given in writing on the person's arrival at the place of safety. There may be scope for co- operation between hospitals and the police in preparing suitable leaflets or letters.

Assessment

10.12 The local implementation policy should ensure that the doctor examining the patient should wherever possible be approved under section 12 of the Act. Where the examination has to be conducted by a doctor who is not approved, the reasons for this should be recorded.

10.13 Assessment by both doctor and ~~social worker~~ AMHP should begin as soon as possible after the arrival of the individual at the place of safety. Any implementation policy should set target times for the commencement of the assessment and the NHS bodies and local social services authority should review local practice against these targets.

10.14 The person must be seen by both the doctor and the ~~ASW~~ AMHP. Unless the circumstances set out in para 10.8a apply. The local policy should include the necessary arrangements to enable the person to be jointly assessed.

a. If the doctor sees the person first and concludes that admission to hospital is unnecessary, or the person agrees to informal admission, the individual must still be seen by an ~~ASW~~ AMHP, who must consult with the doctor about any other arrangements that might need to be made for his or her treatment and care.

b. It is desirable for a consultant psychiatrist in learning disabilities and an ~~ASW~~ AMHP with experience of working with people with learning disabilities to be available to make a joint assessment if it appears that the detained person has a learning disability.

10.15 The role of the ~~ASW~~ AMHP includes: - interviewing the person; - contacting any relevant relatives, carers or friends; - ascertaining whether there is a psychiatric history; - considering any possible alternatives to admission to hospital; - making arrangements for compulsory admission to hospital; - making any other necessary arrangements.

Treatment

10.16 Part IV of the Act does not apply to persons detained under section 136. In the absence of consent, a person aged 16 or over can only be treated ~~with consent, or if the person is 16 years or older and~~ if they lack capacity to consent to the necessary treatment and the treatment is administered in accordance with the ~~provisions of the common law~~ Mental Capacity Act 2005. (see Chapter 16A) See 31.7-31.12 for further information on consent to medical treatment for children and young people aged under 18.

Necessary arrangements

10.17 Once the assessment has been concluded it is the responsibility of the doctors and ~~ASW~~

AMHP to consider if any necessary arrangements for the person's treatment and care have to be made.

10.18 Where compulsory admission is indicated: a. where the hospital is the place of safety the person should be admitted either under section 2 or section 3, as appropriate. When the approved doctor providing one recommendation is on the staff of the hospital, the second recommendation should be provided by a doctor with previous knowledge of the person, for example his or her GP. When a person detained under section 136 is not registered with a GP, the second opinion should be provided by a second approved doctor;

b. persons detained under section 136 in hospital pending completion of their assessment should not have their detention extended by use of section 5(2) or section 5(4);

c. where the police station is the place of safety then compulsory admission should be under section 2 or 3 as appropriate. Section 4 may be used if there is an urgent need to move the person to hospital.

10.18a Where the patient is on SCT and compulsory admission is indicated, the SCT should be revoked (see chapter 12A SCT)

Section 135

10.19 Powers of entry under section 135(1) or (2) may be used when it is necessary to gain access to a mentally disordered person who is not in a public place and, if necessary, remove him or her to a place of safety. They require a magistrate's warrant. Local authorities should issue guidance to ~~ASWs~~ AMHPs on how and when to ~~use the power~~ to apply for a warrant.

10.19a When a warrant issued under Section 135(2) is being used to gain access it would be good practice for the police officer to be accompanied by a person authorised by the hospital (section 135(4)(b)) For patients on SCT, if practicable, it would be good practice for this to be a member of the multi-disciplinary team.

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Chapter 11 Conveyance of patients

(Para 31 of the Memorandum)

Powers

x11.1 The Act provides authority to convey individuals, usually to hospital, in a number of circumstances. Whether such an instance is to enable the individual to be assessed or treated, to transfer them between hospitals or to return and readmit them to hospital if they are absent without leave or when it is decided that a community patient (i.e. a person subject to supervised community treatment (SCT) – see chapter XXX) should be recalled to hospital, the rules in this chapter apply.

11.1. A properly completed application for admission under the Act, together with the required medical recommendations, gives the applicant (~~ASW~~ AMHP or nearest relative) the authority to convey the patient to hospital. ~~In the case of patients subject to after- care under supervision, the supervisor has the power to take and convey the patient to a place where he or she is required to attend for medical treatment, occupation, education or training. (See Chapter 28)~~

Conveying to hospital – patients recalled from SCT

11.1a Following the decision by the responsible clinician to recall an SCT patient, the patient can be taken and conveyed to hospital by any AMHP, officer on the staff of the hospital, any constable or by any person authorised in writing by the responsible clinician or the hospital managers. The responsible clinician will have responsibility for co-ordinating the recall. The way to achieve the patient's return to hospital will need to be considered in the light of the assessment of any risk and practical considerations.

General

11. 2 Authorities, including the ambulance service and the police, who are involved in conveying patients should agree joint policies, procedures and protocols to include:

a. a clear statement of the roles and obligations of each authority and its staff;

b. the form of any authorization to be given by the ~~ASW~~, AMHP ~~or supervisor,~~ to others to convey the patient;

c. guidance on powers in relation to conveying patients.

11.3 The ~~ASW~~ AMHP has a professional obligation to ensure the most humane and least threatening method of conveying the patient is used, consistent with ensuring that no harm comes to the patient or to others. The ~~ASW~~ AMHP should take into account:

- the guiding principles in Chapter 1
- ~~the patient's social and family circumstances;~~
- the nature of the ~~illness/ behaviour~~ mental disorder and its course;
- ~~the patient's preferences;~~
- ~~the views of relatives or friends involved with the patient;~~
- ~~the views of other professionals involved in the application or who know the patient;~~
- ~~his or her judgment of the patient's state of mind, and the likelihood of the patient behaving in a violent or dangerous manner;~~
- the impact that any particular mode of conveying the patient will have on the patient's

relationship with the community to which he or she will return;

- the availability and appropriateness of various transport options;
- the distance to be travelled;
- the person's need for support and supervision during the period of travel;
- the availability of transport to return home those who accompany the patient (including whether the professionals in attendance will need to return to their own vehicles); and
- the effect of individuals or professionals accompanying the patient (including whether, for example, the presence of one or more of the examiners following an initial assessment that an individual must be detained may have a detrimental effect on the patient).

11.4 When conveying a patient to hospital the ~~ASW~~ AMHP (or any other person with the authority to convey) has the power of a police constable. The task of conveying the patient may be delegated, eg to ambulance staff or the police. The ~~ASW~~ AMHP ~~or supervisor~~ retains ultimate responsibly to ensure that the patient is conveyed in a lawful and humane manner and should give guidance to those asked to assist.

11.5 If the patient is conveyed by ambulance, the ~~ASW~~ AMHP ~~or supervisor~~ may accompany the patient. Where requested by the applicant, the ambulance authority should make the necessary arrangements. The patient may be accompanied by another person, provided the ~~ASW~~ AMHP or supervisor is satisfied that this will not increase the risk of harm to the patient or others.

11.6 The patient should not be conveyed by car unless the ~~ASW~~ AMHP ~~or supervisor~~ is satisfied that they do not present a danger to the patient or others. There should always be an escort for the patient other than the driver.

11.7 If the patient is likely to be violent or dangerous the police should be asked to help. Where possible an ambulance should be used. Otherwise a police vehicle suitable for conveying such a patient should be used. While the police may have to exercise their duty to protect persons or property while the patient is being conveyed they should, where possible, comply with any directions or guidance given by the ~~ASW~~ AMHP ~~or supervisor~~.

Conveying to hospital for admission

11.8 If an ~~ASW~~ AMHP is the applicant, he or she has a professional responsibility for ensuring that all the necessary arrangements are made for the patient to be conveyed to hospital.

11.9 If the nearest relative is the applicant, the assistance of an ~~ASW~~ AMHP should be made available if requested. If this is not possible, other professionals involved in the admission should give advice and assistance.

11.10 The ~~ASW~~ AMHP should telephone the receiving hospital to ensure that the patient is expected and give the likely time of arrival. If possible the ~~ASW~~ AMHP should ask the name of the person who will be formally receiving the admission documents.

11.11 The ~~ASW~~ AMHP must ensure that the admission documents arrive at the receiving hospital at the same time as the patient. If the ~~ASW~~ AMHP is not travelling in the same vehicle as the patient, the documents should be given to the person authorised to convey the patient with instructions for them to be presented to the officer authorised to receive them.

11.12 If the ~~ASW~~ AMHP is not travelling with the patient, he or she should arrive at the hospital at the same time or as soon as possible afterwards. He or she should ensure that the admission documents have been delivered, that the admission of the patient is under way and that any relevant information is passed to the hospital staff. The ~~ASW~~ AMHP should remain in the hospital

with the patient until satisfied that the patient has been detained in a proper manner.

11.13 The ~~ASW~~ AMHP should leave an outline report at the hospital when the patient is admitted, giving reasons for the admission and any practical matters about the patient's circumstances which the hospital should know and, where possible, the name and telephone number of a social worker who can give further information. Local Social services Authorities should consider the use of a form on which ~~ASWs~~ AMHPs can make this outline report. A full report should also be prepared for the formal social services department record.

11.14 A patient who has been sedated before being conveyed to hospital should whenever possible be accompanied by a nurse, a doctor or a suitably trained ambulance person or other professional experienced in the management of such patients.

11.15 If the ~~ASW~~ AMHP or authorised person is refused access to the premises where the patient is, and forcible entry will be needed to remove the patient, an application should be made for a warrant under section 135 (2).

Chapter 12 Receipt and scrutiny of documents

(Paras 44- 54 of the Memorandum)

12.1 The Hospital Managers should formally delegate their duties to receive and scrutinise admission documents to a limited number of officers, with a knowledge of the relevant parts of the Act, who can provide 24 hour cover. A ~~general~~ manager of appropriate seniority should take overall responsibility on behalf of the Hospital Managers for the proper receipt and scrutiny of documents.

12.2 There is a difference between "receiving" documents and "scrutinising" them. Documents should be scrutinised at the same time as they are received, if possible, otherwise as soon after as possible.

Receipt of documents

12.3 a. If the Hospital Managers' obligation to receive documents is delegated to ward ~~nursing~~ staff such delegation should be to the practitioner (most likely a nurse) in charge of the ward. If the ~~nurse~~ person is below the grade of first level nurse or equivalent, he or she should seek the advice of a first level nurse, or equivalent, when "receiving" documents

b. The hospital should have a checklist for the guidance of those delegated to receive documents, to detect errors which cannot be corrected at a later stage in the procedure (see section 15).

c. When the patient is being admitted on the application of an ~~ASW~~ AMHP the person "receiving" the admission documents should check their accuracy with the ~~ASW~~ AMHP.

d. The "receiving" officer should have access to a manager for advice, especially at night.

"Scrutinising documents"

12.4

a. Where the person delegated to receive the documents is not authorised by the Hospital Managers to rectify a defective admission document, the documents must be scrutinised by a person who is authorised immediately on the patient's admission or during the next working day if admitted at night, during weekends or on public holidays when such a person is not available.

b. The Hospital Managers must arrange for the medical recommendations to be medically scrutinised, to ensure that they show sufficient legal grounds for detention. The clinical description of the patient's mental condition should include a description of his or her symptoms and behaviour, not merely a diagnostic classification. This scrutiny should be carried out at the same time as the administrative scrutiny.

Hospital Managers

12.5

a. The Hospital Managers are responsible for ensuring that patients are detained lawfully; they should therefore monitor the receipt and scrutiny of admission and SCT documents on a regular basis.

b. Those delegated to scrutinise documents must be clear about what kind of errors on application forms and medical recommendations can and cannot be corrected (see paras 48- 49

of the Memorandum). If no original pink forms are available photocopies of an original form can be used as can computer-generated forms. However, forms must correspond to the current statutory versions of the forms set out in regulations.

c. Details of defective admission documents, whether rectifiable or not, and of any subsequent action, must be given to the Hospital Managers on a regular basis.

d. Hospital Managers should ensure that those delegated to receive and scrutinise admission documents understand the requirements of the Act, and if necessary receive appropriate training.

12A Supervised Community Treatment

Purpose

12A.1 Supervised community treatment (SCT) is an arrangement by which a patient can be treated in the community following an initial period of detention and treatment in hospital. The aim of the provisions is to ensure that patients receive the treatment they need in the community and to enable action to be taken, where necessary, to prevent relapse and re-admission to hospital. It applies only to patients whose treatment needs have already been fully assessed in hospital under one of the sections outlined in paragraph12A.5 below.

12A.2 The intention is that patients should receive the treatment and services they need to maintain their mental health whilst living in the community, and that they will be subject to conditions designed to promote safe community living. While on SCT, a patient may be treated anywhere - in hospital as an outpatient, in any other healthcare setting, or at home - provided that they consent to such treatment. (Or the Act provides for a patient to be treated without consent where a patient lacks the capacity to give it.

12A.3 The responsible clinician has the power to recall a patient to hospital if, despite the arrangements in place, the patient requires medical treatment in hospital and there would be a risk of harm to the patient or others if the patient did not receive further hospital treatment. Treatment without consent can only be given in hospital on recall (in certain cases patients who lack capacity to consent to the treatment in question can be treated in the community). (See **paragraphs**12A.41 etc below and chapter 16)

12A.4 A patient will become subject to supervised community treatment from the point when the community treatment order is made – see below.

Criteria for the use of a Community Treatment Order (CTO)

12A.5 To be eligible to be considered for SCT the patient must be liable to be detained in hospital under one of the following provisions of the 1983 Act):

- section 3;
- an unrestricted hospital order made under sections 37 or 51(5);
- an unrestricted transfer direction under sections 47 or 48;
- hospital direction under section 45A where the limitation direction has ceased to have effect;
- having been transferred from guardianship (or guardianship order under section 37) under resolutions made by virtue of section 19
- Treated as being subject to section 3 or subject to an unrestricted hospital order or transfer direction, after transfer from Northern Ireland, Scotland, Isle of Man or Channel Islands.

12A.6 Before the patient's responsible clinician may consider making a CTO, they must be satisfied that:

- the patient is suffering from a mental disorder of a nature or degree which makes it appropriate for them to receive medical treatment;
- it is necessary for their health or safety or for the protection of other persons that they should receive such treatment;
- subject to their being liable to be recalled as mentioned below, such treatment can be provided without their continuing to be detained in a hospital;
- it is necessary for their health or safety or for the protection of other persons that they should be liable to be recalled to hospital for medical treatment;
- appropriate medical treatment is available for the patient.

12A.7 All of the above criteria must be satisfied for a patient to be eligible for SCT. As with applications for admission to hospital or reception into guardianship, the responsible clinician and AMHP will need to consider whether the objectives of the proposed CTO could safely and effectively be achieved in a less restrictive way.

12A.8 Guidance on the appropriate treatment test is to be found in chapter 2A. In the context of SCT, the appropriate treatment in view is, for obvious reasons, medical treatment for mental disorder wherever it is to be provided to the patient (not just treatment in hospital). References in chapter 2A should be read accordingly.

12A.9 In considering whether the criteria for SCT are met, the following considerations will be relevant:

- the guiding principles in Chapter 1 the patient's social and family circumstances;
- the nature of the mental disorder and its course;
- whether the necessary treatment could be provided safely and effectively without the use of SCT
- The cultural needs and background of the patient.
- Any other considerations that may be relevant to the patient's individual circumstances

Making a CTO

12A.10 The decision to make a CTO is made by the responsible clinician and an AMHP with reference to the criteria set out in paragraph 12A.9. The AMHP may be a member of the multi-disciplinary team ("MDT") involved in the care of the patient, but this is not essential. In all cases the AMHP must reach an independent professional view.

12A.11 The responsible clinician is responsible for initiating the process of making a CTO. In considering whether this is an appropriate option for the patient, the responsible clinician should consult with members of the MDT, including - where appropriate - the patient's GP.

12A.12 Before deciding whether to make a CTO, the responsible clinician and /or the AMHP should consult the patient, the nearest relative (unless the patient objects or it is not reasonably practicable – see Chapter 2.16**)** and any person with the authority to act on the patient's behalf and ascertain their views about the use of a CTO and the nature of any conditions to be applied.

12A.13 The AMHP must decide whether or not to agree with the responsible clinician that the patient meets the criteria for SCT, and whether it is appropriate for that patient. The AMHP must also agree the conditions to be applied. It would be useful for the responsible clinician and AMHP to work towards agreement of the conditions at an early stage. If the AMHP does not agree that a CTO should be made, or agree to the conditions, then SCT cannot go ahead. It would not be appropriate for the responsible clinician to approach another AMHP in the absence of any change in circumstances.

12A.14 In making their decision as to whether a CTO is appropriate, the AMHP should ensure that they consider the wider social context for the person concerned. For example, they should consider any support networks the patient may have, the potential impact on the rest of the patient's family and other family-related matters, and employment issues etc**.** The AMHP should also ensure the cultural background and nature of the patient's family and/other support structures is taken into consideration (see also paragraph 12A.9 above).

12A.15 Where the AMHP agrees that a CTO should be made, they should record the reasons for supporting the use of CTO and the conditions to be applied. This will be recorded in the CTO.

The guiding principles and assessing risk as part of considering a Community Treatment Order

A Case Example

John is a young man in his late twenties detained in hospital under Sec 3. Over the past 5 years he has had a number of previous admissions of similar duration (3-6 months) for the same psychiatric condition. All his admissions have been characterised by amongst other things aggressive incidents immediately prior to detention. In addition to his mental health problems, John has hearing loss.

He is being considered for a Community Treatment Order. As part of this consideration, his responsible clinician carries out a risk assessment in conjunction with the multi –disciplinary team.

When assessing risk, the responsible clinician applies the guiding principles of this Code, and accordingly considers

- the best way of informing John of the purpose and process for undertaking the risk assessment
- whether it is appropriate to consult John in English or whether another language should be used (eg Sign Language) with the use of an interpreter.
- John's views on what went well in previous discharges and what would contribute to successful community living this time.
- significant past incidents involving John – but the responsible clinician is careful to consider
    - how interpretations of that behaviour may have been influenced by stereotypes based on John's physical shape and size, his past history, ethnicity, manner, religion, gender, age and other aspects of his individual personality and characteristics.
    - John's own understanding of his illness and the factors which contribute to aggressive incidents, He asks John about such factors as ongoing unresolved disputes, alcohol/substance use, social isolation, lack of regular activity or occupation or frustration with communication difficulties.
- the views of others involved with family and friends, carers both paid and informal, the patient's GP and any other person the patient identifies, such as an advocate or neighbour. Where needed interpreters should be used to facilitate consultations. See guidance at (Chapter 34BA) on the specific circumstances in which sharing of information with professional agencies should be made even in the absence of patient consent.

12A.16 The services that a patient receives while on SCT will, by definition, consist in whole or in part of after-care under Section 117 of the 1983 Act. The aftercare arrangements should be drawn up as part of the normal care planning arrangements in line with the requirements of the Care Programme Approach ("CPA") (or its equivalent for children or older people) and section 117 and, where appropriate, the arrangements for providing aftercare will need to be agreed between the PCT and the Local Social Service Authority.

12A.17 The responsible clinician should ensure that all those responsible for delivering aspects of the care plan reach agreement about the plan and how, and where, the patient is to receive treatment for mental disorder while living in the community. It is envisaged that patients can be treated on an outpatient basis, or by their GP, on the basis that they agree to receive such treatment, and this can be set out in the conditions. The arrangements for supervising the patient's treatment and compliance with the conditions will need to be agreed.

12A.18 Following the decision to make the CTO, the responsible clinician must inform the patient, orally and in writing, of the reasons for making them subject to a CTO, the conditions to be applied, and of their right to appeal to a Tribunal for discharge. Unless the patient objects, the nearest relative should also be informed of the conditions to be applied and their right to discharge the patient where practicable. The patient's GP should be informed that the patient is to be made subject to a CTO. If the patient does not have a GP, the patient should be encouraged and helped to register with a practice.

12A.19 The CTO should record the responsible clinician's and AMHP's decisions to make the patient subject to SCT. It should set out how the patient meets the criteria, the reasons for the CTO and the conditions to be put in place. As a matter of good practice details of the care plan to be provided should be attached to the CTO.

12A.20 On completion, the CTO should be signed by the responsible clinician and the AMHP and sent to the Hospital Managers. The CTO will be effective from the date on which the patient is discharged from detention. It is the responsibility of the hospital managers to liaise with the PCT and LA to ensure that the correct services are in place following the multidisciplinary team's assessment of requirements.

Professional disagreements

12A.21 Handled properly, disagreements between professionals can offer an opportunity to safeguard the interests of the patient by widening the discussion on the best way of meeting the patient's needs. Where there is a difference of opinion between the professionals on making a CTO, the responsible clinician and AMHP should consult colleagues whilst retaining for themselves the final responsibility for making the decision.

12A.22 The responsible clinician and AMHP should ensure that they discuss any disagreements between themselves and should try to negotiate a way forward. Where they are unable to resolve their differences they should seek further guidance along their management lines. Hospitals and LSSA's should consider whether a procedure is needed to resolve any such disagreements, which should not disadvantage or compromise the patient and the care they receive.

Conditions

12A.23 Conditions must be attached to a CTO that relate to a patient's treatment needs. The conditions are intended to secure that a patient receives medical treatment, to highlight to the patient what is expected while the CTO is in force, and to ensure the protection of the patient or others from serious harm. They should be kept to a minimum number consistent with achieving the purpose. The conditions with which the patient must comply will be set out in the CTO. Depending on the patient's circumstances, they may (but do not necessarily have to) include:

- That the patient resides at a particular place;
- That the patient makes himself available at particular times and particular places for medical treatment;

- That the patient receives medical treatment in accordance with the clinical supervisor's direction; and
- That the patient abstains from particular conduct.

This last condition may be appropriate, where, for example, the patient needs to avoid usage of illegal drugs because it is known that if he does not do so, the likelihood of relapse will be greater. It should not be used unless the conduct in question is directly relevant to the patient's medical condition.

The above is not an exhaustive list of conditions which may be applied - there may be others depending on the patient's individual circumstances.

Varying /suspending the conditions

12A.24 The responsible clinician has the power to **vary** or **suspend** conditions when appropriate to do so. There is no requirement to obtain an AMHP's agreement before so doing (but see 12A.27 below).Before varying or suspending the conditions the responsible clinician should consult with the patient, any carer and any person with the authority to act on the patient's behalf, unless impracticable and inappropriate. Before consulting a carer or the nearest relative, they must establish the patient's wishes and feelings about doing so.

12A.25 The responsible clinician may **vary** the conditions in situations where for example the patient's treatment needs or living circumstances have changed and the conditions may need to be amended to reflect the changes. For example, a patient may have been attending a clinic weekly to receive medication and it is agreed that the medication needs to be given fortnightly. The responsible clinician may vary the conditions to reflect this change

12A.26 The responsible clinician may **suspend** a patient's conditions at any stage. For example, the clinical supervisor may suspend the conditions to allow the patient to be temporarily absent from where he is required to live while on holiday. (Because a suspension of one or more conditions can deal with those situations where a detained patient could be granted leave of absence, there is no provision in the Act for leave of absence to be granted to SCT patients.)

12A.27 It would not be good practice for the responsible clinician to vary, or suspend, conditions which had recently been agreed with an AMHP unless a change of circumstances had occurred

Review

12A.28 Although the responsible clinician may vary or suspend the conditions to respond to changes in the patient's circumstances, the CTO as a whole should also be kept under review to ensure it continues to be appropriate for the patient's treatment needs. A review of the CTO may be prompted if, for example:

- the patient's mental condition improves;
- the patient plans to return to employment;
- the patient's mental condition appears to have deteriorated;
- the patient fails to comply with conditions;
- the patient, their nearest relative, a carer or person with legal authority to act on their behalf requests a review;
- the patient's carer becomes unavailable.
- the patient shows signs of becoming a greater risk to himself or others

12A.29 It is good practice to review the CTO as part of all reviews of the CPA care plan or its equivalent. The CTO is of course be part of, and closely linked to, the CPA (or the appropriate planning framework).

12A.30 As part of any review of the CTO the patient, the nearest relative and any involved carer,(unless the patient objects) or person with legal authority to act on his behalf, any professionals involved with the patient's care, such as the GP, should be consulted and have their views taken into consideration.

12A.31 If any changes are made the patient and any person consulted should be informed. The patient should be told both orally and in writing and should be given a revised copy of the CPA care plan and requirements of the CTO.

Responding to concerns raised by the patient's carer/others

12A.32 Particular attention should be paid to carers/ relatives when they raise a concern with the members of the team that the patient is not complying with their conditions and/or their mental health appears to be deteriorating. The team needs to give due weight to those concerns and any requests made by the carers/relatives in deciding what action to take It may prompt a review of the CTO, as outlined above. It is good practice to develop local protocols to consider how concerns raised should be addressed and taken forward. Hospital managers could take responsibility for overseeing the development and monitoring adherence to the protocol concerns raised by carers

Extension of CTO

12A.33 CTOs are subject to regular review. The CTO will initially apply for six months and can subsequently be extended for a further six months, then for further periods of one year at a time.

12A.34 Before the CTO **can be extended**, the responsible clinician must examine the patient in the two months preceding the expiry date. The responsible clinician must make sure that one or more people who have been professionally concerned with the patient's treatment are consulted, and that their views taken into account.

12A.35 The responsible clinician may impose a condition on an SCT patient to be available for examination for the purpose of establishing if extension of the CTO is needed or for examination by a SOAD for the purpose of a Part 4A certificate (see chapter 16). If the patient fails to comply with the condition they may be formally recalled to hospital under section 17E(2) for the examination, and if necessary taken into custody and conveyed to hospital.

12A.36 The grounds for determining whether to extend the CTO are the same as those that are applied to determine whether it is appropriate to make a patient subject to a CTO.

12A.37 If the CTO is to be extended a report must be completed by the responsible clinician and the AMHP and sent to the hospital managers. On receipt of the report, the hospital managers can exercise their right to discharge the patient (in the same way as for detained patients).

12A.38 Following any extension of the CTO, the following people should be informed:

- the patient: orally and in writing. The implications of the extension must be made clear, in particular the right to apply to a tribunal and the hospital managers;
- the nearest relative (unless the patient objects) who should be informed of their rights to discharge the patient.

What happens to extension of the CTO when a patient is recalled?

12A.39 It is the responsibility of the hospital managers of the responsible hospital to oversee the process for extending the CTO, even if the patient is recalled to a different hospital. If the CTO is not revoked, the patient remains subject to SCT and the community treatment period continues, subject to the process of extension.

12A.40 In circumstances where the patient has been formally re-detained and their CTO has been revoked, a new renewal period of their original detention (e.g. under section 3 of the 1983 Act) will start from the point at which the patient is formally re-detained.

What is recall?

12A.41 Any decision to recall a patient to hospital should be by reference to defined criteria:

- that the patient needs to receive treatment for mental disorder in hospital;
- that there would be a risk of harm to the health or safety of the patient or to other persons if the patient were not recalled.

12A.42 These criteria may - but not always - be satisfied if a patient has not been complying with the conditions in the CTO about receiving medical treatment for their mental disorder, and as a result is relapsing, or is at risk of so doing. For some patients, the risk arising from a failure to attend for treatment could mean that immediate recall will be appropriate, before the risk begins to escalate. For others, it may be sufficient to monitor the situation carefully before deciding whether the patient should be recalled.

12A.43 A need for recall might also arise where a patient has been complying with the conditions, but is still deteriorating, and the situation cannot be addressed otherwise than by securing treatment in hospital.

12A.44 Recall to hospital for treatment should not become a regular or normal event for any patient on SCT. In circumstances where recall is being used frequently, the responsible clinician may wish to review the patient's treatment under SCT to consider whether the treatment could be made more acceptable to the patient, or whether, in the individual circumstances of the patient, the use of a CTO is appropriate.

12A.45 In all cases recall should be only be used following the consideration of other options. Interventions should be based on the balance of risks; any actions should be proportionate to the level of risk posed by the patient's non-compliance with their CTO (if that is the reason for the risk arising).

12A.46 Before making any decision about recall, the responsible clinician should, where practicable and appropriate, consult other relevant professionals involved in the patient's care, and where possible the patient's carer, friends, family and nearest relative.

12A.47 Before the use of recall, the responsible clinician should (unless the need for recall is urgent) consider:

- *Negotiation:* this could be done through a visit, a phone call or a letter, or a conversation with the patient's carer, friends or family. Unless the risk presenting is such that immediate recall is needed, or there has been severe deterioration in the patient's condition requiring urgent action, this should normally be the first course of action;
- *Varying the conditions:* It may be that the patient cannot fulfil the conditions of the order or the treatment plan for practical reasons. In this case, the responsible clinician might consult with the patient on a variation in the conditions.

The responsible clinician should always consider the patient's specific cultural needs and background when negotiating or varying the conditions.

Process for recall

12A.48 If the responsible clinician considers it appropriate in all the circumstances the patient should be recalled to hospital. The notice recalling the patient should be in writing (see 12A.53 below) and wherever practicable, a copy given to the patient.

12A.49 On recall the patient can be taken and conveyed to hospital immediately.

12A.50 There may be some circumstances in which the responsible clinician thinks it appropriate to allow the patient to make their own way to the hospital, without the need for conveyance, for example where they are accompanied by a family member. If the patient then fails to attend, in spite of having been recalled, they are considered AWOL and can be taken and conveyed to hospital

12A.51 Following the decision by the responsible clinician to recall the patient, the patient can be taken and conveyed to hospital by any AMHP, officer on the staff of the hospital, any constable or by any person authorised in writing by the responsible clinician or the hospital managers. The way to achieve the patient's return to hospital will need to be considered in the light of the assessment of any risk and practical considerations. Any health and safety issues need to be addressed *(see chapter on conveyance).*

12A.52 It is the responsibility of the hospital managers, to ensure that there is a clear written policy in relation to action to be taken where a patient subject to a CTO goes absent without leave (see AWOL chapter).

12A.53 Once recalled to hospital the patient can be treated without consent subject to safeguards under Part 4 and Part 4A of the Act. (see chapter 16) On deciding to recall the patient the responsible clinician should complete a recall form to be sent to the hospital managers. This form will outline the grounds for recalling the patient. The responsible clinician will need to inform the hospital managers on any occasion where a patient has been recalled to hospital.

12A.54 Following recall to hospital the responsible clinician and AMHP need to consider further action. The Act allows the patient to be detained on recall for up to 72 hours before the CTO must be revoked or the patient to be released back into the community, but it would be good practice for any decision to be made as soon as practicable.

Options following recall

12A.55 The responsible clinician can treat and release the patient at any point in the 72 hours period, following which the patient will remain subject to the CTO and will be required to continue complying with the conditions imposed.

12A.56 The responsible clinician may decide that the patient requires a period of treatment in hospital and will therefore revoke the CTO.

12A.57 If the CTO has not been revoked within the 72 hours the patient must be discharged from inpatient detention but the CTO will remain in force.

Revoking the CTO

12A.58 Before the CTO can be revoked, the responsible clinician and an AMHP must agree that the patient requires medical treatment as an inpatient and meets the grounds for detention as set out in section 3 of the 1983 Act, i.e.

- they are suffering from a mental disorder of a nature or degree which makes it appropriate for them to receive medical treatment in hospital;
- It is necessary for the health or safety of the patient or for the protection of other persons that the patient should receive such treatment and it cannot be provided unless they are detained in hospital under this section
- appropriate medical treatment is available.

12A.59 If the CTO is revoked, the patient's detention under their original detaining section of the 1983 Act will be re-instated and a new detention period begins for the purposes of subsequent review and applications to the MHRT (but not for the purposes of treatment safeguards under section 58.)

12A.60 Where the CTO has been revoked, the hospital managers are required to refer a patient case to the Mental Health Review Tribunal for review as soon as is practicable.

Discharge from SCT

12A.61 The patient can be discharged from SCT by the following means:

- the responsible clinician can discharge the patient from SCT at any time;
- the patient's nearest relative can apply to the hospital managers for the patient to be discharged from SCT, giving not less than 72 hours notice. The discharge can be barred by the responsible clinician if following the notification the responsible clinician provides the managers with a report certifying that if the patient were to be discharged from the CTO they would be likely to act in a manner dangerous to other persons or to themselves (see Nearest Relative chapter);
- the patient has the right to apply to the hospital managers for discharge;
- the patient has the right to apply to the MHRT (see chapter on Tribunals).

12A.62 A patient subject to a CTO may be received into guardianship by an application made in the normal way. The effect will be to end the CTO and the underlying liability to detention.

Chapter 13 Guardianship (section 7)

(Paras 38- 42 of the Memorandum)

Purpose of guardianship

13.1 The purpose of guardianship is to enable patients to receive care in the community where it cannot be provided without the use of compulsory powers. Such care may, or may not, consist of specialist medical treatment for mental disorder. It 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 must be part of the patient's overall care and treatment plan. Crucially, however, it differs from SCT in being primarily directed at the welfare of the patient, rather than the patient's health or safety. For that reason, it does not confer any power to give treatment without consent.

~~13.2 After- care under supervision provides an alternative statutory framework for the after-care of patients who have been detained in hospital for treatment and meet the criteria set out in section 25A of the Act. Detailed guidance on after- care under supervision is given in Chapter 28.~~

Assessment for guardianship

13.3 ~~ASW AMHP and doctors should consider guardianship as a possible alternative to admission to, or continuing care in, hospital.~~ An application for guardianship may be made on the grounds that the patient is

- suffering from 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.

13.3a As with applications for detention, AMHPs and doctors making recommendations should consider whether the objectives of the proposed application could be achieved in another, less restrictive way.

13.3b Where the patient lacks capacity to make some or all important decisions concerning their own welfare, one obvious alternative means will be to rely on the Mental Capacity Act (MCA), and especially the protection from liability for actions taken in connection with care or treatment provided by section 5 MCA.

13.3c While this is a factor to be taken into account, it will not by itself determine whether guardianship is necessary or unnecessary. AMHPs and doctors need to consider all the circumstances of the particular case. Possible situations in which guardianship might be considered in relation to a mentally disordered person who lacks capacity to make important decisions about their own welfare include cases where

- it is thought to be important that decisions about where the person is to live are placed in the hands of a single person or authority over a continuing period – for example where have been long-running or particularly difficult disputes about where the person should live;

- the person is thought 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 (whether they are able to consent to it, or it is being provided for them under the MCA).

- there is a particular need to have explicit authority for the person to be returned to the place the person is to live (eg a care home).

Components of effective guardianship [title moved]

13.4 An application for guardianship should be accompanied by a comprehensive care plan established on the basis of multi- disciplinary discussions. It is important that any procedures instituted by social services departments are no more than the minimum necessary to ensure the proper use of guardianship and that guardianship can be used in a positive and flexible manner.

~~**Components of effective guardianship**~~

13.5 A comprehensive care plan is required (under the Care Programme Approach (CPA) in England, or its equivalent) which identifies the services needed by the patient and who will provide them. The care plan should include care arrangements, suitable accommodation, treatment and personal support. For those subject to guardianship the care plan should also indicate which of the powers under the Act are necessary to achieve the plan. If no powers are required guardianship should not be used.

13.6 Key elements of the plan should include:

~~a. depending on the patient's level of "capacity", his or her recognition of the "authority" of, and willingness to work "with", the guardian~~;

b. support from the local authority for the guardian;

c. suitable accommodation to help meet the patient's needs;

d. access to day care, education and training facilities;

e. effective co-operation and communication between all persons concerned in implementing the care plan. The guardian should be willing to 'advocate' on behalf of the patient in relation to those agencies whose services are needed to carry out the care plan.

Duties of Local Social Services ~~Departments~~ Authorities

13.7 Each local authority should establish a policy setting out the arrangements for:

a. receiving, considering and scrutinising applications for guardianship. Such arrangements should ensure that applications are properly but speedily dealt with;

b. monitoring the progress of the guardianship including steps to be taken to fulfil the authority's statutory obligations in relation to private guardians and to arrange visits to the patient;

c. ensuring the suitability of any proposed private guardian, and that he or she is able to understand and carry out the statutory duties, including the appointment of a nominated medical attendant;

d. ensuring that patients under guardianship receive, both orally and in writing, relevant aspects of the information that Hospital Managers are required to give to detained patients under section 132 (patient leaflets 10 and 11);

e. ensuring that the patient is aware of his or her right to apply to a Mental Health Review Tribunal and that a named officer of the local authority will give any necessary assistance to the patient in making such an application;

f. maintaining detailed records relating to the person under guardianship;

g. ensuring the review of the guardianship towards the end of each period of guardianship;

h. discharging the patient from guardianship as soon as it is no longer required.

The powers of the guardian

13.8 Section 8 of the Act sets out the three powers of the guardian as follows:

a. to require the patient to live at a place specified by the guardian. This does not provide the legal authority to detain a patient physically or remove the patient against his or her wishes to that place. A patient who is absent without leave from the specified place may be returned within the statutory time limit [see paras 72- 74 of the Memorandum] by those authorised to do so under the Act;

b. to require the patient to attend at specified places for medical treatment, occupation, education or training. If the patient refuses to attend, the guardian is not authorised to use force to secure such attendance, nor does the Act enable medical treatment to be administered in the absence of the patient's consent;

c. to require access to the patient to be given at the place where he or she is living to persons detailed in the Act. A refusal without reasonable cause to permit an authorised person to have access to the patient is an offence under section 129 but no force may be used to secure entry.

13.8a Any guardian should be a person who can appreciate any special disabilities and needs of a mentally disordered person and who will look after the patient in an appropriate and sympathetic way. The guardian should display an interest in promoting the patient's physical and mental health and in providing for his occupation, training, employment, recreation and general welfare in a suitable way. The local social services authority must satisfy itself that the proposed guardian is capable of carrying out his functions and should assist the guardian with advice and other facilities

If the patient consistently resists the exercise of the guardian's powers it can be concluded that guardianship is not the most appropriate form of care for that person and the guardianship order should be discharged.

13.9 Points to remember:

a. guardianship does not restrict the patient's access to hospital services on an informal basis. A patient who requires treatment but does not need to be detained may be admitted informally;

aa. nor does it prevent an authorisation being granted under the Bournewood procedure in the MCA, where the person needs to be detained in a hospital or a care home in their best interests (although only rarely will guardianship remain necessary where a person is so detained more than for a short period)

b. guardianship can also remain in force if the patient is admitted to hospital under section 2 or 4 but not under section 3;

c. it is possible in certain circumstances for a patient liable to be detained in hospital by virtue of an application under Part II of the Act to be transferred into guardianship and for a person subject to guardianship under Part II of the Act to be transferred into the guardianship of another local social services authority or person approved by such authority or to be transferred to hospital. (See section 19 and regulations 7- 9 of the Mental Health (Hospital, Guardianship and Consent to Treatment) Regulations 1983.)

13.10 Particular practice issues:

a. guardianship must not be used to require a patient to reside in hospital except where it is

necessary for a very short time in order to provide shelter whilst accommodation in the community is being arranged;

b. where an adult is assessed as requiring residential care, but owing to mental incapacity is unable to make a decision as to whether he or she wishes to be placed in residential care, those who are responsible for his or her care should consider the applicability and appropriateness of guardianship for providing the framework within which decisions about his or her current and future care can be planned. (But see also Chapter 16A on the interface with the Mental Capacity Act 2005)

Guardianship under section 37

13.11 Guardianship may be used as an alternative to hospital orders by courts where the prescribed criteria, which are similar to those of a hospital order, are met. The court should be satisfied that the local authority or named person is willing to act as guardian. The local authority should be satisfied with the arrangements. In considering the appropriateness of guardianship they should be guided by the same principles as apply under Part II of the Act. The powers and duties conferred on the local authority or private guardian and the provisions as to duration, renewal and discharge are the same as in guardianship applications except that the power to discharge is not available to the nearest relative.

Chapter 14 Information for detained patients, those subject to Supervised Community Treatment or guardianship and nearest relatives

(Paras 297- 302 of the Memorandum)

14.1 Under section 132 the Hospital Managers must ensure that all detained patients and those subject to SCT are given and understand:

a. specific information as soon as is practicable after their admission or they are placed on SCT *[see section 132 and para 297 of the Memorandum];*

b. particular information in so far as it is relevant to the patient *[see section 132(2) and para 298 of the Memorandum].*

14.1(a) It is important that patients are told of the reasons for their detention promptly and adequately. In addition a copy of the detention application (or its equivalent for patients detained by order of a court, or direction of the Secretary of State, or on transfer from another jurisdiction) must be provided to the patient.

14.2 The managers are also required to ensure that the above information is given in writing to the patient's nearest relative - unless the patient wishes otherwise. ~~Health Authorities and Trusts~~ NHS bodies are reminded that sample letters to nearest relatives were circulated at Annex B of Circular HC(83)17.

14.3 Under Section 133 the Hospital Managers should, if the patient does not object, give the nearest relative of a detained patient at least seven days notice of his or her discharge from hospital ~~or mental nursing home~~ and discharge from SCT.

The Hospital Managers' information policy

14.4 In order to fulfil their statutory duties Hospital Managers should implement a system which is consistent with the principles set out in Chapter 1 and ensures that:

a. the correct information is given to the patient and the patient's nearest relative;

b. the information is given in accordance with the requirements of the law and at a suitable time and in an accessible format including where appropriate with the aid of assistive technologies and interpretive and advocacy services. ~~a suitable manner and at a suitable time and in accordance with the requirements of the law;~~

c. the member of staff who is to give the information has received sufficient training and guidance and is identified in relation to each ~~detained~~ patient;

d. a record is kept of the information given, including how, when, where and by whom it was given and an assessment of how well the information was understood by the recipient;

e. a regular check is made that information has been properly given to each ~~detained~~ patient, and understood by them.

f. information is given to the patient when they are placed on SCT and when the community treatment order is revoked, as their rights will be different.

g steps are taken to find out whether a patient has an attorney or deputy with authority to make decisions about their personal welfare which they lack capacity (see chapter 16A). Where there is such a person, that person acts as the agent of the patient, and should be informed in the same way as the patient themselves about matters within the scope of their authority.

Specific information

14.5

a. Information on consent to treatment

The patient must be informed;

- of the nature, purpose and likely effects of the treatment which is planned;
- of their rights to withdraw their consent to treatment at any time and of the need for consent to be given to any further treatment;
- how and when treatment can be given without their consent, including by the second opinion process and when treatment has begun if stopping it would cause serious suffering to the patient.

b- Information on detention, renewal and discharge

- The patient should be informed; of the provisions of the Act under which they are detained or liable to recall, and the reasons for their detention or SCT;
- that they will not automatically be discharged when the current period of detention or SCT ends;
- that their detention or SCT will not automatically be renewed or extended when the current period of detention or liability to recall ends;
- of their right to have their views about ~~their continued detention~~ being detained, being subject to SCT or discharged considered before any decision is made.

c- Information on applications to Mental Health Review Tribunals:

Patients and nearest relatives must be informed;

- of their rights to apply to Mental Health Review Tribunals;
- about the role of the Tribunal;
- how to apply to a Tribunal (this is particularly important when a patient is placed on SCT and may not have daily contact with people who could help the patient apply); how to contact a suitably qualified solicitor;
- that free Legal Aid - Advice by way of representation (ABWOR) may be available;
- how to contact any other organisation which may be able to help them make an application to a Tribunal.

d- Information on the Mental Health Act Commission

Patients must be informed:

- about the role of the Mental Health Act Commission;
- when the Commission is to visit a hospital or unit;
- of their right to meet the Commissioners;
- of their right to complain to the Commission.

~~Mental health advocates, where available, can help patients to understand information they are given and to understand what is happening to them. They can also help to ensure patients' voices are heard by supporting them to articulate their own views and engage with the clinical team.~~ [See amended 14.4b]

~~Hospital Managers should ensure that these rights are explained to patients them in a form which they can understand taking into consideration age, language barriers and learning difficulties disabilities. On admission a patient may be too distressed to understand their rights so it is good practice from time to time to remind the patients of these rights. It is the responsibility of each individual hospital to ensure the information is available.~~ [See amended 14.4b and 14.2. Also the amended guidance on communication in chapter 1]

Chapter 15 Medical treatment

(Paras 212- 230 of the Memorandum)

Introduction

15.1 This chapter gives guidance on medical treatment, capacity (see paras 15.9 -15.12), consent to treatment (see paras 15.13- 15.17) and the treatment of those without capacity (see paras 15.18- 15.24). It should be read alongside chapters 16 and 16A.

Definition of medical treatment

15.1a For the purposes of the Act, medical treatment includes nursing, psychological intervention and also specialist mental health ~~and care~~, habilitation, ~~and~~ rehabilitation and care. ~~under medical supervision~~, i.e. the broad range of activities aimed at alleviating, or preventing a deterioration of, the patient's mental disorder. ~~It includes physical treatment such as ECT and the administration of drugs, and psychotherapy.~~

Duties of ~~rmo~~ responsible clinicians and approved clinicians in charge of the treatment

15.2 Everyone involved in the medical treatment of mental disorder should be familiar with the provisions of Part ~~IV~~ 4 and 4A of the Act, related statutory instruments, relevant circulars and advice notes. But it is for the approved clinician in charge of the treatment in question to ensure that there is compliance with the Act's provisions relating to medical treatment.

15.2a The approved clinician in charge of the treatment will often be the patient's responsible clinician. But there may be circumstances where the responsible clinician is not (or does not feel) appropriately qualified to be in charge of a particular treatment, for example, the prescribing of medication where the responsible clinician is not a registered medical practitioner or a nurse prescriber, or psychotherapies which require specialist expertise which the responsible clinician does not have. In this case, the responsible clinician will maintain their overarching responsibility for the patient's case, but the part of the patient's treatment that they are not qualified to be in charge of will be in the charge of an appropriately qualified approved clinician. For example, a patient's responsible clinician may be a chartered psychologist, because the patient has a personality disorder which will require mainly psychological interventions. The responsible clinician would be responsible for a significant element of the treatment, but the patient may also require some medication that the responsible clinician is not qualified to be in charge of. In this case an approved clinician who is qualified to prescribe would be in charge of this aspect of the treatment, but the responsible clinician would retain overall responsibility for the patient's case.

15.2b Where the approved clinician in charge of a particular treatment is not the patient's responsible clinician, they should ensure that the responsible clinician is kept informed about the treatment and that treatment decisions are discussed with the responsible clinician.

Human Rights Act

15.2c One of the primary functions of the Act is to provide a legal framework within which treatment may, where necessary, be given to patients who do not wish, at the time, to receive it. That includes patients who have the capacity to consent to the treatment, but who do not do so, and those who lack capacity to consent, but who nonetheless are clear in their own minds (for whatever reason, or even without a reason) that they do not wish to be treated.

15.2d The Act provides a framework of legal authority and safeguards within which such treatment may be given. Clinicians making use of that framework to provide necessary treatment are performing a function of a public nature and are therefore subject to provisions of the Human Rights Act 1998. In particular, it is unlawful for them to act in a way which is incompatible with

patients' Convention rights.

15.2e Scrupulous adherence to the requirements of the legislation and good clinical practice should ensure that there is no such incompatibility. But clinicians should always bear in mind that

- compulsory administration of treatment which would otherwise require consent is invariably a breach of Article 8 of the Convention (respect for family and private life). Such a breach can be justified where it is in accordance with law, and it is proportionate to a legitimate aim (in this case, the reduction of the risk posed by a person's mental disorder and the improvement of their health.)
- compulsory treatment is capable of being inhumane treatment (or in extreme cases even torture) contrary to Article 3, if its effect on the person concerned reaches a sufficient level of severity. However, it will not be a breach if it is convincingly shown to be a medical necessity.

15.2f In determining whether treatment is a medical necessity, the questions a court will ask itself include: (a) how certain is it that the person suffers from a treatable mental disorder; (b) how serious a disorder it is ; (c) how serious a risk is presented to others; (d) how likely is it that, if the patient does suffer from such a disorder, the proposed treatment will alleviate the condition; (e) how much alleviation there is likely to be; (f) how likely it is that the treatment will have adverse consequences for the patient; (and (g) how severe may they be. (*R (on the application of N) v Dr M and others* [2002] EWCA 1789). These are no more than the questions which a clinician would naturally consider before prescribing or administrating treatment.

Duty of the Hospital Managers

15.3 The managers should monitor compliance with the provisions of Part 4 and 4A of the Act. (For a more detailed discussion of Part 4and 4A of the Act see Chapter 16.)

~~**Medical treatment**~~

~~15.4 For the purposes of the Act, medical treatment includes nursing, psychological interventions and also specialist mental health and care, habilitation, and rehabilitation and care. under medical supervision, ie the broad range of activities aimed at alleviating, or preventing a deterioration of, the patient's mental disorder. It includes physical treatment such as ECT and the administration of drugs, and psychotherapy.~~

Treatment plans

15.5 Treatment plans are essential for ~~both~~ informal~~, and~~ detained and SCT patients. [~~Consultants~~ Responsible clinicians should co- ordinate the formulation of a treatment plan in consultation with their professional colleagues. The plan should form part of a coherent care plan under the CPA (or its equivalent), ~~for patients in England~~, and be recorded in the patient's clinical notes.

15.6 A treatment plan should include a description of the immediate and long term goals for the patient with a clear indication of the treatments proposed and the methods of treatment. The patient's progress and possible changes to the care programme should be reviewed at regular intervals. Treatment plans and the care programme will require review as part of the decision to apply for a Community Treatment Order on behalf of a patient.

15.6a ~~Mental health~~ Professional advocates, where available, can ~~may~~ help the patient to engage in their treatment plan by helping them understand what treatment they will receive, why they are receiving it, the legal authority for providing it and the safeguards in relation to the treatment.

15.7 Wherever possible the whole care programme should be discussed with the patient, with

a view to enabling him or her to contribute to it and express agreement or disagreement. Additionally, consultations with others should address the understanding those others have of the views of the patient, either past or present, and any evidence supporting this understanding. Clinicians will need to make judgements as to the relative weight to give to contrary or inconsistent views. ~~The patient may have made advance statements about the care they would like to receive~~ The care programme should be discussed with the patient's relatives or carers, with the consent of the patient if he or she is capable of giving consent, and, if the patient is not capable, on the basis of whatever discussions are necessary in the best ~~personal~~ interests of the patient.

15.7a The continued involvement of carers is particularly important if the person they care for requires treatment under compulsory powers. Carers play a vital role in helping to look after family members and friends who are users of mental health services. The Mental Health National Service Framework for England (Standard Six) stresses the importance of identifying all individuals who provide regular and substantial care for those with severe mental disorder, to ensure that health and social services assess the needs of carers and, where relevant, to provide ~~services care~~ to meet those needs.

Capacity and consent to treatment: introduction

15.8 Under the common law, valid consent ~~(see para 15.13)~~ is required from all patients before medical treatment can be given~~, except where common law or statute provides authority to give treatment without consent. The common law (change needed re: MCA?) may authorise treatment where the patient is incapable of consenting or, rarely, where the patient may be capable of consent. Treatment may be authorised by statute for example under Part IV and Part IVA of the Act (see Chapter 16).~~ Where a patient will not, or cannot, consent, there must be another explicit legal authority for giving the treatment.

15.8a In general terms, there is no other legal authority by which treatment may be given to an adult who has the capacity to consent to treatment but who does not do so. However, Parts 4 and 4A of the Act specifically provide that authority in relation to most people who are liable to be detained under the Act, or subject to a community treatment order (as the case may be).

15.8b Where people aged 16 and over lack capacity to consent to treatment, the framework for their treatment in their best interests is to be found in the Mental Capacity Act 2005 (MCA). However, the MCA does not apply in cases where Parts 4 and 4A of the Mental Health Act themselves provide the authority for the treatment of patients who are liable to be detained or subject to SCT.

See also Chapter 31 for special considerations in relation to children.

Capacity to make treatment decisions

15.9 The assessment of a patient's capacity to make a decision about his or her own medical treatment is a matter for clinical judgment, guided by current professional practice and subject to legal requirements. It is the personal responsibility of any doctor or other professional proposing to treat a patient to determine whether the patient has capacity to give a valid consent.

15.9a Clinicians should be familiar with the principles of the MCA and its definition of when a person lacks capacity. Although Part 4 of the Mental Health Act does not directly refer to the MCA, to all intents and purposes the test of capacity to be used under Part 4 is the same as in Part 4A and therefore in the MCA. If a person does not lack capacity to take a particular decision, then by definition they have capacity to do so.

~~Capacity: the basic principles~~

15.10~~ An individual is presumed to have the capacity to make a treatment decision unless he or~~

~~she:~~

- ~~is unable to take in and retain the information material to the decision especially as to the likely consequences of having or not having the treatment; or~~
- ~~is unable to believe the information; or~~
- ~~is unable to weigh the information in the balance as part of a process of arriving at the decision [ReC (Refusal of Treatment) [1994] 1 FLR 31 and Re MB [1997] 2 FCR 541].~~

It must be remembered:

- any assessment as to an individual's capacity has to be made in relation to a particular treatment, proposed admission, or other decision.
- capacity in an individual with a mental disorder can be variable over time and should be assessed at the time the admission or treatment is proposed;
- all assessments of an individual's capacity should be fully recorded in the patient's medical notes;

~~15.11 Where an individual lacks capacity at a particular time it may be possible to establish that there was an advance refusal of treatment in the past. To be valid an advance refusal must be clearly verifiable and must relate to the type of treatment now proposed. If there is any reason to doubt the reliability of an advance directive, then an application to the court for a declaration could be made [Guideline 3 in R v Collins ex parte S (No. 2) [1998]]. The individual must have had the capacity to make an advance refusal when it was made. An advanced refusal of medical treatment for mental disorder does not prevent the authorization of such treatment by Part IV or IVA of the Act in the circumstances where those provisions apply.~~

15.12 Mental disorder does not necessarily mean that a patient lacks capacity to give or refuse ~~make a patient incapable of giving or refusing~~ consent, or taking any other decision. Capacity to consent is variable in people with mental disorder and should be assessed in relation to the particular patient, at the particular time, as regards the particular treatment proposed. Not everyone is equally capable of understanding the same explanation of a treatment plan. The explanation should be appropriate to the level of his or her assessed ability.

Consent: the basic principles

15.13 `Consent' is the voluntary and continuing permission of the patient to receive a particular treatment, based on an adequate knowledge of the purpose, nature, likely effects and risks of that treatment including the likelihood of its success and any alternatives to it. Permission given under any unfair or undue pressure is not `consent'. Nor does a patient's co-operation with treatment amount to consent if the patient lacks capacity to give such consent.

~~Consent from patients with capacity to consent~~

15.14 It is the duty of everyone proposing to give treatment to use reasonable care and skill, not only in giving information prior to seeking a patient's consent but also in meeting the continuing obligation to provide the patient with adequate information about the proposed treatment and alternatives to it.

15.15 The information which must be given should be related to the particular patient, the particular treatment and the relevant medical knowledge and practice. In every case sufficient information must be given to ensure that the patient understands in broad terms the nature, likely effects and risks of that treatment including the likelihood of its success and any alternatives to it. Additional information is a matter of professional judgment for the ~~doctor professional~~ person proposing the treatment.

15.16 The patient should be invited to ask questions and the ~~doctor~~ professional should answer fully, frankly and truthfully. There may be a compelling reason, in the patient's interests, for not disclosing certain information. A ~~doctor~~ professional who chooses not to disclose must be prepared to justify the decision. If a ~~doctor~~ professional chooses not to answer a patient's question, he or she should make this clear to the patient so that the patient knows where he or she stands.

15.17 The patient should be told that his or her consent to treatment can be withdrawn at any time and that fresh consent is required before further treatment can be given or reinstated. The patient should receive an explanation of the likely consequences of not receiving the treatment. (See para 16.11 on withdrawing consent in relation to treatment administered under Part IV or IVA of the Act.)

~~Treatment of those without capacity to consent~~ [A replacement set of paragraphs covering this heading can be found at 15.25a-15.25b]

~~15.18 The administration of medical treatment to people incapable of taking their own treatment decisions is a matter of much concern to professionals and others involved in their care. It is the personal responsibility of professionals to ensure that they understand the relevant law.~~

~~15.19 Principles governing a child's capacity to consent to treatment are set out in Chapter 31.~~

~~15.20 An adult patient may be mentally incapable of consenting to treatment or refusing treatment (see paras 15.9- 15.12). The mental incapacity may be due to temporary factors such as delirium, shock, pain or drugs, or mental incapacity may be more long- lasting as with patients who have severe learning disabilities or some patients who suffer from a degenerative condition such as Alzheimer's disease.~~

~~15.21 There are particular considerations that doctors must take into account in discharging their duty of care for those who lack capacity to consent. Treatment for their condition may be prescribed for them in their best interests under the common law doctrine of necessity [see the decisions in the House of Lords in Re F [1990] 2 AC 1 and R v Bournewood Community and Mental Health NHS Trust ex parte L [1998] 3 ALL ER 289]. According to the decision in the case of in Re F, if treatment is given to a patient who is not capable of giving consent "in the patient's best interests", the treatment must be:~~

- ~~necessary to save life or prevent a deterioration or ensure an improvement in the patient's physical or mental health; and~~
- ~~in accordance with a practice accepted at the time by a reasonable body of medical opinion skilled in the particular form of treatment in question [the test that was originally laid down in Bolam v Friern Hospital Management Committee [1957] 1 WLR 582].~~

~~15.22 There are exceptional circumstances in which the proposed treatment should not be carried out on mentally incapacitated patients without first seeking the approval of the High Court by way of a declaration (see para 15.23). Sterilisation, according to the House of Lords in Re F, is one such circumstance.~~

~~15.23 The procedures to be used when applying for a declaration that a proposed operation for sterilisation is lawful were set out initially by Lord Brandon of Oakbrook in Re F and developed by the Official Solicitor in [Practice Note (Official Solicitor: Sterilisation) (1996) 2 F. L. R. 111]. In outline, the procedure is as follows:~~

~~a. applications for a declaration that a proposed operation for sterilisation of a patient can lawfully be carried out despite the inability of such patient to consent thereto should be by way of Originating Summons issuing out of the Family Division of the High Court;~~

~~b. the applicant should normally be the person(s) responsible for the care of the patient or intending to carry out the proposed operation or other treatment, if it is declared to be lawful;~~

~~c. the patient must always be a party and should normally be a respondent. In cases in which the patient is a respondent the patient's guardian ad litem should normally be the Official Solicitor. In any cases in which the Official Solicitor is not either the 'next friend' or the guardian ad litem of the patient or an applicant he shall be respondent;~~

~~d. with a view to protecting the patient's privacy, but subject always to the judge's discretion, the hearing will be in chambers, but the decision and the reasons for that decision will be given in court.~~

~~15.24 The Handbook of Contraceptive Practice (Department of Health 1990) considers the effect of Re F on operations for sterilisation, as well as other matters relating to the sexuality of people with learning disabilities.~~

Treatment of those who may have capacity to consent where consent is not given

15.25 A patient capable of giving consent can only be given medical treatment for mental disorder against his or her wishes in accordance with the provisions of Part 4 or 4A of the Act. A patient on SCT or conditional discharge and who is capable of consent cannot be treated without their consent when they are in the community. An SCT or conditionally discharged patient capable of consent can only be treated against his or her wishes on recall to hospital in accordance with the provisions of Part IV of the Act. Even where the Act authorises treatment despite a patient's refusal to consent, efforts should first be made to obtain such consent. It should always be remembered that nothing in the Act authorises treatment without consent where that treatment is not for mental disorder. In an emergency, where it is not possible immediately to apply the provisions of the Mental Health Act, a patient suffering from a mental disorder which is leading to behaviour that is an immediate serious danger to him or herself or to other people may be restrained. ~~given such treatment as represents the minimum necessary response to avert that danger. The administration of such treatment is not an alternative to giving treatment under the Mental Health Act and its administration should not delay the proper application of the Act to the patient at the earliest opportunity. (See Chapter 16).~~ If the patient has the capacity to consent to treatment, even such an emergency does not provide a lawful basis for administering invasive medical treatment without consent.

Treatment of those without capacity to consent [This replaces 15.18-15.24 from current code]

15.25a Except where Parts 4 And 4A of the Act provide specific authority for the treatment of patients who lack capacity to consent to the treatment in question, clinicians will need to rely on the provisions of the MCA to treat such patients if they aged 16 or over.

15.25b A summary of how the interface between the MCA and the Mental Health Act is at chapter 16A However, to understand how the MCA itself works and is to be applied, clinicians and other decision-makers should refer to the MCA itself and to the Code of Practice which accompanies it.

See 31.7-31.12 for further information on consent to medical treatment for children and young people aged under 18.

Chapter 16 Medical treatment under the Act and second opinions

[To note: This chapter has been renumbered because of the major changes made within it]

(Paras 212- 230* and 69A to 69L *of the Memorandum)

This chapter deals with the provisions in the Act which confer, or limit, authority to treat patients either with or without their consent. It should be read alongside chapters 15 (medical treatment) and 16A (Mental Capacity Act 2005).

General

16.1 ~~The common law (see Chapter 15) applies to patients detained under subject to the Act's powers but additional~~ ~~Additional~~ Specific provisions affecting medical treatment of detained patients are to be found in Part 4 of the Act and provisions affecting medical treatment of SCT patients in the community are to be found in Part 4A of the Act.

16.1(za) Part 4 of the Act provides specific statutory authority for forms of medical treatment for mental disorder to be given to most patients liable to be detained, without their consent in certain circumstances. It also provides specific safeguards. Patients 'liable to be detained' are those who are detained or have been granted leave of absence (section 17) and includes SCT patients who have been recalled to hospital and those whose community treatment order (CTO) has been revoked.

16.1 (zb) Part 4 also provides specific safeguards to all patients (whether otherwise subject to the Act ~~detained~~ or not) in relation to treatments that give rise to special concern.

16.1a Part 4A of the Act regulates the administration of treatment provided under SCT. Where a patient has the capacity to consent, treatment cannot be given without that patient's consent in the community. Part 4A provides specific statutory authority to administer treatment in the community to adult patients (aged 16 or over) lacking capacity and children (aged under 16) who lack competence both routinely and in emergency situations. It also provides specific safeguards to all SCT patients similar to those provided by section 58 for detained patients.

16.1b Everyone involved in the operation of Part 4 and Part 4A of the Act should be familiar with:
[based on and replaces 16.3 of current code]

a. the provisions of Part 4 and Part 4 A of the Act;

b. paras 69A to 69L of the Memorandum;

c. MHAC guidance on consent to treatment and Second Opinion Appointed Doctors at http://www.mhac.org.uk/

16.1c Part 4 and Part 4A of the Act only apply to medical treatment for mental disorder~~.~~ This includes treatment to alleviate the symptoms and manifestations of mental disorder as well as treating the underlying cause of the condition. [B v Croydon Health Authority [1995] 2 WLR 294]. It does not apply to the treatment of physical disorders unless it can reasonably be said that ~~the physical disorder is a symptom or underlying cause of the mental disorder~~ treating the physical disorder is ancillary to the treatment of the mental disorder (eg treating self-inflicted wounds). If in doubt the ~~rmo~~ approved clinician in charge of the treatment should seek legal advice. (See also the Mental Health Act Commission's note on Anorexia Nervosa). **[based on and replaces 16.5 of current code]**

16.1d It should not be assumed that a patient subject to the Act lacks capacity to consent to any or all of their treatment. For detained and SCT patients, the patient's consent should be sought for all proposed treatments, even if they may lawfully be given under the Act without consent. It is

the personal responsibility of the approved clinician to ensure that valid consent has been sought. The interview at which such consent was sought should be properly recorded in the patient's notes. **[based on and replaces 16.4 of current code]**

16.2 The provisions of Part 4 can be summarized as follows:

a. Section 57 - Treatments requiring the patient's consent and a second opinion - ~~psychosurgery~~ neurosurgery for mental disorder (sometimes known as "psychosurgery") and the surgical implantation of hormones for the reduction of male sexual drive. These provisions apply to all patients whether or not they are liable to be detained or otherwise subject to the Act.

b. Section 58 - Treatments requiring the patient's consent or a second opinion - the administration of medicine beyond three months and treatment by ECT at any time. These provisions apply to all patients liable to be detained except those detained under section 4 (until the second medical recommendation is submitted), sections 5(2) or 5(4), sections 35, 135, 136 and 37(4~~);~~ ~~also patients~~ and those conditionally discharged under section 42(2) and sections 73 and 74. ~~Patients detained under those sections can be treated under common law.~~ The provisions also apply to SCT patients recalled to hospital, or where the CTO is revoked, unless Section 62A applies (see below)

c. Section 62 - Urgent Treatment - in certain circumstances the safeguards in sections 57 and 58 do not apply where urgent treatment is required. (See para 16.19-16.20) Section 62 is only applicable to those patients and types of treatments set out in a and b above.

d. Section 62A – Treatment on recall of community patient or revocation of order

Where the Part 4A certificate requirement is met, Section 58 does not apply to patients recalled to hospital from SCT. Similarly, where an SCT patient's CTO is revoked, relevant treatment can be given if the Part 4A certificate requirement is met, but only pending compliance with section 58.

e. Section 63 - Treatments that do not require the patient's consent - all medical treatments for mental disorder given by or under the direction of the approved clinician in charge of the ~~patient's rmo~~ treatment and which are not ~~referred to in~~ regulated by sections 57 or 58. This provision applies to the same patients as section 58.

~~16.3 Everyone involved in the operation of Part 4 of the Act should be familiar with:~~

~~a. the provisions of Part 4 of the Act;~~

~~b. paras 212- 230 of the Memorandum;~~

~~c. DHSS circular Dear Doctor Letter (DDL) (84) 4.~~

~~In addition, rmos approved clinicians in charge of treatment should obtain copies of 'Advice to Second Opinion Appointed Doctors' published by the Mental Health Act Commission.~~

~~16.4 A detained patient is not necessarily incapable of giving consent. The patient's consent should be sought for all proposed treatments, which may lawfully be given under the Act. It is the personal responsibility of the patient's current rmo responsible clinician to ensure that valid consent has been sought. The interview at which such consent was sought should be properly recorded in the medical notes.~~

~~16.5 Part 4 of the Act applies to medical treatment for mental disorder. Medical treatment may be interpreted as including care and treatment to alleviate the symptoms of mental disorder [B v Croydon Health Authority [1995] 2 WLR 294]. Part 4 does not apply to the treatment of physical disorders unless it can reasonably be said that the physical disorder is a symptom or underlying cause of the mental disorder. If in doubt the rmo approved clinician in charge of the treatment~~

~~should seek legal advice. (See also the Mental Health Act Commission's note on Anorexia Nervosa).~~

Section 57 - Treatments requiring consent and a second opinion

16.3 A decision to give treatment under section 57 requires careful consideration because of the ethical issues and possible long- term effects. Procedures for implementing this section must be agreed between the Mental Health Act Commission and the hospitals concerned.

16.4 Before the ~~rmo or doctor~~ approved clinician in charge of the treatment refers the case to the Mental Health Act Commission:

a. the referring ~~doctor~~ approved clinician should personally satisfy him or herself that the patient is capable of giving valid consent and has consented;

b. the patient and, if the patient agrees, his or her close relatives and carers should be told that the patient's willingness to undergo treatment does not necessarily mean that the treatment will be given. The patient should be made fully aware of the provisions of section 57;

c. for neurosurgery for mental disorder ~~psychosurgery~~, the consultant considering the patient's case should have fully assessed the patient as suitable for such ~~psycho~~surgery;

d. for neurosurgery for mental disorder ~~psychosurgery~~, the case should be referred to the Commission before the patient is transferred to the neuro-surgical centre for the operation. The Commission organises the attendance of two appointed persons and a doctor. The appointed persons and the doctor will usually visit and interview the patient at the referring hospital at an early stage in the procedure;

e. for surgical implantation of hormones for the purpose of reducing male sexual drive, the relationship of the sexual disorder to mental disorder, the nature of treatment, the likely effects and benefits of treatment and knowledge about possible long- term effects require considerable care and caution should be observed.

16.5 Section 57 refers to the surgical implantation of hormones only for the reduction of male sexual drive where it is administered as a medical treatment for mental disorder. If there is any doubt as to whether it is a mental disorder which is being treated, independent legal and medical advice must be sought. The advice of the Mental Health Act Commission should also be obtained about arrangements for implementing section 57 where necessary.

Section 58(1)(a) - Treatments requiring consent or a second opinion: ECT

16.6 When ECT is proposed valid consent should always be sought by the ~~patient's rmo~~ approved clinician in charge of the treatment: a. if the patient consents the ~~rmo~~ approved clinician in charge of the treatment or the Second Opinion Appointed Doctor (SOAD) should complete form 38 and include on the form the proposed maximum number of applications of ECT. In addition, a record of the discussion with the patient with reference to his or her capacity to consent should be made by the ~~rmo~~ approved clinician in charge of the treatment in the medical notes. Such information should be included in the patient's treatment plan;

b. if:

- the patient withdraws consent which has been given, or
- there is a break in the continuity of the patient's detention, or
- there is a change in the ~~rmo~~ approved clinician in charge of the treatment, the form 38 lapses and consent should be given again on a fresh form 38 or a second opinion obtained. Arrangements should be made for ensuring that invalid consent forms are clearly marked as lapsed;

c. if the patient's valid consent is not forthcoming, or is withdrawn, or if his or her wishes appear to fluctuate and the ~~rmo~~ approved clinician in charge of the treatment plans to proceed with the treatment, the ~~rmo~~ approved clinician in charge of the treatment must comply with the requirements of section 58(3) (b), which should be initiated as soon as possible

16.7 Patients treated with ECT should be given a leaflet which helps them to understand and remember, both during and after the course of ECT, the advice given about its nature, purpose and likely effects.

Section 581(b) – Treatments requiring consent or a second opinion: Medication

a. The first three months

16.8 The 3 month period gives time for the ~~doctor~~ approved clinician in charge of the medication to develop a treatment programme suitable for the patient's needs. Even though the Act allows treatment to be given without consent during the first three months the approved clinician in charge of the medication should ensure that the patient's valid consent is sought before any medication is administered. The patient's consent or refusal should be recorded in the case notes. If such consent is not forthcoming or is withdrawn during this period, the ~~rmo~~ approved clinician in charge of the medication must consider whether to proceed in the absence of consent, to give alternative treatment or no further treatment.

16.9 The 3 month period starts on the occasion when medication (of any type) for mental disorder was first administered by any means during a period of continuing detention. This does not include detention under section 4 (until the second medical recommendation is supplied) sections 5(2), or 5(4) (holding power), section 35 (remand to hospital), section 37(4) (court order for detention in a place of safety), section 135 (warrant for removal to a place of safety), and section 136 (removal to a place of safety). Medication does not necessarily have to be administered continuously throughout the three months. The definition of this period is not affected by renewal of the patient's detention, withdrawal of consent, leave of absence, placement of the patient onto SCT, or change in or discontinuance of the treatment. A fresh period will only begin if there is a break in the patient's liability for detention, where the patient is not on SCT during that break. Detention should never be allowed to expire as a means of enabling a fresh three month period to start.

b. Medication after three months

16.10 A system should be in place for reminding both ~~rmos~~ approved clinicians in charge of medication and patients at least four weeks before the expiry of the three months. Before the three month period ends the approved clinician in charge of the patient's medication ~~current rmo~~ should personally seek his or her consent to any continuing medication, and such consent should be sought for any subsequent administration of medication. A record of the discussion with the patient with reference to his or her capacity to consent should be made by the ~~rmo~~ approved clinician in charge of the patient's medication in the medical notes.

16.11 If the patient consents, the ~~rmo~~ approved clinician in charge of the medication must certify accordingly (form 38). On the certificate the ~~rmo~~ approved clinician in charge of the medication should indicate all drugs proposed, including medication given "as required", either by name or, ensuring that the number of drugs authorised in each class is indicated, by the classes described in the British National Formulary (BNF). The maximum dosage and route of administration should be clearly indicated for each drug or category of drugs proposed.

16.12 Specific advice relating to the management of high-dose antipsychotic treatment can be found at: http://www.rcpsych.ac.uk/files/pdfversion/CR138.pdf ~~inclusion of clozapine in a treatment programme is given in the Mental Health Act Commission's Practice Note 1 (June~~

~~1993).~~

16.13 The original form 38 should be kept with the original detention papers, and copies kept in the case notes and with the patient's medicine chart, so as to ensure that the patient is given only medication to which he or she has consented. It is important that all such additional copies are cancelled if the patient's consent is withdrawn (see para 16.16 below). If the patient's consent is not forthcoming the ~~rmo~~ approved clinician in charge of the medication must comply with the safeguard requirements of section 58. For urgent treatment section 62 may apply (see paras 16.19- 16.20).

16.14 The ~~rmo~~ approved clinician in charge of the medication should satisfy him or herself that consent remains valid. It is advisable to seek a second opinion under the section 58 procedures if there is doubt about whether the patient is consenting or not, or if his or her wishes appear to fluctuate.

c. Nurses and the administration of medication

16.15 Advice on the position of nurses in relation to the administration of medication is given in the Mental Health Act Commission's Practice Note 2 (March 1994)

Withdrawal of consent

16.16 A patient being treated in accordance with section 58 may withdraw consent at any time. Fresh consent for the implementing of section 58 procedures is then required before further treatment can be carried out or reinstated. Where the patient withdraws consent he or she should receive a clear explanation, which should be recorded in the patient's records,

- of the likely consequences of not receiving the treatment; -
- that a second medical opinion under Part 4 of the Act may or will be sought, if applicable, in order to authorise treatment in the continuing absence of the patient's consent;
- of the ~~doctor's~~ power of the approved clinician in charge of the treatment to begin or continue urgent treatment under section 62 until a second medical opinion has been obtained, if applicable.

Section 63 treatments not requiring the patient's consent

16.17 Apart from the forms of treatment specified in sections 57 and 58, treatment for the patient's mental disorder which is given by or under the direction of the ~~rmo~~ approved clinician in charge of the treatment does not require the patient's consent - although consent should always be sought. Medical treatment is defined in section 145, (see para 16.1c for a reference to relevant case law) The treatment must be for the mental disorder(s) from which the patient is suffering, but this need not be the disorder on the basis of which the patient was first detained.

16.18 **[moved from original 16.38]** As well as medication in the first three months (see paras 16.8- 16.9) section 63 covers a wide range of therapeutic activities involving a variety of professional staff and includes psychological and social therapies. In practice, it is unlikely that these psychological and social therapies could be undertaken without the patient's acceptance and active co- operation. Acceptance in relation to such procedures requires a clear expression of agreement between the patient and the therapist before the treatment has begun. The agreement should be expressed positively in terms of willingness to co- operate rather than as an indication of passive submission (see also chapter 19).

Urgent treatment in hospital

16.19 Any decision to treat a patient urgently under section 62 is a responsibility of the ~~rmo~~ approved clinician in charge of the ~~patient's~~ treatment in question or, in the ~~rmo's~~ absence of the

approved clinician in charge of the treatment, of the ~~doctor~~ appropriately qualified approved clinician for the time being in charge of the ~~his or her~~ treatment. The ~~rmo~~ approved clinician in charge of the treatment, or other ~~doctor~~ approved clinician, should bear in mind the following considerations:

a. Treatment can only be given where it is immediately necessary to achieve one of the objectives set out in section 62 and it is not possible to comply with the safeguards of Part 4 of the Act. It is insufficient for the proposed treatment to be simply 'necessary' or 'beneficial. '

b. The section specifically limits the use of "irreversible" or "hazardous" treatments. The approved clinician in charge of the treatment ~~patient's rmo~~, or other appropriately qualified approved clinician ~~doctor~~, is responsible for judging whether treatment falls into either of these categories, and whether therefore the Act allows it to be given, having regard to generally accepted medical opinion.

c. Urgent treatment given under section 62 can only continue for as long as it is immediately necessary to achieve the statutory objective(s).

d. Before deciding to give treatment under section 62 the ~~patient's rmo~~ approved clinician in charge of the treatment, or the ~~doctor~~ approved clinician for the time being in charge of the ~~his or her~~ treatment should wherever possible discuss the proposed urgent treatment with others involved with the patient's care.

It is essential that the approved clinician in charge of the treatment in question ~~rmos~~, or the ~~doctor~~ approved clinician for the time being in charge of the ~~patient's~~ treatment, have a clear understanding of the circumstances when section 62 applies (see para 16.2.c).

16.20 The Hospital Managers should monitor the use of section 62 in their hospitals. They should ensure that a form is devised to be completed by the approved clinician in charge of the ~~patient's~~ treatment in question ~~rmo~~ or the doctor for the time being in charge of the ~~patient's~~ treatment every time urgent treatment is given under section 62, giving details of;

- the proposed treatment;
- why it is of urgent necessity to give the treatment;
- and the length of time for which the treatment was given.

arrangements are made to enable rmos to discharge their responsibilities, but all professional staff involved with the implementation of Part 4 should be familiar with its provisions and the procedures for its

Part 4A

The key provisions of Part 4A can be summarised as follows:

64B – Community patients not recalled to hospital – provides that a patient aged 16 or more may only be treated in the community if

- the patient has capacity to consent and has done so; or
- the patient lacks capacity to consent, but the conditions in section 64D or 64G are met, or there an attorney, a deputy or the Court of Protection has consented on the patient's behalf

and

- where relevant, there is a certificate authorising the giving to the patient of medication or another treatment regulated by section 58 ("a section 58 type treatment").

A certificate must be in place before section 58 type treatment can be given to patients aged over 16 in the community. Although in certain circumstances, this requirement does not need to be met: in emergencies under 64G or if the treatment is immediately necessary and the patient consents or an attorney, donee or deputy or Court of Protection consents on the patient's behalf. The certificate requirement in relation to treatment regulated by section 58(1)(b) – i.e. medication - does not apply during the first month after the patient is placed on SCT or during the period of 3 months from when medication was first given to the patient either while liable to be detained or in the community, whichever is longer.

Section 64D – Community patients lacking capacity - provides the authority to treat patients aged over 16 without capacity in the community, subject to certain conditions. In particular, force may not be used to treat the patient if the patient objects.

Section 64E – Child Community patients not recalled to hospital - makes equivalent provision to s64B for children and young people under the age of 16 (except that such children and young people will not have an attorney or deputy).

Section 64F – Child community patients – makes equivalent provision to s64C for patients aged under 16 who lack competence to consent to treatment in the community.

Section 64G – Emergency treatment for patients lacking capacity or competence – this provides the authority to use force to treat patients who lack capacity or competence) in the community in emergencies. Any force used must be necessary to prevent harm or must be proportionate response to the likelihood of the patient suffering harm.

Safeguards for SCT patients

16.21a The responsible clinician must ensure as part of preparing for a CTO that a patient who has the capacity or competence to consent to it is prepared to give valid consent to the treatment to be given in the community.

16.21b All patients on SCT have the safeguard of a SOAD review of any section 58 type treatment they may receive as an SCT patient.

16.21c As with patients who are liable to be detained, this does not apply to medication during the period beginning 3 months after the patient is first given medication. The 3 month period starts on the occasion when medication for mental disorder was first administered by any means, whether the patient was at the time liable to be detained or subject to SCT.

16.21d Additionally there is no requirement to have a certificate for the first month from when the patient is discharged from hospital onto a CTO. This is to ensure there is no delay in discharging a patient from hospital onto SCT. The responsible clinician should obtain a Part 4A certificate as soon as practical, if this is required.

16.21e During any period during which the certificate requirement does not apply, the approved clinician in charge of the medication should ensure that the patient's valid consent is sought before any medication is given. This should be recorded in the case notes. If consent is not forthcoming from or is withdrawn by a patient who has the capacity to give it, the responsible clinician must consider whether it is necessary to recall the patient to hospital for treatment. Treatment for patients who have the capacity or competence to consent cannot be given without a patient's valid consent within the community.

16.21f A certificate issued by a SOAD in respect of section 58 type treatment is required whether a patient is capable of providing valid consent to the treatment or not. The SOAD must determine whether the treatment proposed by the approved clinician in charge of the treatment is appropriate, having regard to the nature and degree of the patient's mental disorder and all the other circumstances of the patient's case. The SOAD must determine whether the proposed

treatment is appropriate in the light of accepted medical practice in relation to treatment for the condition. In order to reach this judgement the SOAD must consider whether the patient is capable of giving consent as well as the therapeutic efficacy of the proposed treatment. The SOAD decision is recorded though the Part 4A certificate.

16.21g The proposed treatment covered by the certificate might include medication that the clinician is proposing to give in the community as well as any medication that the appropriate clinician judges as appropriate on recall of the patient to hospital. Where possible, the SOAD should approve treatment to be given in the event of recall to hospital. However, SOADs should only do so where they believe they have sufficient information on which properly to be able to make such a judgement.

16.21h The Part 4A certificate enables the SOAD to apply conditions to the approval of any treatment authorised by the certificate. For some patients there may be instances where the patient's consent status is a key factor and the SOAD might not wish to certify that the treatment may continue to be given if a consenting patient subsequently withdraws consent. The approved clinician and SOAD may specify whether any set of circumstances should result in the need for a further certificate before treatment can be given.

Treatment of SCT patients on recall or on revocation of SCT

16.22a In general, an SCT patient recalled to hospital is subject to Part 4. However, on recall to hospital an SCT patient can be given treatment which would otherwise require a certificate under s58 on the basis of a Part 4A certificate (see above). Treatment can only be given where that particular treatment is covered by the certificate i.e. if that certificate specifies treatment that is appropriate in the circumstances, and giving the treatment would not be contrary to any condition imposed on the approval. Otherwise, a new certificate under section 58 will be needed unless such a certificate was put in place before the patient was made subject to a CTO. If that certificate still covers the patient's treatment needs then the certificate remains valid for that treatment.

16.22b Similarly on revocation of a community treatment order the Part 4A certificate may cover the patient's treatment (subject to that treatment being specified in the certificate and certified as appropriate on recall, as above), but only pending compliance with section 58. As above, a new Part 4 certificate may be required if one is not already in place. Where a new SOAD certificate is required to comply with section 58, hospital managers should ensure that approved clinicians request a SOAD to visit without delay once a CTO is revoked.

16.22c There are certain circumstances in which a patient can be treated without a certificate under Part 4 or Part 4A. If the approved clinician considers that discontinuing the treatment or the plan of treatment would cause serious suffering to the patient who has been recalled or whose CTO has been revoked (eg by triggering or failing to control a serious relapse of the patient's condition), that treatment can continue in the absence of any certificate that would otherwise be required. That treatment must cease as soon as its cessation would no longer cause the patient serious suffering (unless an appropriate certificate has by then been issued.)

16.22d Additionally, there is no requirement for a certificate to be in place for one month after the patient's CTO was made (for medicinal treatments as described in section 58(1)(b) - see 16.21.d above).And if treatment is immediately necessary under s62 of the Act, it can be given without a certificate being in place.

Treating patients without capacity in the community

16.23a Part 4A provides the authority to treat patients without capacity in the community, subject

to safeguards.

16.23b Treatment can only be given in the community to a patient without capacity or competence to consent to it by an approved clinician or by a person under the direction of that clinician.

16.23c A step by step approach may be helpful for anyone authorise to give relevant treatment for mental disorder under Part 4A to patients lacking capacity or competence to consent to it.

- First reasonable steps must be taken to ascertain whether the patient has capacity to consent to the treatment. As Chapter 15 explains this should be done in accordance with the principles and requirements of the MCA.
- Secondly consideration must be given to the principles of the Act set out in chapter 1.
- Thirdly consideration must be given as to whether force is necessary to give the treatment and whether the patient objects to the use of that force. If force is necessary, treatment may only be given in the community if the person proposing to give the treatment has no reason to be believe that the patient objects. Otherwise, the treatment cannot be given to the patient in the community and recall to hospital may be necessary.

16.23d In determining whether a patient objects to treatment, the person proposing to give the treatment must consider the question in the round, taking into account all the circumstances so far as they are reasonably ascertainable. In many cases, the patient will be perfectly able to state their objection. But in other cases, especially where the patient is unable to communicate (or only to a limited extent) clinicians will need to consider the patient's behaviour, wishes, feelings, views, beliefs and values, both present and past, so far as they can be ascertained. If there is reason to think that a patient would object, if able to do so, then the patient should be taken to be objecting. Occasionally, it may be that the patient's behaviour initially suggests an objection, but is in fact not directed at the treatment at all. In that case the patient would not be taken to be objecting. But clinicians should always bear in mind that their job is to establish whether the patient objects to treatment – the reasonableness of that objection is not the issue.

16.23e Force may occasionally be required to treat even a willing patient (e.g. where disability leaves a patient with uncontrollable movement of their body). That is permissible, as is treating a patient who objects if no force is needed. Force here means the application of physical force (to whatever extent) to the patient. However if force is needed and the person giving the treatment reasonably believes that the person objects to being given it, or would object if they were in a position to do so the treatment cannot be given in the community (unless it is an emergency) and recall to hospital for treatment may be necessary.

16.23f The same set of considerations should to be taken into account when treating a child without competence in the community

16.23 g For patients aged over 16, neither forcible treatment nor any other treatment outside hospital is to be permitted if the proposed course of treatment would conflict with a decision made on the patient's behalf by an attorney, donee or a deputy or the Court of Protection or if the person who proposes to give it reasonably believes that the patient has made an advance decision (within the meaning of the Mental Capacity Act 2005) which is valid and applicable to treatment. See chapter 16A.

Emergency Treatment in the community

16.24 a Within certain limits, section 64G permits force to be used in emergencies to treat a patient who lacks capacity or competence to consent to it. This is intended to be used where the patient's interests are better served by being treated with the use of force in the community than

by being transported to hospital for treatment. Any decision to treat a patient without capacity or competence in an emergency under s64G by an approved clinician or by a person under the direction of that clinician must take the following considerations into account:

- Reasonable steps must first be taken to ascertain whether the patient has capacity or competence to consent to the treatment. As Chapter 15 explains this should be done in accordance with the principles and requirements of the MCA.
- The same considerations should be taken into account as in 16.19 when giving urgent treatment in hospital.
- Finally, consideration must be taken as to whether the force to be used is necessary. If it is necessary in this emergency situation, it must be a proportionate response to harm which may be caused to the patient and the seriousness of the harm

16.24b The use of 64G should be monitored by the hospital managers or their responsible staff. A record should be kept of the treatment given, why it was necessary to give it in the emergency, the length of time for which it was given, whether force was necessary and what the outcome was for the patient i.e. was the patient recalled to hospital for further treatment in detention.

Procedure for second opinions ***[was paragraph 16.20-16.34]***

a. *The Role of the Second Opinion Appointed Doctor (SOAD)[see paras 216- 221 of the Memorandum] [This covers the SOAD's role in both Part 4 and Part 4A]*

16.25 The role of the SOAD is to provide an additional safeguard to protect the patient's rights. When interviewing a patient the SOAD must determine whether he or she is capable of giving valid consent. If the patient does not give or is not capable of giving consent, the SOAD has to determine whether the treatment proposed by the ~~rmo~~ approved clinician in charge of that treatment is ~~likely to alleviate or prevent a deterioration of the patient's condition~~ appropriate for the patient's mental disorder and should be given.

16.26 The SOAD acts as an individual and must reach his or her own judgment as to whether the proposed treatment is appropriate in the light of the general consensus about treatment for the condition in question. In reaching this judgment the SOAD should consider not only the therapeutic efficacy of the proposed treatment but also, where a capable patient is withholding consent, the reasons for such withholding, which should be given their due weight.

16.27 The SOAD should seek professional opinion about the nature of the patient's disorder and problems, the appropriateness of various forms of treatment including that proposed, and the patient's likely response to different types of treatment. The SOAD should take into account any previous experience of comparable treatment of a similar episode of disorder. The SOAD should give due weight to the opinion, knowledge, experience and skill of those consulted.

b. Responsibilities of the Hospital Managers

16.28 In anticipation of, and preparation for, a consultation under Part 4 or Part 4A the Hospital Managers and their staff should ensure that:

a. the statutory documents are in order and available to the SOAD;

b. a system exists for reminding the ~~rmo~~ approved clinician in charge of the treatment in question prior to the expiry of the three month period set by section 58 or (as the case may be) the one month period for SCT patients (see 16.21b and c) and for checking the ~~doctor's~~ approved clinician's response;

c. a system exists for letting a patient liable to be detained know towards the expiry of the '3 month period' that his or her consent, or a second opinion, is required;

cii. a system exists for informing SCT patients that at the expiry of the specified period that a second opinion is required, even if they are consenting to treatment

ciii. a system exists for reminding the approved clinician when a new certificate will be needed, either at the end of the period specified in the SOAD's certificate, or where an expiry date has been set under section 61.

d appropriate personnel, including a person other than a doctor or nurse professionally concerned with the patient's care are available

c. Arranging and preparing for the visit of the SOAD

16.29 If a SOAD visit is required, the approved clinician in charge of the treatment in question ~~rmo~~ has the personal responsibility of ensuring that the request is made. He or she should ensure that the arrangements are made with the Mental Health Act Commission. Ordinarily, the Commission aims to arrange for a visit from a SOAD to take place within two working days of the request where ECT is proposed, and, in the case of medication, five working days.

16.30a The SOAD should visit an SCT patient at a mutually agreed place e.g. at an outpatient clinic which the patient might visit weekly.

16.31 The treatment proposal for the patient, together with notes of any relevant multidisciplinary discussion, must be given to the SOAD before or at the time of the visit. The Hospital Managers [or their staff] in consultation with the approved clinician ~~rmo~~ are responsible for ensuring that the patient is available to meet the SOAD and (for detained patients) that the following people are available in person at the time the SOAD visits:

- the ~~rmo~~ approved clinician in charge of the treatment in question;
- the patient's responsible clinician (if that person is different to the approved clinician in charge of the treatment in question)
- the statutory 'consultees' ~~(see para 16.31~~);
- any other relevant persons;

and that the following documents are available:

- the patient's original detention documents wherever possible or copies of such documents. The original document should be available for viewing by the SOAD if he or she requests;
- where appropriate the CTO documentation
- all the patient's case notes including records of past responses to similar treatment.

It is desirable that a single professional record is kept for each patient which contains all records relating to that patient. Adequate facilities must be made available for the visit.

d. The visit of the SOAD

16.32 During a visit the SOAD should:

a. in the case of a ~~treatment under section 58~~ section 58 type treatment satisfy him or herself that the patient's detention or CTO papers are in order;

b. interview the patient in private if possible. Others may attend if the patient and the SOAD agree, or if it is thought that the doctor would be at significant risk of physical harm from the patient;

c. discuss the case with the approved clinician in charge of the treatment in question ~~rmo responsible clinician~~ face to face, or on the telephone in exceptional circumstances;

d. consult with two other persons professionally concerned with the patient's care as statutorily required (ie the 'statutory consultees'). The SOAD should be prepared, where appropriate, to consult a wider range of persons professionally concerned with the patient's care than those required by the Act (e.g. the GP) and, with the patient's consent, the patient's nearest relative, family, carers or advocates.

16.33 The SOAD may not be able to reach a decision at the time of the first visit. In these circumstances the patient should be told of the delay. Once a decision has been reached, SOADs will record details of the visit and the reasons for the decision they have made. They will provide the relevant approved clinician with a copy of those reasons. The SOAD will also indicate whether, in his/ her view, disclosure of the reasons to the patient would be likely to cause serious harm to his/her physical or mental health or to that of any other person.

16.33a. Where it is intended to impose the authorised treatment without delay, or where the written statement of reasons will be required on the day of the SOAD visit, the Commission should be so informed when the request for a second opinion is made.

16.33b It is the personal responsibility of the approved clinician to communicate the results of the SOAD visit to the patient In most cases, communication of the result of the visit need not be postponed until a statement of reasons has been received by the SOAD. When the SOAD's statement is received, the patient should be given the opportunity to see it as soon as possible, unless the approved clinician (or the SOAD) thinks that it would be likely to cause serious harm to the physical or mental health of the patient or any other person. Documents provided by the SOAD consequent to his/her visit and decision are a part of – and should be kept in – the patient's medical records. Approved clinicians should record of their actions in providing patients with – or denying them access to the reasons supplied by a SOAD

- For patients treated under Part 4, only when the SOAD has signed form 39 may treatment be given without the patient's consent, except as provided in section 62.
- For patients treated under Part 4A only when the SOAD has signed the Part 4A certificate may treatment be given for which such a certificate is required even if the patient consents to it.

The SOAD may direct that a review report on the treatment be sent from the Mental Health Act Commission at a date earlier than the next date for review under section 61.

16.34 Every attempt should be made by the ~~rmo~~ approved clinician in charge of the treatment and the SOAD to reach agreement. If the SOAD is unable to agree with the ~~rmo~~ approved clinician, the ~~rmo~~ approved clinician should be informed by the SOAD personally as soon as possible. It is good practice for the SOAD to give reasons for his or her dissent. Neither ~~doctor~~ clinician should allow a disagreement in any way to prejudice the interests of the patient. If agreement cannot be reached, the position should be recorded in the patient's case notes by the ~~rmo~~ approved clinician in charge of the treatment in question and the patient's responsible clinician (if this is a different person to the approved clinician in charge of the treatment in question) should be informed.

16.35 The opinion given by the SOAD is the SOAD's personal responsibility. It cannot be appealed against to the Mental Health Act Commission.

16.36 If the patient's situation subsequently changes the ~~rmo~~ approved clinician in charge of the treatment in question may contact the Mental Health Act Commission and request a further second opinion. In these circumstances it is the policy of the Commission to ask the same SOAD

to return.

16.36a In all cases it remains the approved clinician's responsibility to decide whether to administer treatment authorised by the SOAD. The fact that the SOAD has authorised a particular treatment does not, of itself, mean that it will be appropriate to administer it on any given occasion, or even at all.

e. Role of the 'statutory consultees. '

16.37 For patients treated under Part 4, the SOAD must consult:

a. a nurse, who must be qualified (nursing assistants, auxiliaries and aides are excluded) and has been professionally concerned with the patient's care;

b. another person similarly concerned, who has direct knowledge of the patient in their professional capacity, and who is neither a nurse nor a doctor; for example, a social worker, occupational therapist, psychologist, psychotherapist, or pharmacist.

16.38a For SCT patients treated under Part 4A, the SOAD must consult two persons who have direct knowledge of the patient in their professional capacity. One of these must not be a doctor. None of these must be the patient's responsible clinician. Consultees could be for example an AMHP, psychologist, psychiatric nurse, occupational therapist or care co-ordinator .

16.38 Any person whom the SOAD proposes to consult must consider whether he or she is sufficiently concerned professionally with the patient's care to fulfil the function. If not, or if the person feels that someone else is better placed to fulfil the function, he or she should make this known to the approved clinician in charge of the treatment in question and the SOAD in good time.

16.39 Both consultees may expect a private discussion (only in exceptional cases on the telephone) with the SOAD and to be listened to with consideration.

16.40 Amongst the issues that the 'consultees' should consider commenting upon are:

- the proposed treatment and the patient's ability to consent to it;
- other treatment options; - the way in which the decision to treat was arrived at;
- the facts of the case, progress, attitude of relatives etc; - the implications of imposing treatment upon a non- consenting patient and the reasons for the patient's refusal of treatment;
- any other matter relating to the patient's care on which the 'consultee' wishes to comment.

'Consultees' should ensure that they make a record of their consultation with the SOAD which is placed in the patient's records.

Review of treatment

a. General

16.41 All treatments, whether or not section 61 applies to them should be regularly reviewed and the patient's treatment plan should include details of when this will take place. Where a patient is receiving treatment under section 58(3)(a) ie the patient has consented and form 38 been completed, the form 38 should always have been completed by either the approved clinician in charge of the treatment in question ~~rmo~~ or the SOAD. Although the Act does not direct review of the validity of form 38, it is good practice for them to be reviewed at regular intervals. When a form 38 review is carried out and it is found that the conditions are satisfied a new form 38 should be completed, if appropriate. A new form 38 should also be completed:

- if there is a change in the treatment plan from that recorded;
- if consent is re- established after being withdrawn;
- when there is a break in the patient's detention; - when there is a permanent change of ~~rmo~~ the approved clinician in charge of the treatment in question;
- when the patient's detention is renewed (or annually, whichever is earlier);
- if there is a change in the hospital where the patient is detained.

If the patient no longer consents and it is considered that the treatment should still be given, a second opinion must be sought.

16.41a When a Part 4A certificate review is carried out, a new Part 4A certificate should be completed:

- if there is a change in the treatment plan from that recorded;
- if the conditions applied to the certificate are to change

b. Section 61

16.42 When a patient has been treated under section 57 or when a SOAD has authorised treatment in the absence of the patient's consent under section 58(3)(b), or where an SCT patient whose treatment would otherwise have required such a certificate has been treated in accordance with s62A on recall to hospital or on revocation of the SCT a review by the Mental Health Act Commission on behalf of the Secretary of State has to take place: All Section 57 treatments should be reported

a. in the circumstances set out in section 61 (all professionals involved should be familiar with the procedures for completing form MHAC1);

b. where the SOAD has time limited his or her certificate or made it conditional on making of a review report on the treatment at a date earlier than the first statutory review (See MHAC1).

Once the treatment has been reviewed and form MHAC1 completed, a copy of that form should be given to the patient.

16.43 When submitting a report under section 61 in respect of a patient who is liable to be detained, the ~~rmo~~ approved clinician in charge of the treatment should advise the Mental Health Act Commission if a patient for whom a certificate of second opinion has previously been issued has since given consent and the consent is still valid.

16.43a After receipt of a review report, the Mental Health Act Commission will, when necessary, send a SOAD to reassess the patient and decide whether the treatment should continue.

Responsibilities for operating Part 4 and 4A

16.44 Promoting the welfare of the patient by the implementation of Part 4 and 4A and its safeguards requires careful planning and management. The patient's ~~rmo~~ responsible clinician is personally responsible for ensuring that Part 4 and Part 4A procedures are followed in relation to that patient. Such responsibility is a continuing one and will apply even if another approved clinician is in charge of the relevant aspect of the patient's treatment.

16.45 Overall responsibility for ensuring that the provisions of the Act are complied with rests with the Hospital Managers who should ensure that proper arrangements are made to enable rmos to discharge their responsibilities, but all professional staff involved with the implementation of Part IV and 4A should be familiar with its provisions and the procedures for its implementation ~~in the hospital.~~

16.46 Patients have a statutory right to be informed about the provisions of Part 4 and 4Aof the Act as it relates to them. They should be reminded by letter in addition to receiving the statutory leaflet when either their consent to treatment is needed or a second opinion is due.

CHAPTER 16A – THE MENTAL CAPACITY ACT 2005

Introduction

16A.1za This chapter provides guidance on the interface between the Mental Health Act (MHA) and the Mental Capacity Act 2005 (MCA). It should be read alongside chapter 2 and 15.

General

16A.1 Just because a person is subject to detention, guardianship or SCT under the MHA there is no reason to assume that they lack capacity to take decisions about their own mental health care or any other matter.

16A.2 Equally, people who do lack capacity to make decisions do not cease to be protected by the MCA just because they happen to be subject to the MHA.

16A.3 All those who are involved in treating or making decisions about patients who are (or who might be) subject to detention, guardianship or SCT under the MHA need to be familiar with the key points of the MCA as they relate to the treatment and care of people who lack capacity to make particular decisions for themselves.

16A.4 AMHPs need to be familiar with the MCA because otherwise they cannot properly evaluate alternatives to applications for admission or guardianship or determine whether to agree to the making of community treatment orders.

16A.5 s12 approved and other doctors making recommendations in support of applications similarly need to be familiar with the MCA in order to make appropriate recommendations in support of applications for admission or guardianship.

16A.6 Responsible clinicians need be familiar with the MCA in order properly to exercise their functions in relation to discharge, renewal and extension of compulsory measures. The same is true of hospital managers in relation to their powers of discharge

16A.6 All approved clinicians need to understand the MCA in order correctly to apply the provisions of Part 4 and Part 4A of the Act.

16A.7 All professional staff involved in the treatment of people with mental disorders need to understand what they can and cannot do under the MCA where they believe it necessary or appropriate to take actions in relation to the treatment or care of people who lack capacity to consent to it, either for mental disorder (where the MHA does not provide its own authority) or for other purposes.

16A.8 This chapter does not attempt to describe in detail the way in which the MCA works. For more detailed information, readers are advised to look at the MCA itself and at the associated Code of Practice. Key concepts with which they will need to be familiar include:

- the **principle**s of the MCA (see box 1)
- the meaning of a **lack of capacity** (see box 2)
- section 4 of the MCA which sets out the steps required to determine what is in a person's "**best interests**"

- the effect of **section 5** of the MCA – which gives people protection from any liability they would otherwise incur for doing an act in connection with a person's care or treatment without that person's consent, if they reasonably believe the person lacks capacity in relation to the matter in question and the act is done in accordance with the MCA. For health care professionals, this is the main legal authority to treat patients aged 16 or over in their best interests where they lack capacity to consent. In this respect it has replaced the common law doctrine of necessity.

- the **limitations on section 5** imposed by section 6, especially in relation to restraint (which includes restricting a person's liberty of movement)

- the meaning of an **advance decision** to refuse treatment, and the circumstances in which it is to be treated as if it were a contemporaneous refusal of treatment.

- the role and function of a **donee of a lasting power of attorney (an "attorney")** [1] who can be given authority by a person to take decisions on their behalf in relation to their personal welfare (if they lack the capacity to do so themselves) or their property and affairs – including the power to consent or refuse treatment on a person's behalf

- the role of the Court of Protection, and in particular its power to appoint a **deputy** to take specified decisions on behalf of a person who lacks capacity to make them – again potentially including the power to consent or refuse treatment on a person's behalf

- the role and function of **Independent Mental Capacity Advocates (IMCAs)**

- the **Bournewood safeguards and the procedure** for authorising deprivation of liberty for the purpose of providing care or treatment to people in hospitals and care homes who lack the capacity to consent to it.

Box 1 - Mental Capacity Act 2005 – the principles

(1) A person must be assumed to have capacity unless it is established that he lacks capacity

(2) A person is not be to treated as unable to make a decision unless all practicable steps to help him to do so have been taken without success

(3) A person is not to be treated as unable to make a decision merely because he makes an unwise decision

(4) An act done, or decision made, under this Act for on or behalf of a person who lacks capacity must be done, or made, in his best interests

(5) Before that act is done, or the decision is made, regard must be had to whether the purpose for which it is needed can be as effectively achieved in a way that is less restrictive of the person's rights and freedom of action.

[1] Both the MHA and MCA use the term "donee", but "attorney" is used in the MCA Code of Practice.

Box 2 - Defining capacity in the MCA

A person lacks capacity in relation to a matter if at the material time he is unable to make a decision for himself in relation to the matter because of an impairment of, or a disturbance in the functioning of the mind or brain. It does not matter whether the impairment or disturbance is permanent or temporary.

A person is unable to take a decision for himself if he is unable to

- to understand the information relevant to that decision
- retain that information
- use or weigh that information as part of the process of making the decision, or
- communicate his decision (whether by talking, using sign language, visual aids or any other means)

16A.9 For the most part, the MCA applies to people subject to the MHA in same way as it applies to anyone else, both in relation to decisions about their property and affairs and their personal welfare. However, there are certain differences, described in the following paragraphs

Circumstances where the MCA may not be relied upon to give treatment to people subject to the Mental Health Act

16A.10 Where treatment is regulated by Part 4 or Part 4A of the MHA (that is to say, where those parts either prohibit or provide legal authority for it to be given to patients who lack capacity to consent to it) section 5 of the MCA may not be relied upon as an alternative legal basis on which to give or consent to the giving of - such treatment. In other words, Parts 4 and 4A "trump" the MCA in this respect.

16A.10a The main effect of this is that where the MHA itself provides the authority for someone to be treated without their consent because they are detained or subject to a community treatment order, the MCA cannot be relied upon to give the treatment instead. A second, but equally important, effect is that no-one who lacks capacity to consent to it may be given a treatment for mental disorder which is regulated by section 57 (eg neurosurgery for mental disorder). This applies to everyone, whether or not they are otherwise subject to the MHA.

Advance decisions to refuse treatment

16A.11 An advance decision to refuse treatment is not, in principle, affected by the fact that a patient is subject to the MHA However, because Parts 4 and 4A of the MHA provide the authority to treat certain patients for their mental disorder without their consent (subject to various safeguards) it also provides the authority to treat them for mental disorder despite their advance refusal of any such treatment. In other words, an advance refusal of treatment may be over-ridden in the same way, and subject to the same limitations, as a contemporaneous refusal to consent to treatment for mental disorder when a patient is liable to be detained or subject to SCT and therefore subject to Part 4 or 4A of the MHA.

16A.12 Even where it may be over-ridden, an advance decision to refuse treatment should be taken into account by the clinicians concerned, as if it were a contemporaneous refusal of consent by a patient. This means, for example, that the clinicians concerned should consider whether the same effect could be achieved by a different form of treatment to which the patient has not refused in advance. But like the patient's own contemporaneous refusal, ultimately an advance decision which relates to treatment which may be given without consent under Part 4 or 4A of the MHA may be overridden if clinicians think it necessary, even if it is otherwise valid and applicable and would have to be respected in any other circumstances. A decision to over-ride an advance decision in this way should be recorded in the person's notes.

16A.13 The fact that a patient is liable to be treated for mental disorder without consent under Part 4 of the MHA does not affect the operation of an advance decision to refuse other kinds of treatment. Nor does it affect the operation of the advance decision in relation to treatment that might otherwise be given under Part 4A and patients who have not been recalled to hospital, except where such treatment is authorised in urgent cases by section 64F.

Roles and powers of attorneys, deputies and the Court of Protection

16A.14 The fact that a person is subject to the MHA does not affect the validity of any Lasting Power of Attorney (LPA) or the authority of an attorney or deputy (or the Court of Protection) to make decisions on their behalf. Similarly, it does not prevent such people creating new LPAs, provided that they have the capacity to do so, nor does it prevent the Court from appointing a deputy to take decisions for them which they lack the capacity to make themselves.

16A.15 Attorneys and deputies are therefore able to take any decisions in relation to the welfare, property or affairs of a person subject to the MHA that they are otherwise authorised to take, with two exceptions:

- they will not be able to consent on the patient's behalf to treatment which is regulated by Part 4 of the MHA (including neurosurgery for mental disorder and other treatments under section 57)

- they will not be able to take decisions about where a person subject to guardianship is to reside, nor take other decisions which conflict with those of a guardian.

16A.16 Where conditions are imposed on patients subject to the MHA in relation to leave of absence from hospital, SCT or conditional discharge, a decision by an attorney or deputy on the patient's behalf which went against one of these conditions, would result in the patient being taken to have breached the condition. This might result in the patient's being recalled to hospital being considered.

16A.17 Attorneys and deputies are able to exercise patients' rights under the MHA on their behalf, if they have the relevant authority under the LPA or the order of the Court appointing them and the patients concerned lack the capacity to do so themselves. In particular, personal welfare attorneys and deputies may be able to exercise the patient's various rights to apply to the Mental Health Review Tribunal (MHRT) for discharge from detention, guardianship or after-care under supervision.

16A.18 Attorneys and deputies may not exercise the rights of nearest relatives, unless they are themselves the nearest relative (because the rights belong to the nearest relative, not the patient.) Where there is disagreement between a nearest relative and an attorney or deputy (eg about whether the attorney or deputy should exercise the patient's right to apply to apply to the MHRT, or the nearest relative should make a discharge order), it may be helpful for the two to discuss the issue, perhaps with the assistance of the patient's clinicians or social worker. But ultimately, however, they have different roles and both must act as they think best. Specifically, an attorney or deputy must act in accordance with their authority and in what they believe to be the patient's best interests.

16A.19 It is good practice for clinicians and others involved in the assessment or treatment of patients under the MHA to try to find out if the person has an attorney or deputy. However, it may not always be practicable. To ensure that they are informed, and where relevant consulted, about the patient's care, attorneys and deputies are advised to make themselves known either to the clinician responsible for the patient's care or to the managers of the hospital at which the patient is detained or which is the responsible hospital for the purpose of SCT, or (as the case may be) to the patient's guardian (normally the local social services authority).Attorneys and deputies may find it helpful to use hospitals' Mental Health Act Administrators' office as a useful first point of contact in relation to patients who are detained or subject to SCT.

Independent Mental Capacity Act Advocates

16A.20 Under the MCA, NHS bodies or local authorities (as appropriate) are required to instruct Independent Mental Capacity Advocates (IMCAs) to represent people who are otherwise unbefriended where the NHS body or local authority proposes to provide accommodation for them in a hospital or care home for more than a short period, or where the NHS body proposes to provide them with serious medical treatment (a term which is defined in regulations under the MCA0.

16A.21 The duty to instruct an IMCA does not arise if the serious medical treatment is to be provided under the authority of Part 4 or Part 4A the MHA, or if the patient is to be required to live in the accommodation as a result of an obligation placed on them under the MHA (eg as condition of leave of absence, SCT or conditional discharge from hospital or a requirement imposed by a guardian).

16A.22 However, a duty to consult an IMCA may arise in connection with serious medical treatment for physical disorder proposed for a patient who happens to be detained under the MHA. Similarly such a duty may arise in connection with accommodation being planned for other people who are to be accommodated as part of the after-care which the NHS and local social services authorities are required to provide under section 117 of the MHA for people who have been detained under certain sections of the MHA. This is because the MHA places no obligation on such people to accept that accommodation.

Bournewood authorisations

16A.23 In determining whether an application should be made for admission under the Mental Health Act – or whether detention, SCT or guardianship should be renewed or continue – regard must always be had to the alternative courses of action.

16A.24 As set out in chapter 2, where a person aged 16 or over lacks capacity to consent to admission and/or treatment for mental disorder, the Mental Capacity Act may offer a viable alternative, which makes compulsory admission unnecessary. However, in the case of a person who needs to be detained in hospital for assessment or treatment or mental disorder, the MCA will only offer an alternative if the patient is 18 or over and could be made subject to the Bournewood procedure.

16A.25 Six qualifying conditions must be satisfied before a person may be made the subject to Bournewood authorisation. One of those is that the person is eligible, given that they are, or could be, subject to the MHA. Specifically, a person is not eligible for a Bournewood authorisation if

(a) the proposed authorisation is for detention in hospital for the purpose of being treated wholly or partly for mental disorder, and

(i) the patient meets the criteria for admission to hospital under section 2 or 3 of the MHA;

(ii) there is no attorney or deputy able and willing to consent to the admission and treatment in question; and

(iii) the patient objects to being admitted or treated for mental disorder (having regard not only to what (if anything) the patient is currently saying but also to the patient's past and present behaviour, wishes, feelings, views, beliefs and values so far as they can are reasonably ascertainable.)

(b) the person is detained in hospital under sections 2, 3, 4. 35, 36, 37, 38, 44, 45A, 47, 48 or 51 of the MHA (or their equivalent)

(c) the person is liable to be detained under one of those sections but is not in fact detained (eg because they are on leave of absence or are a conditionally discharged restricted patient), or is subject to SCT and

(i)the authorisation would conflict with an obligation imposed on the patient under the MHA (eg a condition of leave of absence), or

(ii) the authorisation would be for the purpose of detaining the patient in hospital wholly or partly for medical treatment for mental disorder

(d) the person is subject to guardianship and the authorisation would conflict with an obligation placed on the person (eg about where to live) by the guardian or a condition of the community treatment order.

16A.26 Where a standard authorisation under the Bournewood procedure is already in force it must be reviewed by the supervisory body (i.e. the PCT) if the person becomes ineligible under (a) above.

16A.27 If the person becomes ineligible under (b), (c) or (d) above, the authorisation must be suspended by the managing body (i.e. the managers of hospital or care home in question). If the person remains ineligible for more than 28 days, the authorisation ceases to have effect.

16A.28 The main effect of this is that a Bournewood authorisation may be used to deprive someone of their liberty in hospital for assessment or treatment of mental disorder if they meet the criteria for admission under the Mental Health Act, but only if they do not object to be admitted or treated. It may not be used if the patient objects.

16A.29 In determining whether a patient objects, the decision-maker must consider the question in the round, taking into account all the circumstances so far as they are reasonably

ascertainable. In many cases, the patient will be perfectly able to state their objection. But in other cases, especially where the patient is unable to communicate (or only to a limited extent) decision-makers will need to consider the patient's behaviour, wishes, feelings, views, beliefs and values, both present and past, so far as they can be ascertained. If there is reason to think that a patient would object, if able to do so, then the patient should be taken to be objecting. Occasionally, it may be that the patient's behaviour initially suggests an objection, but is in fact not directed at the treatment at all. In that case the patient would not be taken to be objecting. But decision-makers should always bear in mind that their job is simply to establish whether the patient objects to treatment – the reasonableness of that objection is not the issue.

16A.30 Even where a patient does not object, and a Bournewood authorisation is possible, it should not be assumed that such an authorisation is invariably the correct course. As explained in chapter 2 there may be other factors which suggest the Mental Health Act should be used.

16A.31 For fuller details on the Bournewood regime and all the other topics in this section please see the Mental Capacity Act Code of Practice. [Note: for obvious reasons, the Bournewood regime is not yet covered in the MCA Code, but a draft chapter has been made available alongside this Code.]

Chapter 17 Part III of the Act - patients concerned with criminal proceedings

Treatment and care in hospital

17.1 A patient who is remanded to hospital for a report (section 35) or for treatment (section 36) is entitled to obtain, at his or her own expense, or through Legal Aid, an independent report on his or her mental condition from a registered medical practitioner or approved clinician of the patient's choosing for the purpose of applying to court for the termination of the remand. The Hospital Managers should help in the exercise of this right by enabling the patient to contact a suitably qualified and experienced solicitor, or other adviser.

17.2 The consent to treatment provisions of the Act do not apply to patients remanded under section 35, ~~so in the absence of the patient's consent,~~ so treatment can only be administered with consent or, in the case of a patient aged 16 or over who lacks capacity to consent, in accordance with the Mental Capacity Act 2005.

17.3 Where a patient remanded under section 35 is thought to be in need of medical treatment for mental disorder under Part IV of the Act, the patient should be referred back to court as soon as possible with an appropriate recommendation, and with an assessment of whether he or she is in a fit state to attend court. If there is a delay in securing a court date, consideration should be given to whether the patient meets the criteria for detention under section 3 of the Act.

17.4 A report prepared in pursuit of a section 35 remand order should contain:

- a statement as to whether a patient is suffering from ~~a specified form of~~ mental disorder ~~as required by the section~~, identifying its relevance to the alleged offence. The report should not comment on guilt or innocence. It may be appropriate to suggest that a further report be submitted to the court between conviction and sentence;
- relevant social factors; - any recommendations on care and treatment, including where and when it should take place
- and who should be responsible for that care and treatment.

Chapter 18 Psychological treatments

18.1 Psychological treatments carried out competently can be beneficial to patients. If carried out incompetently they can be harmful. Some treatments interfere with patients' basic human rights and it is important that no one deprives a patient of food, shelter, water, warmth, a comfortable environment, confidentiality or reasonable privacy (both physical and in relation to their personal feelings and thoughts). The possibility of misapplication of techniques and serious errors in therapy can be reduced by ensuring that people offering such treatments (on an individual or group basis) are appropriately qualified and supervised, and that they demonstrate a commitment to evidence- based practice. Recruitment and selection procedures should ensure appropriate qualification, using appropriate external assessors. A medical or nursing qualification does not, in itself, confer competence to practise psychotherapeutic treatment. Membership of, or affiliation to, an appropriate professional body may help to promote the maintenance of a high standard of professional practice.

18.2 The Hospital Managers must ensure that psychological treatment programmes are set out clearly so that they can be understood by staff, patients and relatives. Guidelines should include procedures for noting and monitoring their use. A person with sufficient skills in implementing programmes should be available to monitor procedures as well as the progress of patients.

18.3 Any programme of psychological treatment should form part of a patient's previously agreed care programme. At no time should it be used as a spontaneous reaction to a particular type of behaviour.

18.4 A decision to use any psychological treatment programme for an individual patient should be preceded by a full discussion with the professional staff concerned with the patient.

18.5 Such a programme should be regularly reviewed in the case of each patient, and abandoned if it has proved ineffective or otherwise modified if necessary.

18.6 Patients and, with the patient's consent, their relatives, carer, and if they have one, mental health advocate should be fully informed of the planned use of any such methods as part of a patient's treatment. ~~and t~~ The patient's consent should always be sought.

18.7 Psychological treatments may proceed in the absence of a patient's consent only where this is justified legally (see Chapter 15 and 16). If consent is not or cannot be given, and the patient is detained, or mentally incapacitated, a locally agreed procedure should be adopted in which the ~~rmo~~ responsible clinician should seek the advice of a suitably qualified person who is not a member of the clinical team responsible for the patient. This could be a psychologist, doctor, social worker or nurse or other professional who has received special training that equips them to supervise psychological procedures.

18.8 The ~~rmo~~ responsible clinician can authorise other members of staff to use such programmes. It remains the ~~rmo~~ responsible clinician's responsibility to ensure that those who are so authorised have adequate skills and abilities to carry out the procedures to the required standard. The Hospital Managers must ensure that such members of staff have received relevant training and have regular professional supervision.

~~**Time out**~~ **[**DN now at paragraphs 19.23a to 19.23c in revised form**]**

Chapter 19 ~~Patients presenting particular management problems~~ The safe and therapeutic management of patients

~~19.1 Patients, or people who may become patients, may behave in such a way as to disturb others around them, or their behaviour may present a risk to themselves or others around them or those charged with their care. These problems may occur anywhere, and the issues addressed here relate to general health care settings as well as to psychiatric facilities. It is important to distinguish:~~

- ~~the needs of patients who pose an immediate threat to themselves or those around them and where techniques for the immediate management and control of a difficult situation must be used; and~~
- ~~the need for some patients to remain in a secure environment as a result of a perceived risk to the general public or as a result of pending or past decisions of the courts, but who pose no immediate threat to those around them~~. (moved to 19.4b)

19.1(a) The guidance in this chapter covers a range of interventions, which may be considered in the safe and therapeutic management of patients whose behaviour may present an imminent risk to themselves or to others, including those charged with their care. This guidance applies to all patients presenting such behaviour, whether or not they are liable to compulsion under the Mental Health Act. In some circumstances, there may be other legal authority for taking immediately necessary steps in relation to patient who are not subject to the Mental Health Act.

19.1(b) Service providers, in conjunction with key stakeholders including service users and carers should review their existing practice against the NICE guidelines on the short-term management of disturbed/violent behaviour in psychiatric in-patient settings and accident and emergency settings[2] and should develop local policies, which cover the use of de-escalation techniques, physical intervention, seclusion and observation. The NICE guideline offers detailed guidance in these areas and all local policies should be developed in accordance with this guidance

NHS bodies, independent hospitals and local social services authorities are responsible for ensuring that staff are trained in the relevant local policy and procedures

Behaviour contributing to harm to self and others

19.2 Patients' behaviour should be seen in its context. Professionals should not categorise behaviour as disturbed without taking account of the circumstances under which it occurs. Nor should they assume that a previous history of disturbance means the patient ~~will behave that way again~~ will necessarily behave in the same way in the immediate future. However, research does show that past behaviour is a strong predictor for future behaviour ~~the best predictor of future behaviour is past behaviour~~. ~~However they~~ Staff should also recognise that due to the nature of their contact ~~though~~ they may experience the disturbed behaviour as intermittent, whilst fellow residents or carers will experience it ~~through 24 hours~~ over prolonged periods~~19~~.~~3 Behaviour which can give rise to managerial problems can include:~~

- ~~refusal to participate in treatment programmes;~~
- ~~prolonged verbal abuse and threatening behaviour;~~

[2] National Institute for Clinical Excellence (2005) The Short-term Management of Disturbed/ Violent Behaviour in Adult Psychiatric In-patient Settings and Accident and Emergency Settings. London: Department of Health

- ~~destructive behaviour;~~
- ~~self- injurious behaviour;~~
- ~~physical attacks on others;~~
- ~~going missing.~~

Possible causes

19.4 In exploring preventive methods staff should be aware of some possible, often very evident causes of problem behaviours:

- boredom and lack of environmental stimulation; - too much stimulation, noise and general disruption;
- overcrowding; - antagonism, aggression or provocation on the part of others;
- influence of alcohol or substance abuse;
- an unsuitable mix of patients;
- the rewarding of undesirable behaviour by attention.

19.4 (a)The primary focus when dealing with patients who may present with disturbed and/or violent behaviour should be the establishment of a culture which focuses on early recognition of potential aggression and prevention and de-escalation techniques to minimise the risk of its occurrence.

This is best achieved through effective systems of organisational, environmental and clinical risk assessment and management. Such risk assessment and risk management approaches should also promote therapeutic engagement and collaboration with patients.

Services and staff should demonstrate and encourage respect of racial and cultural diversity, and recognise the need for privacy and dignity. These essential values that must be engendered and asserted in all policy, educational material, training and practice initiatives related to the safe and therapeutic management of patients.

19.4(b) High-risk behaviour or situations may occur anywhere, and the issues addressed here relate to general health care settings as well as to in-patient and community-based psychiatric facilities. It is important to distinguish:

- the need for some patients to remain in a secure environment as a result of an assessed risk to the general public, or as a result of pending or past decisions of the courts, but who pose no immediate threat to those around them; and
- the needs of patients who pose an immediate threat to themselves or those around them, where techniques for the immediate management and control of a difficult situation must be used.

General preventive measures

19.5 In addition to individual care plans much can be done to prevent behaviour problems by examining the ward or other environment and pinpointing problem areas. Among such general measures are:

- keeping patients fully informed of what is happening and why;
- giving each patient a defined personal space and a secure locker for the safe keeping of possessions;
- ensuring access to open space; - organising the ward (in hospital) to provide quiet rooms, recreation rooms, single sex areas and visitors' rooms;
- providing all necessary help for patients with any type of disability or impairment;
- ensuring access to a telephone;
- ~~providing structured activities by professional staff;~~
- seeking patients' co- operation, and encouraging their participation in the general running of the ward;
- identifying those patients most at risk and ensuring appropriate levels of observation;
- ~~encouraging energetic activities for younger patients~~; providing appropriate activities for all patients and encouraging patients to take part in activities appropriate to them
- providing training for staff in the management of disturbed behaviour, including de- escalation
- ~~techniques, diversional therapies and other non- physical intervention skills;~~
- monitoring the skill mix of staff
- ~~monitoring the mix of patients~~
- developing a therapeutic relationship between each patient and a key/ nurse worker;
- consistent application and monitoring of any individual programme;
- ensuring that patients' complaints are dealt with quickly and fairly.

19.5(a) Interventions such as restraint, seclusion, rapid tranquilisation should only be considered if de-escalation and other strategies have failed to calm the patient. They must never be used to punish a patient's behaviour. Where such interventions are deemed necessary, clinical need and the safety of the patients and others should be taken into account. The method chosen must balance the risk to others with the risk to the patient's own health and safety The intervention selected must be a reasonable and proportionate response to the risk posed by the patient (as below, restraint is sometimes carried out in the absence of risk unless this includes risk to health, e.g. as in some cases of forcibly giving medication)

Restraint

~~19.6 Restraint may take many forms. It may be both verbal and physical and may vary in degree from an instruction to seclusion~~.

19.6 (a) Any limitation on a patient's freedom of movement amounts to restraint. This includes, for inpatients, being subject to close observation through to being unable to move around the ward or clinical area freely through to various forms of physical restraint.

The purposes of restraint are:

- to take immediate control of a dangerous situation;
- to contain or limit the patient's freedom for no longer than is necessary; and

- to end or reduce significantly the danger to the patient or those around.

The most common reasons for restraint are:

- physical assault;
- dangerous, threatening or destructive behaviour;
- non-compliance with treatment; self- harm or risk of physical injury by accident; - extreme and prolonged over- activity likely to lead to physical exhaustion.

19.7 The basic considerations which should underlie any methods aimed at reducing and eliminating unacceptable behaviour should take account of:

- the need for individual care planning;
- the physical condition of the patient;
- the physical environment of the ward or unit;
- the need to maintain adequate staffing levels.

Where the risk of problem behaviour is identified in a group of patients, but its onset cannot be predicted, an agreed strategy for dealing with such behaviour should be developed. This should include continuing risk assessment and management.

19.8 If the patient is not detained but restraint in any form has been deemed necessary, whether as an emergency or as part of the patient's treatment plan, consideration should be given to whether formal detention under the Act is appropriate, especially if restraint has occurred on a repeated basis, provided, of course, that the criteria for detention are met. Where a patient is detained in a hospital for mental health treatment under the Bournewood safeguards, the use of restraint may well indicate that the patient objects to treatment or to being in the hospital and has therefore ceased to be eligible to be detained under a Bournewood authorisation. If so, consideration will need to be given to whether the patient can and should be detained under the Mental Health Act.

~~**Training**~~ **(moved to 19.34a)**

~~19.9 Staff in NHS hospitals and private mental nursing homes who are ordinarily likely to find themselves in situations where training in the management of actual or potential aggression might be necessary should attend an appropriate course taught by a qualified trainer. The trainer should have completed an appropriate course of preparation designed for health care settings and preferably validated by one of the health care bodies (English National Board or Royal College of Nursing Institute).~~

~~**Methods of restraining behaviour**~~

~~19.10 Physical restraint should be used as little as possible. Restraint which involves tying (whether by means of tape or by using a part of the patient's garments) to some part of a building or to its fixtures or fittings should never be used. Staff must make a balanced judgment between the need to promote an individual's autonomy by allowing him or her to move around at will and the duty to protect that person from likely harm.~~

Policy on restraint and physical interventions

19.11 Restraining aggressive behaviour by physical means should be done only as a last resort and never as a matter of course. It should be used in an emergency when there seems to be a

real possibility that ~~significant~~ harm would occur if no intervention is made. Any initial attempt to restrain aggressive behaviour should, as far as the situation will allow, be non- physical:

a. assistance should be sought by call system or orally;

b. one member of the team should assume control of the incident;

c. the patient should be approached where possible and agreement sought to stop the behaviour, or to comply with a request. Approaches to deaf and hearing impaired patients should be made within their visual field (not from behind) and gestures used to engage them in calm communication;

d. where possible an explanation should be given of the consequences of refusing the request from staff to desist;

e. other patients or people not involved in the use of restraint should be asked to leave the area quietly.

~~19.12 A large number of staff, acting in an uncoordinated way, in attempting to restrain a patient can be counter- productive whereas fewer, but well briefed staff are likely to be more effective~~. If non- physical methods have failed or immediate action is needed, the person in control of the incident may decide to use physical restraint and should organise a small number of staff members to assist in managing the incident. Any restraint used should;

- be reasonable in the circumstances;
- apply the minimum force necessary to prevent harm to the patient or others;
- be used for only as long as is absolutely necessary;
- be sensitive to gender and race issues.
- Monitor physical state as per NICE guidelines

Where physical restraint is used staff should;

- record the decision and the reasons for it;
- state explicitly in a care plan under what circumstances restraint may be used;
- record what form the restraint may take and how its application will be reviewed; and
- document and review every episode of physical restraint.

~~In doing so staff should:~~

~~a. make a visual check for weapons;~~

~~b. aim at restraining arms and legs from behind if possible, seek to immobilise swiftly and safely;~~

~~c. explain the reason for sustaining the action continuously;~~

~~d. enlist support from the patient for voluntary control as soon as possible. If the patient is deaf or hearing impaired he or she must be able to see the staff member in control of the incident so that the attempt to communicate can be sustained;~~

~~e. not use neck holds;~~

~~f. avoid excess weight being placed on any area, but particularly on stomach and neck;~~

~~h. not slap, kick or punch.~~

~~Post- incident analysis and support should be developed for both staff and patients.~~

19.13 All providers should have clear, written policies on the use of restraint and physical interventions, of which all staff should be aware. The policy should follow the recommendations identified as priorities for implementation contained in the NICE guidelines. (Clinical guideline 25 Violence: the short term management of disturbed /violent behaviour in inpatient psychiatric settings and emergency departments)Then policy should include provision for review of each incident of restraint and its application. All uses of physical restraint should be audited and reported to the Hospital Managers.

19.14(a) Mental health service providers should put in place a system of post-incident support and review, which allows staff and the organisation to learn from experience. The following groups may need to be catered for:

- Staff involved in the incident.
- Patients, including the restrained patient
- Carers and family, where appropriate.
- Other patients who witnessed the incident.
- Visitors who witnessed the incident.

Restraint and complaints (moved from 19.13)

19.14 The Hospital Managers should appoint a senior officer who should;

- be informed of any patient who is being subjected to any form of restraint that lasts for more than two hours;
- see the patient as soon as possible;
- visit and talk to the patient about the incident and ascertain if he or she has any concerns or complaints and if so assist in putting them forward.

The senior officer may delegate this task to a member of staff who has a good relationship with the patient.

Medication – general

Restraint is also used in order to administer medication (or other forms of treatment) to an unwilling patient, where there is legal authority to treat the patient without consent. It should not be used unless there is such legal authority (see chapters 15, 16 and 16A).

The use of restraint to administer treatment in non-emergency circumstances should be properly document in the patient's notes, along with the justification for it. The principles at 19.12 apply to restraint used in connection with the administration of treatment.

19.15 Medication should never be used to manage patients in the absence of adequate staffing. ~~Medication to reduce excitement and activity may be useful to facilitate other therapeutic interventions.~~ Other than in exceptional circumstances, the control of behaviour by medication should only be used after careful consideration, and as part of a treatment plan (See Chapters 15 and 16**)**

Even in emergencies, the normal rules of consent apply. Medication should not be given to a person who a capacity to consent to it, but does not, unless there is specific authority to do so under the Act. If the patient lacks capacity, medication may only be administered in accordance

with the Act or (if the patient is not subject to a relevant provision of the Act) the Mental Capacity Act. For special consideration in relation to children and young people under 18 see chapter 31

Rapid Tranquillisation – policy

19.15(a) Local protocols should be produced which cover all aspects of rapid tranquillisation. Such protocols should be in accordance with legal requirements (especially in respect of detained patients, the consent to treatment, and the emergency treatment powers under the Mental Health Act) and relevant NICE guidelines[3] . They should be kept under review

Seclusion

19.16 Seclusion is the supervised confinement of a patient in a room, which may be locked to protect others from significant harm. Its sole aim is to contain severely disturbed behaviour which is likely to cause harm to others.

Seclusion should be used;

- as a last resort
- for the shortest possible time

Seclusion should not be used;

- as a punishment or threat
- as part of a treatment programme
- because of shortage of staff
- where there is any risk of suicide or self- harm .

Seclusion of an informal patient should be taken as an indicator of the need to consider formal detention.

19.17 Hospitals should have clear written guidelines on the use of seclusion which should reflect the NICE guidelines [4]

- ensure the safety and well being of the patient;
- ensure the patient receives the care and support rendered necessary by his or her seclusion both during and after it has taken place;
- distinguish between seclusion and `time- out' (See paras 19.9- 19.10);
- specify a suitable environment taking account of patient's dignity and physical well being;
- set out the roles and responsibilities of staff;
- set requirements for recording, monitoring, reviewing the use of seclusion and any follow- up action.

Procedure for seclusion

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[3] The National Institute for Clinical Excellence(2005) The Short term Management of Disturbed/Violent Behaviour in Adult Psychiatric Inpatient Settings and Accident and Emergency Settings, London, Department of Health

[4] [4] The National Institute for Clinical Excellence(2005) The Short term Management of Disturbed/Violent Behaviour in Adult Psychiatric Inpatient Settings and Accident and Emergency Settings, London, Department of Health

19.18 The decision to use seclusion can be made in the first instance by a doctor, or the ~~nurse in charge~~ a suitably qualified approved clinician or the practitioner in charge of the ward. Where the decision is taken by someone other than ~~a doctor~~ suitably qualified approved clinician or a doctor, the ~~rmo~~ responsible clinician or duty doctor should be notified at once and should attend immediately unless the seclusion is only for a very brief period (no more than five minutes). It is for providers to determine which of their non-medical approved clinicians are suitably qualified to fulfil functions in relation to seclusion.

19.19 A suitably skilled practitioner ~~nurse~~ should be readily available within sight and sound of the seclusion room at all times throughout the period of the patient's seclusion, and present at all times with a patient who has been sedated.

19.20 The aim of observation is to monitor the condition and behaviour of the patient and to identify the time at which seclusion can be terminated. The level should be decided on an individual basis and the patient should be observed continuously. A documented report must be made at least every 15 minutes.

19.21 The need to continue seclusion should be reviewed

- every 2 hours by 2 nurses (or other suitably skilled practitioners) (1 of whom was not involved (directly in the decision to seclude), and
- every 4 hours by a doctor or a suitably qualified approved clinician .

A multidisciplinary review should be completed by a senior doctor or suitably qualified approved clinician, nurses and other professionals, who were not involved in the incident which led to the seclusion if the seclusion continues for more than: (however even if the decision is in the hands of such, it seems good MDT practice for those involved in the original decision to be involved in discussions about it)

- 8 hours consecutively; or
- 12 hours intermittently over a period of 48 hours.

If the need for seclusion is disputed by any member of the multidisciplinary team, the matter should be referred to a senior manager.

Conditions of seclusion

19.22 The room used for seclusion should;

- provide privacy from other patients - enable staff to observe the patient at all times
- be safe and secure - not contain anything which could cause harm to the patient or others
- be adequately furnished, heated, lit and ventilated
- be quiet but not soundproofed and with some means of calling for attention; the means of operation should be explained to the patient.

Staff may decide what a patient may take into the seclusion room, but the patient should always be clothed.

Long-term use of seclusion

19.22 (a) The above guidance is provided to guide practitioners in the practice of dealing with a situation when an individual is behaving in such a way as to present such a risk to others that they required containment, separately until they have calmed sufficiently to be re-introduced into the ward community This is often used in conjunction with other procedures, most notably increased observation which may proceed and/or follow this. It is intended to be for an 'acute'

short lived event where the behaviour is resolved within hours.

19.22(b) There are an extremely small number of patients, who almost exclusively reside in high security services, who are not responsive to short term management of their aggression and violence and could be described as 'long term dangerous' By this it is mean that they present not an acute state of fleeting danger to others but their risk to others is a constant feature of their presentation and is not subject to amelioration by a short period of seclusion combined with any other form of treatment. The clinical judgement in these cases is that if allowed to mix freely in the general ward environment other patients and/or staff would be open to the potential of serious injury/harm.

19.22 (c) This small number of patients can be managed by ensuring that their contact with the general ward population is strictly limited and when not locked in a room on their own (which can be their own bedroom rather than a seclusion room) then they would be nursed under close observation.

19.22 (d) In these cases the way that the patient's situation is reviewed needs to reflect the specific nature of their management plan. The purpose of a review is to determine whether the person has settled sufficiently to return to the ward community and to check on their general health and welfare. The decision to return these patients to the general community will be taken by their multi-disciplinary team, following a thorough risk assessment and observations from staff of their presentation during close observation in the company of others.

19.22 (e) These cases present a special case. For the first 72 hours, the seclusion review must be as per the above procedure for all acute episodes of seclusion. If it is considered that the person remains too great a risk to be in open contact with others then the situation should be subjected, where practicable to external clinical review by a senior clinician not involved with the case and not a member of staff of the relevant Trust. If the independent clinician is in agreement with the continuation. (It is essential that regular review periods are built into to any plan to effectively keep excluded for more than this time)

Record keeping

19.23 Detailed and contemporaneous records should be kept in the patient's case notes of any use of seclusion, the reasons for its use and subsequent activity, cross- referenced to a special seclusion book or forms which should contain a step- by- step account of the seclusion procedure in every instance. The principal entry should be made by the nurse in charge of the ward and the record should be countersigned by a doctor and a senior nurse. The Hospital Managers should monitor and regularly review the use of seclusion.

Time out [based on and replaces paragraphs 18.9 and 18.10 in current code]

19.23a Time out is a behaviour modification technique which may be used immediately following an incident of unacceptable behaviour. Time out denies a patient, for a period of no more than 15 minutes, opportunities to participate in an activity or to obtain positive reinforcement. The patient is then returned to his or her original environment. Time out should never include the use of a locked room and should be clearly distinguished from seclusion which is to be used only to deal with acutely disturbed behaviour or imminent risk which cannot effectively be managed in a less restrictive manner. Unlike time out, seclusion should never form part of a behavioural programme.

19.23c Time out should:

- form part of a programme which enables the patient to achieve positive goals as well as reducing unwanted behaviour
- enable a patient, following a change of behaviour, to be subject to fewer restrictions
- ordinarily not take place in a room which is used for seclusion on other occasions
- be used only as part of a planned approach to managing a difficult or disturbed patient.

19.23b Services should have a clear written policy on the use of time out which includes both a clear definition of this form of therapy and procedures for noting and monitoring its use on individual patients.

Locking ward doors on open wards

19.24 The management, security and safety of patients should be ensured by means of adequate staffing. Service providers are responsible for ensuring that staffing is adequate to prevent the need for the practice of locking patients in (open) wards, individual rooms or any other area.

19.25 The practitioner ~~nurse~~ in charge of any shift is responsible for the care and protection of patients and staff and the maintenance of a safe environment. This responsibility includes the care of patients who have been detained in hospital because they are considered a danger to other people. The ~~nurse~~ practitioner in charge of a shift has discretion for all or part of that shift to lock the door of the ward, to protect patients or others, because of the behaviour of a patient or patients. The practitioner ~~nurse~~ in charge should:

a. inform all staff of why this action is being taken, how long it will last and a notice to that effect should be displayed at the entrance to the ward;

b. inform the patient or patients whose behaviour has led to the ward door being locked of the reason for taking such action;

c. inform all other patients that they may leave on request at any time and ensure that someone is available to unlock the door;

d. inform his or her line manager of the action taken;

e. inform the or nominated deputy;

f. keep a record of this action and reasons, and make use of an incident reporting procedure.

19.26 When handing over to the relieving shift the practitioner in charge should discuss in detail the reasons for the action taken. Where the relieving nurse considers it necessary to keep the door locked, (a) to (e) above apply. Where any ward is locked for three consecutive shifts (excluding night duty) the senior manager responsible for that ward should be informed.

19.27 The safety of informal patients, who would be at risk of harm if they wandered out of a ward or hospital at will, should be ensured by adequate staffing and good supervision. Combination locks and double-handed doors should be used only in units where there is a regular and significant risk of patients wandering off accidentally and being at risk of harm. There should be clear policies on the use of locks and other devices and a mechanism for reviewing decisions. Every patient should have an individual care plan which states explicitly why and when he or she will be prevented from leaving the ward. Patients who are not deliberately trying to leave the ward, but who may wander out accidentally, may legitimately be deterred from leaving the ward by those devices. In the case of a patient who persistently and/ or purposely attempts to leave a ward or hospital ~~mental nursing home~~, whether or not they understand the risk involved, consideration must be given to whether, they are, in fact deprived of their liberty and if so whether an authorisation needs to be sought for under the Bournewood safeguards of the Mental

Capacity Act and/or to assessing whether they ~~would more appropriately~~ should be formally detained under the Act ~~in a hospital or a mental nursing home registered to take detained patients, than remain as informal patients~~ (see Chapter 2).

Locked wards and secure areas

19.28 There are some detained patients in general psychiatric hospitals ~~and mental nursing homes~~ who may be liable to cause danger to themselves or others. For these patients professional judgment, or the requirement of a Court as an alternative to imprisonment, may point to the need for varying degrees of security. In such cases, where the need for physical security is a prerequisite, the patient's ~~rmo~~ responsible clinician, in consultation with the multi- disciplinary team, should ensure that:

a. he or she has carefully weighed the patient's individual circumstances and the degree of danger involved;

b. he or she has assessed the relative clinical considerations of placing the patient in a physically secure environment; in addition to or as opposed to providing care by way of intensive staffing;

c. treatment in secure conditions lasts for the minimum necessary period;

d. arrangements are made to enable his or her speedy return to an open ward when physical security is no longer required.

19.29 Service providers should ensure that:

a. a ward/ area is specifically designated for this purpose with adequate staffing levels;

b. written guidelines are provided, setting out;

- the categories of patient for whom it is appropriate to use physically secure conditions;
- those for whom it is not appropriate
- a clear policy for practice, procedure and safeguards for treatment in secure conditions

Observation and engagement

The primary aim of observation should be to positively engage with the service user. Observation as an intervention is used both for the short term management of disturbed/violent behaviour and to prevent self-harm. Each service should have a policy on observation and engagement (reflecting the needs of specialist facilities) that adheres to the terminology and definitions as defined in NICE guidelines [5] Adherence to the agreed frequency of observations should be recorded

Observation, care and management of patients at risk of self injury

19.30 Patients must be protected from harming themselves when the drive to self injury is a result of mental disorder for which they are receiving care and treatment. On admission, all patients should be assessed for immediate and potential risks of going missing, suicide, self harm and self neglect, taking into account their social and clinical history. Individual care plans should include;

- a clear statement of the degree of risk of self harm;

[5] The National Institute for Clinical Excellence(2005) The Short term Management of Disturbed/Violent Behaviour in Adult Psychiatric Inpatient Settings and Accident and Emergency Settings, London, Department of Health

- the measures required to manage the risk safely,
- the level of observation needed to ensure the patient's safety.

Staff must balance the potentially distressing effect on the patient of close observation, particularly when one- to- one observation is proposed for many hours, against the risk of self injury. Levels of observation and risk should be regularly reviewed and a record made of agreed decisions.

Staff should observe changes in the patient's:

- general behaviour;
- movement;
- speech;
- expression of ideas;
- appearance;
- orientation;
- mood and attitude;
- interaction with others;
- reaction to medication.

Use of CCTV

13.31A General observation through closed circuit television (CCTV) is used in some psychiatric settings. Justification for the use of overt or covert CCTV will normally involve a risk assessment which sets the prevention of criminal activity and/or a significant, identified danger to patients or others against the restriction of individual privacy and freedom. The Mental Health Act Commission assessment framework on the use of CCTV summarises the standards that should apply in this area.

Deprivation of daytime clothing

19.32 Patients should never be deprived of appropriate daytime clothing during the day, with the intention of restricting their freedom of movement. They should not be deprived of other aids necessary for their daily living.

Staff

19.33 Staff must try to gain the confidence of patients so that they can learn to recognise potential danger signs. Staff should understand when to intervene to prevent harm from occurring. Continuity of staffing is an important factor both in the development of professional skills and consistency in managing patients.

Management responsibilities

19.34 Staff who take part in incidents involving control and physical restraint may experience a degree of stress. Hospital Managers should ensure that they are given the opportunity to discuss these issues with them (the managers) and with colleagues. Hospital Managers should formulate

and make available to staff a clear written operational policy on all forms of restraint, including post- incident analysis and support for patients and staff.

Training

19.34a Mental health service providers should ensure that all policies, procedures, education and training programmes promote recognition, prevention and de-escalation as the first line approach when responding to aggressive behaviour.

19.34b All service providers should have a policy for training staff who work in areas where they may be exposed to aggression and/or violence, or may need to become involved in the restraint of patients. The policy should specify who will receive what level of training (based on risk assessment), how often they will be trained and the techniques in which they will be trained. The training should be delivered during new staff members' induction period or as soon as is practicably possible.

19.34c All staff who undertake training in the recognition, prevention and management of violence and aggression and associated physical skills training (formerly known as control and restraint training) should attend annual refresher/update education and training programmes.

Partnership Working

19.34d Effective partnership working between agencies has an important role to play in managing the prevention of harm to self and others. Mental health service providers should establish multi-agency mental health partnership boards which might include the Police; Crown Prosecution Service (CPS), patients, carers, advocates, Health and Local authority managers, Ambulance Service personnel and other key stakeholders to:

- Develop effective and mutually beneficial communication and information sharing systems.
- Clarify roles, responsibilities and purpose when dealing with situations involving patients being treated under compulsion taking account of the guidance in this code of practice.
- Develop jointly agreed procedures for places of safety and the conveying of patients.
- Determine the circumstances in which the police might become involved in in-patient mental health settings.
- Agree the processes for the bringing of criminal proceedings against patients in mental health settings.
- Develop joint approaches to education, training, policy and practice.
- Share lessons to be learned and positive practice initiatives.
- Agree any arrangements, if required, for searching.

Chapter 20 Leave of absence (section 17)

20.1 A patient who is currently liable to be detained in a hospital or a specified hospital unit, can only leave that hospital, or hospital unit, lawfully - even for a very short period - by being given leave of absence in accordance with the provisions of section 17 or by way of transfer to another hospital under section 19. Leave of absence can be an important part of a patient's treatment plan. Only the patient's ~~rmo~~ responsible clinician, with the approval of the Home Secretary in the case of restricted patients, can grant a detained patient leave of absence. ~~Rmos~~ Responsible clinicians are not entitled to grant leave of absence to patients detained under sections 35, 36 or 38. Except where the patient is detained in a specified hospital unit, no formal procedures are needed to allow a patient to go to different parts of the hospital or hospital grounds as part of the care programme.

20.2 Leave of absence can be granted by the ~~rmo~~ responsible clinician for specific occasions or for longer indefinite or specific periods of time. The period of leave may be extended in the patient's absence. The granting of leave should not be used as an alternative to discharging the patient or to SCT (see below).

20.2(a) Whenever considering whether to grant leave of over seven consecutive days, the responsible clinician should first consider whether the patient should instead go onto SCT. In granting leave the responsible clinician is signalling the intention, or the possibility, that the patient will again need to be detained in hospital for treatment at some future point (whether specified or not). A patient on SCT will be treated while living in the community on an ongoing basis, and will only need to be detained in hospital if it is found necessary to use the power of recall.

20.2(b) Informal patients are not subject to leave requirements under Section 17. A patient who is not detained has the legal right to leave (other than those patients subject to authorisation under the Bournewood safeguards of the Mental Capacity Act 2005) but patients may be asked by staff to inform them when they want to leave the ward.

20.3 The power to grant leave (section 17)

a. Unrestricted patients

The ~~rmo~~ responsible clinician cannot delegate the decision to grant leave of absence to any other doctor or professional. The ~~rmo~~ responsible clinician is responsible for undertaking any appropriate consultation, and may make leave subject to conditions which he or she considers necessary in the interests of the patient or for the protection of other people. Only the ~~rmo~~ responsible clinician can grant leave of absence to a patient formally detained under the Act. In the absence of the ~~rmo~~ usual responsible clinician (for example, if he or she is on annual leave or otherwise unavailable) permission can only be granted by the ~~doctor~~ approved clinician who is for the time being in charge of the patient's treatment (and who is, therefore, temporarily acting as the patient's responsible clinician) ~~Where practicable this should be another consultant psychiatrist, a locum consultant or specialist registrar approved under section 12(2) of the Act [The granting of leave cannot be vetoed by the Hospital Managers~~. However, the fact that the responsible clinician grants leave subject to certain conditions (eg residence at a hostel) does not oblige the managers or anyone else to fund or arrange the particular placement or services the clinician has in mind. Responsible clinicians should not grant leave on such a basis without first taking steps to establish that the necessary services and/or accommodation is available.

b. Restricted patients

Any proposal to grant leave has to be approved by the Home Secretary who should be given as much notice as possible, together with full details of the proposed leave.

Short-term leave

20.4 The ~~rmo~~ responsible clinician, with the authority of the Home Secretary if the patient is subject to restrictions, may decide to authorise short- term local leave, which may be managed by other staff. For example, the patient may be given leave for a shopping trip of two hours every week, with the decision on the particular two hours left to the discretion of the responsible nursing staff. It is crucial that such decisions fall within the terms of the grant of periodic leave by the ~~rmo~~ responsible clinician, and that he or she reviews decisions and their implementation from time to time and explicitly records the outcome in writing (see para 20.6).

Longer periods of leave

20.5 Once the responsible clinician has determined that leave, rather than SCT, is the appropriate option for the patient, the leave ~~Leave of absence~~ should be properly planned, if possible well in advance. Leave may be used to assess an unrestricted patient's suitability for discharge from detention. The patient should be fully involved in the decision to grant leave and should be able to demonstrate to the professional carers that he or she is likely to cope outside the hospital. Subject to the patient's consent there should be detailed consultation with any appropriate relatives, ~~or~~ friends or other persons (especially where the patient is to reside with them) and with community services. Leave should not be granted if the patient does not consent to appropriate relatives, friends or other persons or community services who are to be involved in his or her care being consulted.

Recording and information

20.6 The granting of leave and the conditions attached to it should be recorded in the patient's notes and copies given to the patient, any appropriate relatives or friends and any professionals in the community who need to know. Hospitals should adopt a local record form on which the ~~rmo~~ responsible clinician can authorise leave and specify the conditions attached to it.

Care and treatment while on leave

20.7 The ~~rmo's~~ responsible clinician's responsibilities for the patient's care remain the same while he or she is on leave although they are exercised in a different way. The duty to provide after- care under section 117 includes patients who are on leave of absence (provided they would otherwise qualify).

20.8 A patient granted leave under section 17 remains 'liable to be detained' and the provisions of Part IV of the Act continue to apply. If it becomes necessary to administer treatment in the absence of the patient's consent under Part IV, consideration should be given to recalling the patient to hospital. The refusal of treatment would not on its own be sufficient grounds for recall (see para 20.11). Such a recall direction should be in writing.

Patients in custody or in other hospitals

20.9 The ~~rmo~~ responsible clinician may ~~keep~~ direct that the patient remains in custody while on leave of absence, either in the patient's own interests or for the protection of other people. The patient may be kept in the custody of any officer on the staff of the hospital or of any person authorised in writing by the Hospital Managers. Such an arrangement is often useful, for example, to enable patients to participate in escorted trips, or to have compassionate home leave. However, this power only can be exercised within England and Wales.

20.10 The ~~rmo~~ responsible clinician may also require the patient, as a condition of leave, to reside at another hospital in England and Wales and he or she may then be kept in the custody of an officer of that hospital. ~~The patient's detention can be renewed during such a period of leave~~

~~[RvManagers of Warley Hospital ex parte Barker [1998]COD 309].~~ However, consideration should be given as to whether it would be more appropriate to move the patient from one hospital to another under the provisions of section 19 rather than being given section 17 leave.

Recall to hospital

20.11 The ~~rmo~~ responsible clinician may revoke a patient's leave at any time if he or she considers this to be necessary in the interests of the patient's health or safety or for the protection of other people. The ~~rmo~~ responsible clinician must consider very seriously the reasons for recalling a patient and the effects this may have on him or her. For example a refusal to take medication would not on its own be a reason for revocation; the ~~rmo~~ responsible clinician would have to be satisfied that the likely consequences of the refusal were such as to make it necessary in the patient's interests or for the safety of others for the patient to be recalled. The ~~rmo~~ responsible clinician must arrange for a notice in writing revoking the leave to be served on the patient or on the person for the time being in charge of the patient. The reasons for recall should be fully explained to the patient and a record of such explanation placed in the patient's case notes. A restricted patient's leave may be revoked either by the ~~rmo~~ responsible clinician or the Home Secretary.

20.12 It is essential that any appropriate relatives and friends, especially where the patient is residing with them whilst on leave, and other professionals in the community who need to know should have easy access to the patient's ~~rmo~~ responsible clinician if they feel consideration should be given to the return of the patient to hospital before his or her leave is due to end.

Duration of leave/ renewal of authority to detain

20.13 A period of leave cannot last longer than the duration of the authority to detain which was current when leave was granted. If the authority to detain an unrestricted patient might expire whilst the patient is on leave the ~~rmo~~ responsible clinician may examine the patient and consider writing a report renewing the detention when the patient is still on leave [Barker v Barking Havering & Brentwood Community Healthcare NHS Trust [1998]. The renewal of leave provides a further opportunity to consider if it would be more appropriate for the patient to be placed onto SCT instead.

Chapter 21 Absence without leave (section 18)

(paras 70- 71 of the Memorandum)

21.1 Section 18 provides powers for the return of patients who are absent from hospital without leave, or SCT fail to return to hospital at the end of an authorised leave of absence or when recalled, or are absent without permission from an address where they have been required to live either by the conditions of their leave of absence, or by their guardian. The hospital must know the address of a person on leave of absence.

21.2 A patient who is liable to be detained in hospital may be taken into custody and returned to hospital or the place where he or she is required to live by an ~~ASW~~ AMHP, any officer on the staff of the hospital, any police officer, or any person authorised in writing by the Hospital Managers.

21.3 A patient who has been required to reside in another hospital as a condition of leave of absence can also be taken into custody by any officer on the staff of that hospital or by any person authorised by the managers of that hospital. Otherwise responsibility for the safe return of the patient rests with the detaining hospital. If the absconding patient is initially taken to another hospital that hospital may, if authorised by the managers of the detaining hospital in writing, detain the patient while arrangements are made for his or her return. Such authority can be provided by fax.

21.4 A person absent without leave while under guardianship may be taken into custody by any officer on the staff of the local social services authority, or by any person authorised in writing by the guardian or the local social services authority.

21.4(a) Patients on SCT are absent without leave if they fail to return to hospital upon being recalled, or if following recall they abscond from the hospital. They may be taken into custody by an AMHP, an officer on the staff of the responsible hospital, a constable, or anyone authorised in writing by the responsible clinician or the hospital managers and returned to the hospital to which they were recalled.

21.4(b) It is good practice when a patient returns after a period of absence without leave always to re-examine the patient to establish whether they still meet the criteria for detention or SCT.

21.4(c) All instances of absence without leave should be recorded in the patients records.

Local policies

21.5 It is the responsibility of the Hospital Managers, and of the local social services authority where guardianship is concerned, to ensure that there is a clear written policy in relation to action to be taken when a detained patient, a patient on SCT or a person subject to guardianship goes absent without leave. All staff should be familiar with this policy.

21.6 The policy should include guidance as to:

a. the immediate action to be taken by any member of staff who becomes aware that a patient has gone absent without leave, including the requirement that they immediately inform the nurse in charge of the patient's ward who should in turn ensure that the patient's ~~rmo~~ responsible clinician is immediately informed;

b. the circumstances when a search of the hospital and its grounds should be initiated;

c. the circumstances when other local agencies with an interest, including the local social services authority, should be notified, in the case of a patient detained in hospital.

d. the circumstances when the police should be informed, in the case of a patient detained in hospital or, in the case of an SCT patient, absent without leave following recall to hospital. This

should be the subject of agreed local arrangements with the police. The police should be asked to assist in returning a patient to hospital only if necessary, but they should always be informed immediately of the absence without leave of a patient who is considered to be vulnerable, dangerous or who is subject to restrictions under Part III of the Act. There may be other cases where, although the help of the police is not needed, a patient's history makes it desirable to inform them that he or she is absent without leave in the area. Whenever the police are asked for help in returning a patient they must be informed of the time limit for taking him or her into custody;

e. how and when the patient's nearest relative should be informed. In almost all cases the patient's nearest relative should be informed immediately the patient goes absent without leave and any exceptions to this requirement should be clearly set out in the policy;

f. the action that should be taken in the case of someone received into guardianship who is absent without leave from the place where he or she is required to reside. This should include immediate notification of the specified guardian and the local social services authority.

Chapter 22 Duties of the Hospital Managers

22.1 The Hospital Managers have a central role in operating the provisions of the Act. In England ~~and Wales,~~ in general, NHS Hospitals are owned by NHS trusts, NHS foundation trusts and PCTs. For these hospitals the Trusts themselves are defined as the "managers" for the purposes of the Act. ~~But the three special hospitals are owned by the Secretary of State and Hospital Managers' functions are exercised on behalf of the Secretary of State by the Special Health Authorities which have been set up to manage those hospitals as Special Hospital Authorities.~~ The case of a ~~mental nursing home~~ an independent hospital the person or persons in whose name the home is registered are managers for the purposes of the Act**.**

22.2 It is the Hospital Managers who have the ~~power~~ authority to detain patients who have been admitted under the Act. They have the key responsibility for seeing that the requirements of the Act are followed. In particular they must ensure that patients are detained only as the Act allows, that their treatment and care accord fully with its provisions, and that they are fully informed of, and are supported in exercising, their statutory rights. Hospital Managers are also required to ensure that a patient's case is dealt with in line with other statutory legislation which may have an impact, for example the Human Rights Act 1998, The Race Relations Act, Disability Discrimination Act 1995, or the Data Protection Act 1998.

22.2(a) For patients placed on SCT the Hospital Managers are those of the responsible hospital, that is, where the patient was detained immediately before going onto SCT, or to which responsibility for the patient has subsequently been assigned

22.3 The main responsibilities which the Act confers on the Hospital Managers are set out in paras 22.7- 22.16. More detailed guidance is given in the relevant chapters of the Code. The exercise of the Hospital Managers' powers to discharge patients is dealt with in Chapter 23.

Exercise of the Hospital Managers' functions

22.4 ~~The Trust or Hospital Authority~~ NHS bodies may find it useful to appoint a committee or sub- committee to undertake the Hospital Managers' functions. Regulations permit NHS trusts and PCTs (but not NHS foundation trusts) to delegate functions to committees or sub-committees whose members need not be directors of the trust. ~~.who are The legislation allows such a committee to be made up of Directors of the Trust or Hospital Authority, or outside people, or a mixture of the two~~. The Trust ~~or Hospital Authority~~ retains the ultimate responsibility for the performance of the Hospital Managers' duties, and in view of this the committee should, where possible, include members of the ~~Trust or Hospital Authority~~ Board. The committee should report formally to the Board with an account of its activities not less than once a year.

Most of the Hospital Managers' responsibilities may be delegated to officers ~~of the body Trust or Hospital Authority~~ but the power to discharge patients may only be delegated in accordance with Section 23. The Hospital Managers retain responsibility for the performance of all delegated duties and must ensure that those acting on their behalf are competent to undertake them.

~~22.5 The Trust or Hospital Authority retains the ultimate responsibility for the performance of the Hospital Managers' duties, and in view of this the committee should, where possible, include members of the Trust or Hospital Authority Board. The committee should report formally to the Board with an account of its activities not less than once a year.~~ Trusts must ensure that all those appointed to exercise the Hospital Managers' functions are properly informed about the working of the Act and receive suitable training in their role (this should include training in how to assess risk and comprehend a risk assessment report). Such appointments should be made for a fixed period and any reappointments should be preceded by a review.

22.6 For detained patients placed in an independent hospital ~~mental nursing home~~ under a contract with a Trust, the Trust committee which is appointed to undertake Hospital Managers' functions should also monitor the way those functions are performed by the managers of the independent hospital ~~mental nursing home~~.

Specific duties

Admission

22.7 It is the Hospital Managers' duty to ensure that the grounds for admitting the patient are valid and that all relevant admission documents are in order. Any officer to whom the responsibility is delegated must be competent to make such a judgment, and to identify any error in the documents which may require rectification. Guidance on the receipt, scrutiny and rectification of documents is given in chapter 12 ~~of the Code and paras 44- 54 of the Memorandum.~~

22.8 Where a patient is admitted under the Act following an application by his or her nearest relative, the Hospital Managers should request the relevant local social services department to provide them with the social circumstances report required by section 14.

Transfer between hospitals

22.9 Section 19 of the Act, and the regulations [Regulations 7 and 9 of the Mental Health (Hospital, Guardianship and Consent to Treatment) Regulations 1983 (S. I. 1983 NO. 893) amended by the Mental Health (Hospital, Guardianship and Consent to Treatment) (Amendment) Regulations 1996 (S. I. 1996/540)] made under it allow the Hospital Managers to transfer a detained patient from one hospital to another

22.9(a) Transfers are potentially an interference with a patients family life and should always be justifiable i.e. made for valid reasons. Officers to whom this responsibility is delegated must ensure that consideration is always given to the reasons for the transfer and that the needs and interests of the patient have been considered. Valid reasons for transfer might be clinical for example the need for the patient to be in a more suitable environment or in a specialist facility, it could also be to move the patient closer to home or some other place at the request of the patient or a relative or to return 'out of area' patients to their home areas when this would be in the best interest of the patient. ~~and that The needs and interests of the patient have been fully considered~~. For restricted patients, the Hospital Managers' power is subject to the prior agreement of the Home Secretary. It is important to explain the reasons to the patient and where appropriate, family or friends, and to record the reasons.

22.9(b) Section 19A provides for responsibility for patients on SCT to be assigned to another hospital, in circumstances [to be] set out in regulations. Section 17F of the Act and the regulations made under it allow the Hospital Managers to transfer a patient on SCT who has been recalled to hospital from one ~~-~~hospital to another

Responsibilities under SCT

22.9(c) When a Responsible clinician indicates that SCT is in view for a patient it is the responsibility of the Hospital managers to liaise with the relevant authorities, usually the PCT and the Local Authority, to ensure arrangements are put in place for suitable aftercare services in line with the specifications draw up by the multidisciplinary team.

22.9(d) When a patient is recalled from SCT they may only be detained for a maximum of 72 hours. It is the responsibility of the Hospital Managers to ensure that no patient is detained on recall for longer than 72 hours without having their community treatment order revoked.

Arrangements should be put in place to ensure that the time of recall is recorded and the length of stay monitored. The Hospital Manager also has a duty to ensure a patient is referred to the MHRT as soon as is practical if their community treatment order is revoked.

Discharge

22.10 Section 23 provides for the responsible clinician ~~rmo~~ to discharge a detained patient or an SCT patient by giving an order in writing. The Hospital Managers should ensure that a suitable form is available upon which this order can be given and that it is received and acknowledged by someone authorised to receive and scrutinise documents on their behalf.

22.10(a) Because responsible clinicians have the power to discharge patients, they must keep under review the appropriateness of exercising that power. If at any time, a responsible clinician concludes that the criteria which would justify renewing the patient's detention or extending the patient's CTO (as the case may be) are not met, the responsible clinician should exercise the power of discharge. It is neither necessary nor appropriate to wait until the Act requires the responsible clinician to examine the patient with a view to deciding whether to furnish a report under section 20 or 20A (as the case may be).

22.11 The exercise of the Hospital Managers' own powers to discharge patients is dealt with in Chapter 23 below.

Information for health and local authorities

22.12 Where a Tribunal hearing has been arranged, the Hospital Managers should inform health and local authorities so that they are able to consider the need for a section 117 care planning/Care Programme Approach meeting before the Tribunal takes place and, if necessary, provide a report to the Tribunal. (see para 27.7) and chapter 23A on MHRT.

Information for patients and relatives

22.13 Sections 132 and 133 require the Hospital Managers to give certain information to detained patients and their relatives. Guidance on the exercise of this duty is given in Chapter 14.

Correspondence of patients

22.14 Section 134 allows the Hospital Managers to withhold outgoing mail from detained patients if the addressee has requested this in writing to the Hospital Managers, the patient's responsible clinician ~~rmo~~ or the Secretary of State. The fact that mail has been withheld must be recorded in writing and the patient must be informed.

22.15 The Hospital Managers of the special hospitals have wider powers under section 134 to withhold both incoming and outgoing mail from patients in certain circumstances. This is subject to review by the Mental Health Act Commission. The Hospital Managers of the special hospitals should have a written policy for the exercise of these powers which should be discussed with the Commission.

Access to Mental Health Review Tribunals

~~22.16 If a patient, or the patient's nearest relative, does not exercise his or her right to apply to a Mental Health Review Tribunal, section 68 requires the Hospital Managers to refer a patient's case to the Tribunal.~~

22.16(a) Hospital managers are under a duty to refer cases to the MHRT where a patient has not exercised his right to apply for a tribunal (or been referred by the Secretary of State or the Hospital Manager), within the first 6 months of his detention (or subsequent SCT). This does not include any applications made under s2. Where a patient has applied in the first 6 months for a MHRT hearing but has withdrawn the application, it should not be treated or recorded as an

application, and the patient should therefore still be referred

22.16(b) Hospital managers are required to refer a patient's case to the MHRT if three years (or if the patient has not attained the age of sixteen years, one year) have passed since the last MHRT hearing and a patient has not applied for a tribunal. This provision covers patients on hospital orders as well as patients on s.3 and SCT (or even s2). Managers do not have to refer a patient who is AWOL until they return.

22.16(c) When a patient's supervised community treatment order is revoked the Hospital Managers must refer the patient's case to the MHRT as soon as possible.

Referrals by the Secretary of State for Health

22.16(d) The Secretary of State may at any time refer the case of a Part 2 or unrestricted Part 3 patient to the MHRT. Anyone may request such a referral and the Secretary of State will consider each such request on its merits.

22.16(e) Hospital managers should always consider making such a referral in the case of patients whose detention under section 2 is extended pending a decision of the county court under section 29 (appointment of acting nearest relative) where the patient in question is for any reason unable to make a request. If the patient's case has not already been considered by the MHRT – or a significant period has passed since that hearing - Hospital Managers should consider making a request as soon as the detention is extended. A failure to do so could result in a breach of the patient's rights under the Human Rights Act 1998.

Information to be included in Referrals made by the Hospital Managers

22.16 (f) A referral to the MHRT made by the Hospital Managers should include a statement containing the information about the patient that is set out in Schedule 1 to the MHRT Rules. In the case of a restricted patient, this information must also be sent to the Home Secretary, and he must send the MHRT a statement of any further information relevant to the application that is available to him. Either statement, or any part of it, may be withheld from the patient if its disclosure would adversely affect the health or welfare of the patient or others.

~~a. when six months have elapsed since the patient was admitted under section 3 or transferred from guardianship under section 19 if the patient has not applied for a Tribunal during the first six months (this does not apply to patients admitted under a hospital order or transferred from prison to hospital); and~~

~~b. at the time when the patient's detention is renewed if he or she has not then had a Tribunal review for three years or more; this applies also to unrestricted patients admitted under a hospital order or prison transfer direction.~~

~~The reference should be made within one week of the patient's detention being renewed.~~

~~22.17 The Hospital Managers should ensure that a patient who wishes to apply to a Tribunal is given all necessary help with his or her application.~~

~~22.18 The Hospital Managers should ensure that when a Tribunal hearing has been arranged officers of the Trust provide reports (including any reports about after- care) to the Tribunal within the time limits set in the Tribunal rules.~~

Chapter 23 The Hospital Managers' power of discharge (section 23)

23.1 Section 23 gives the Hospital Managers (see para 22.1) the power to discharge an unrestricted patient from detention or SCT. Discharge of a restricted patient requires the consent of the Home Secretary. The power may be exercised on behalf of the Hospital Managers by three or more members of a committee or sub- committee formed for that purpose, or (in the case of an NHS foundation trust) three or more people appointed for the purpose. ~~In the case of a Trust or Hospital Authority the committee or sub-committee must not include any~~ In NHS bodies the people concerned must not be employees (or in the case of NHS trusts, officers~~)~~ ~~or officer of the Trust or Hospital Authority concerned.~~ of the body concerned.

Principles

23.2 The legislation does not define either the criteria or the procedure for reviewing a patient's detention. However, the exercise of this power is subject to the general law and to public law duties which arise from it. The Hospital Managers' conduct of reviews must satisfy the fundamental legal requirements of fairness, reasonableness and lawfulness:

a. they must adopt and apply a procedure which is fair and reasonable;

b. they must not make irrational decisions, that is, decisions which no body of Hospital Managers, properly directing themselves as to the law and on the available information, could have made; and

c. they must not act unlawfully, that is, contrary to the provisions of the Act, any other legislation and any applicable regulations.

Review panels

23.3 The ~~Trust or~~ NHS body concerned retains the final responsibility for the proper performance of the Hospital Managers' duties in considering whether or not patients should be discharged. To reflect this the review panel should, if possible, include a non- executive member of the Board. The panel must have at least three members. The Board must ensure that all those appointed to this role are properly informed and experienced and receive suitable training (see also para 22.5).

23.4 The person or persons registered in respect of an independent hospital ~~mental nursing home~~ (see para 22.1) retain final responsibility for the performance of the Hospital Managers' duties in considering whether or not patients should be discharged. They may delegate their discharge function to a committee or subcommittee. It is desirable that detention is reviewed by people who are neither on the staff of the home nor have a financial interest.

23.5 ~~Mental nursing home~~ Independent Hospital Managers, and NHS bodies ~~Trusts and Health Authorities~~ should, where possible, cooperate over exercising their respective functions in relation to the discharge of patients detained in independent hospitals ~~mental nursing homes~~.

When to review

23.6 The Hospital Managers should ensure that all patients are aware that they may seek discharge by the Hospital Managers and of the distinction between this and their right to a Mental Health Review Tribunal hearing.

23.7 The Hospital Managers may undertake a review at any time at their discretion, but they must review a patient's detention when the ~~rmo~~ responsible clinician submits a report under section 20(3) renewing detention or section 20A(d) renewing SCT. Such reports should normally be submitted not less than two weeks before the current period of detention or SCT expires, to enable the review to take place as close as possible to the expire date.

23.8 The Hospital Managers must consider holding a review: a. when they receive a request from a patient; b. when the ~~rmo~~ responsible clinician makes a report under section 25(1) opposing a nearest relative's application for the patient's discharge.

23.9 However ~~The~~ Hospital Managers should consider carefully whether it is appropriate to hold a review ~~in the case of patients detained for treatment~~, if there has been a ~~review in the last 28 days~~ recent review and there is no evidence that the patient's condition has changed or a Mental Health Review Tribunal hearing is ~~due in the next 28 days~~ either due soon or has been held recently.

23.10 In the cases covered by para 23.8a and b above the patient, or nearest relative, will be actively seeking his or her discharge. In the case where the ~~rmo~~ responsible clinician submits a report renewing detention or extending SCT, the Hospital Managers are under a statutory obligation to consider the renewal or extension even if the patient does not object to it. The procedures adopted ~~need to~~ may differentiate "uncontested" renewals from reviews where detention is contested by the patient (see paras 23.13- 23.19).

Criteria

23.11 The Act does not define specific criteria to be applied by the Hospital Managers when considering the discharge of a patient who is detained or liable to be detained or recalled. The essential yardstick in considering a review application is whether the grounds for ~~admission or~~ continued detention or continued SCT under the Act are satisfied. To ensure that this is done in a systematic and consistent way the review panel should consider the following questions, in the order stated:

- Is the patient still suffering from mental disorder?
- If so, is the disorder of a nature or degree which makes treatment in a hospital appropriate, or in the case of a patient on SCT, which makes treatment while liable to recall appropriate?
- Is detention in hospital still necessary in the interests of the patient's health or safety, or for the protection of other people, or in the case of a patient on SCT, is liability to recall still necessary in the interest of the patient's health and safety or for the protection of other people?
- in the case of a patient detained under section 3 (or its equivalent) or subject to SCT, is appropriate medical treatment available for the patient ?

If the panel is satisfied from the evidence presented to them that the answer to any of these questions is "no", the patient should be discharged

23.12 In cases where the ~~rmo~~ responsible clinician has made a report under section 25(1), (and the nearest relative hasn't applied to the tribunal for a review) the managers should not only consider the three questions above but also the following question:

- Would the patient, if discharged, be likely to act in a manner dangerous to other persons or to him or herself? [R v Riverside Mental Health NHS Trust ex parte Huzzey [1998]]. This question focuses on the probability of dangerous acts, such as causing serious physical injury, not merely the patient's general need for safety and others' general need for protection: it provides a more stringent test for continuing detention. If, on consideration of the report under section 25(1) and other evidence, the managers disagree with the responsible clinician ~~rmo~~ and decide the answer to this question is "no", they should usually discharge the patient. The managers should ensure that a full risk assessment is carried out when considering discharge.

23.12(a) When exercising their discretion in respect of patients who are liable to be detained,

both the Hospital Managers and the responsible clinician should always bear in mind that detention under the Act (including recall from SCT) will be incompatible with Article 5 of the Convention, and therefore unlawful under the Human Rights Act 1998 unless it complies with the so-called "Winterwerp" criteria, namely that

- except in emergency cases, a true mental disorder has been established by objective medical expertise (Approved clinicians who are not registered medical practitioners are still capable of establishing a true mental disorder through objective medical expertise.)
- the mental disorder is of a kind or degree warranting compulsory confinement
- the validity of continued confinement depends on the persistence of such a disorder.

Scrupulous adherence to the requirements of the Act and the guidance in this Code should prevent any such breach.

Conduct of reviews - where detention or SCT is contested

23.13 The review should be conducted so as to ensure that the case for discharging, or continuing to detain or continuing with an SCT order, the patient is properly considered against the above criteria and in the light of all relevant evidence. This means that the review panel needs to have before it sufficient information about the patient's past history of care and treatment, and details of any future plans. The main source of this will be the patient's CPA documentation or care plan. It is essential that the panel is fully informed about any history of violence or self- harm, and ~~any~~ that a risk assessment ~~which has been~~ is conducted.

23.14 In advance of the hearing the review panel should obtain written reports from the patient's ~~rmo~~ responsible clinicians and others who are directly involved in the patient's care such as the key worker, named nurse, care coordinator, social worker and clinical psychologist. The patient should receive copies of the reports unless the Hospital Managers are of the opinion that the information disclosed would be likely to cause serious harm to the physical or mental health of the patient or any other individual. The patient's nearest or most concerned relatives, and any informal carer should be informed of the review, if the patient consents. Relatives and carers may be invited to put their views to the panel in person. If the patient objects to this a suitable member of the professional care team should be asked to include the relatives' and/ or carer's views in his or her report.

23.15 The report submitted by the ~~rmo~~ responsible clinician should cover the history of the patient's care and treatment and details of his or her CPA or care plan, including all risk assessments. Where there is a responsible clinician ~~rmo~~ report under section 20, 20A or 21B (as the case may be) renewing detention (Form 30) the panel should also have a copy of it before them. This should be supplemented by a record of the consultation undertaken by the responsible clinician ~~rmo~~ in accordance with section 20(5). The written reports should be considered by the panel alongside the documentation compiled under the CPA.

23.16 The procedure for the conduct of the hearing is for the Hospital Managers to decide, but generally it needs to balance informality against the rigour demanded by the importance of the task. Where a patient is being treated in the community, consideration should be given as to the most appropriate venue to meet the patients needs.

Key points are:

- The patient should be given a full opportunity, and any necessary help, to explain why he or she wishes to be discharged.
- The patient should be allowed to be accompanied by a friend or representative of his or her own choosing to help in putting his or her point of view to the panel.

- The responsible clinician ~~rmo~~ and other professionals should be asked to give their views on:
    - whether the patient's continued detention or continued SCT order is justified; and
    - the factors on which those views are based.
- The patient and the other parties to the review should, if the patient wishes it, be able to hear each other's statements to the panel and to put questions to each other. However the patient should always be offered the opportunity of speaking to the panel alone.

23.17 While the panel must give full weight to the views of all the professionals concerned in the patient's care its members will not, as a rule, be qualified to form clinical assessments of their own. If there is a divergence of views about whether the patient meets the clinical grounds for continued detention, especially in relation to matters such as risk assessment, the panel should consider an adjournment to seek further medical or other professional advice.

23.18 In applying the criteria in para 23.11 and 23.12, and deciding in the light of them whether or not to discharge the patient, the panel needs to consider very carefully the implications for the patient's subsequent care. The multi disciplinary team should consider whether a care planning meeting would be appropriate prior to any hearing. The presence or absence of adequate community care arrangements may be critical in deciding whether continued detention is necessary in the interests of the patient's health or safety or for the protection of others. If the panel conclude that the patient ought to be discharged but arrangements for after- care need to be made, they may adjourn the panel, for a brief period, to enable a full CPA/ care planning meeting to take place.

Decision

23.19 The Hospital Managers' decision following the review, and the reasons for it, should be recorded. The decision should be communicated immediately, both orally and in writing, to the patient, to the nearest relative with the patient's consent, and to the professionals concerned. At least one of the members of the panel should offer to see the patient to explain in person the reasons for the decision. Copies of the papers relating to the review, and the formal record of the decision, should be placed in the patient's records.

Uncontested renewals

23.20 If a patient's detention or SCT is renewed or extended under section 20, 20A or 21B (as appropriate), and the patient has indicated that he or she does not object to this, the review panel should meet to consider the papers and should interview the patient and his or her key worker. If the panel then agree that the patient should not be discharged the review can be concluded and the outcome recorded in the patient's records.

CHAPTER 23A – THE MENTAL HEALTH REVIEW TRIBUNAL

Purpose of the MHRT

23A.1 'The MHRT is the statutory body responsible for hearing statutory appeals against liability to detention or recall. Tribunal panels include legal members, medical members and non-legal members who are required to have some special expertise. At a tribunal hearing there will be at least one doctor, lawyer and third member, and the legal member will be the chair.'

Informing Patient and Nearest Relative of rights to apply to the MHR

23A.2 On admission to hospital, whenever their detention or supervised community treatment is renewed, and whenever their status under the MHA changes (eg from SCT to s3 patient) the Hospital Managers must ensure that patients are given information about their rights to apply to the MHRT and their entitlement to free legal advice and representation.

23A.3 Practitioners should inform the patient of their right to represent their own case to a MHRT, and their right to representation by someone else. Local protocols should be developed to ensure that staff are available to help patients make an application, this is especially important for SCT patients who may not have daily contact with practitioners. (for further information see Hospital managers chapter 22)

23A.4 Where a patient wishes to apply to the MHRT but is unable to do so, for example where they are unable to write, it is acceptable for someone else to make a written application on their behalf. There is no requirement for specific information to be included in an application. In fact a patient need only state that they want to make an application for it to be treated as such.

The memorandum provides details of when a patient or their nearest relative can make an application to the tribunal. (Paragraph X of memorandum)

23A.5 An application and accompanying documents can be faxed or emailed, and will be treated as having been signed if the document bears any form of signature. It is good practice for Mental Health Act administrators to ask for a confirmation email so that there is certainty that an application was received.

Response to Applications made by Patient or Nearest Relative

23A.6 When it receives an application the MHRT sends notice of it to the patient, the Hospital Managers, and to the Home Secretary (if the patient is a restricted patient), and to the applicant if it is someone other than the patient.

23A.7 The Hospital Managers have a legal duty to send a statement to the MHRT secretariat within 21 days of being notified of a hearing. The Statement must contain the information about the patient (as set out in Schedule 1 to the MHRT Rules). Hospital managers should avoid any delay in informing the multidisciplinary team of the hearing. In the case of a restricted patient, the report must also be sent to the Home Office, and the Home Secretary who will send the MHRT a statement of any further information relevant to the application that is available to him

Reports

23A.8 It is important that key information is available in good time for any MHRT hearing. Missing, out of date or inadequate reports can lead to adjournments or unnecessarily long hearings which can disrupt the patient and their family and tie up valuable professional time. Where clinicians, social workers or other healthcare professionals are required to provide reports, they should do this promptly and certainly within the statutory timescale. Where those responsible for providing a report have failed to do so, the MHRT may direct that they do so by using a

subpoena to compel attendance.

23A.9 It is the responsibility of the detaining authority to present the tribunal with sufficient evidence to support their decision to treat a patient using the Mental Health Act. The reports form the backbone of this evidence. Care should be given to ensure that all information is as up to date as possible and the necessary information is contained within the report to justify the decision to continue to treat under the Act. Where information is 'hearsay' it should be stated as such. In order to support the tribunal in making its decision all information should be clear and concise.

23A.10 The responsible clinician should provide an up-to-date medical report, prepared for the MHRT, including the relevant medical history and a full report on the patient's medical condition. The report should include details of the patient's previous Tribunal hearings including the decisions reached and the reasons given, details of any leave of absence granted to the patient during the previous two years, and details of any periods of supervised community treatment. All reports regarding detained patients should contain an explanation of why SCT is not considered appropriate for the patient.

23A.11 The social circumstances report should include up-to-date information on the patient's home and family circumstances (including the attitude of the patient's nearest relative). The patient's cultural circumstances should be addressed and should underpin any considerations in the report. It should also consider the financial circumstances of the patient, their opportunities for employment or occupation and the housing facilities which would be available to the patient if discharged. If community support and relevant medical facilities are available it should be noted in the report. If the patient is subject to supervised community treatment or conditional discharge the report should cover their progress in the community. The report should where possible be written by the professional with the best knowledge of the patient's social circumstances.

23A.12 If a MHRT feels it needs more information on any report it may request it, either in the form of a supplementary report or by its questioning of a witness at the hearing itself. If the author of a report prepared for the MHRT is aware of information they do not want the patient to see, they should place that information in a separate addendum and say why it should not be disclosed. The MHRT may order that any such information be disclosed to the patient or withheld from them. In order to ensure fairness to the patient, the default position will be disclosure. It will be for anyone who opposes disclosure to establish why it would have an adverse effect.

Reports should be sent to the appropriate MHRT office, and they may be sent by post, fax or email.

23A.13 Sometimes the MHRT will not sit immediately after receiving the report. In these circumstances the report writers should consider whether anything in the patient's circumstances have changed and produce a concise update to the report . This is especially important if the patient's criteria for detention change, for example if a patient is placed on a CTO or is detained under a section 3 from a s2. Any pending application will need to consider under the new circumstances of the case and the report will need to provide a justification for continued detention or liability to recall under the new circumstances. The MHRT may ask the author of the reports to talk to their report, so it is good practice for the authors to re-familiarise themselves with the content of any report before the hearing.

23A.14 The Hospital Managers must notify the MHRT immediately of any events or changes that might have a bearing on MHRT proceedings, for example where a patient is discharged or one of the parties is unavailable

23A.15 An application may be withdrawn by the person who made it at any time provided that the request is made in writing and the MHRT agrees. The application will also be considered to

be withdrawn if the patient ceases to be treated under the Act. A patient cannot withdraw a referral made by the Hospital Managers, the Home Secretary, the Welsh Ministers or the Secretary of State for Health.

23A.16 A party to MHRT proceedings may amend or supplement their application or statement at any time. However, once they have been notified of the hearing date, they will require the permission of the MHRT to do so, and such permission may be subject to conditions such as the payment of costs and expenses

Hospital managers Referrals

23A.18 The Hospital managers have various duties to refer a patient to the MHRT. These are detailed in chapter 22 above.

Medical Examination

23A.19 At any time before the hearing of the application, the medical member of the tribunal will examine the patient. Practitioners must ensure that the medical member can see the patient in private and examine all his medical records.

Independent Report

23A.20 A patient may commission an independent report on their medical condition or social circumstances if they wish to do so.

The Hearing:-

Accommodation for Hearings

23A.21 The managers of a hospital in which a MHRT hearing is to be held should provide suitable accommodation for that purpose. The hearing room should be private, quiet, clean, and adequately sized and furnished. It should not contain confidential information about other patients. If the room is also used for other purposes care should be taken to ensure that any equipment (such as a video camera or a two-way mirror) would not have a disturbing effect on the patient.

23A.22 The patient should have a separate room in which to hold any private discussions that are necessary, e.g. with his representative, as should the MHRT members so that they can discuss their decision.

23A.23 Where a patient is being treated in the community the Hospital Managers should consider whether a hospital venue is appropriate. They may wish to discus alternatives with the outreach team or the MHRT secretariat.

Translation and Interpretation

23A.24 Where necessary, the MHRT can and will provide free-of-charge, translation and interpretation services for the patient and their representatives involved in tribunal proceedings. Where the patient or their representatives are hard of hearing or have speech difficulties, or both, the tribunal can and will provide such services of sign language interpreters, lip speakers or palantypists as may be necessary. The Hospital Managers should inform the MHRT well in advance if they think any such services might be necessary.

Attendance at Hearings

23A.25 It is not obligatory for a patient to attend their tribunal but practitioners should encourage them to attend unless they judge that it would be detrimental to their health or wellbeing to do so.

23A.26 It is important that the responsible clinician attend the MHRT, supported by other staff involved in the patient's care as appropriate, as their evidence is crucial for making the case for

the patient's detention or supervised community treatment under the Act to continue. If the MHRT is not satisfied that the conditions are met then the patient must be discharged. Wherever possible the responsible clinician, and other relevant staff, should attend for the full hearing so that they are aware of all the evidence made available to the MHRT and the MHRT's decision and reasons.

23A.27 The responsible clinician can attend the hearing solely as a witness or as the nominated representative of the detaining authority. As a representative of the detaining authority the responsible clinician has the ability to call and cross examine witnesses and to make submissions to the MHRT. However this may not be desirable where it is envisaged that the responsible clinician will have to continue working closely with a patient. Hospital Managers should therefore consider whether they want to send an additional person to represent their interests, allowing the responsible clinician to appear solely as a witness. The responsible clinician should be clear in what capacity he is attending the MHRT and understand the implications of his response, as he may well be asked by the panel.

Conducting a Hearing

23A.28 The MHRT must conduct the hearing in the manner it considers most suitable. It will try to ensure that the proceedings are flexible and informal.

23A.29 The remit of the tribunal is to determine whether the criteria for detention or SCT are met and whether the patient should be discharged. They will therefore need to consider the appropriateness of the treatment plan, but in doing so it is not their role to challenge every aspect of the clinician's decision on specific medical treatment.

23A.30 Where the MHRT is not satisfied that the criteria for continued detention or liability to recall are met it must discharge the patient. In the case of detained patients (except restricted patients) it may also recommend that the responsible clinician considers placing a patient on SCT, or transferring them to another hospital or into guardianship or giving a period of leave to help facilitate discharge in the future. Responsible clinicians should seriously consider a recommendation by the MHRT although they are not obliged to undertake the recommendation. A MHRT panel can reconsider a case where a recommendation is not acted upon.

23A.31 If, in the case of a restricted patient, the MHRT is satisfied that the conditions for detention are met it may not discharge the patient. If in the case of a restricted hospital order patient it concludes that they are not met, it may:

- order the discharge of the patient subject to conditions if it concludes that he should remain liable to recall to hospital
- order his absolute discharge(in which case any restriction order will also come to an end)
- where the applicant is a conditionally discharged patient, amend the conditions of his discharge or order his absolute discharge.

23A.32 Where a restricted patient has been transferred to hospital from prison, the Tribunal may recommend discharge but the decision on discharge is for the Home Secretary. Where he decides against discharge, the Hospital Managers must arrange the return of the patient to prison; unless the MHRT concludes that if the patient were returned to prison, the patient's mental state might come to be of a nature or degree as to warrant the provision of medical treatment to them. If that is the case, the MHRT may recommend that the patient continues to be detained in hospital. Where such a recommendation is made, the Home Secretary will refer the case to the Parole Board.

Communication of the Decision

23A.33 The MHRT will normally communicate its decision to all parties verbally at the end of the hearing. Provided it is practicable to do so and the patient wishes it, the MHRT will speak to them personally. Otherwise, the decision will be given to the patient's representative (if there is one). If the patient is unrepresented and it is impracticable to discuss matters with them after the hearing, the managers should ensure that they are told the decision as soon as practicable.

Complaints

23A.34 Complaints from users about the MHRT should be sent to the MHRT offices. The MHRT has procedures in places to deal with complaints promptly.

Further Information on MHRT

23A.35 Further information on the MHRT, including information designed for patients and family members as well as healthcare and social care professionals, can be found on their website at www.mhrt.org.uk.

Chapter 24 Complaints

24.1 Guidance on the ~~arrangements introduced in April 1996 for~~ dealing with complaints about NHS treatment and services is contained in the document ~~Complaints: Listening ... Acting... Improving. Guidance on implementation of the NHS Complaints Procedure (EL(96) 19~~) *Supporting Staff, Improving Services - Guidance to support implementation of the: National Health Service (Complaints) Amendment Regulations 2006 (SI 2006 No. 2084)* for England and the document *Complaints in the NHS A Guide to handling complaints in Wales (2004)* for Wales.~~,~~ ~~and parallel guidance issued in Wales in March 1996. All providers of NHS services have been directed under the Hospital Complaints and Procedures Act 1985 to have complaints handling arrangements in place~~

24.2 Trusts and authorities are responsible for ensuring that staff are adequately trained in the requirements and procedures of the applicable ~~new~~ system, and in dealing with complaints. Staff have the responsibly of bringing to the attention of all patients, both orally and in writing, the procedures for making a complaint through the NHS complaints system, and, in relation to detained patients, their rights to complain to the Mental Health Act Commission. If a patient is unable to formulate a complaint, he or she should be given reasonable assistance to do so by staff, including assistance in accessing advocacy where such services are available.. It is the personal responsibility of all members of staff involved in a patient's care to give such assistance where necessary.

Recording

24.3 The respective guidance on the NHS complaints systems states that as a matter of good practice complaints records should be kept separate from health records. Patients' health records should contain only information which is strictly relevant to their care and treatment.

Chapter 25 Personal searches

25.1 Managers of hospitals ~~and mental nursing homes~~ admitting patients under the Act should ensure that there is an operational policy on the searching of patients and their belongings. The policy should be based on legal advice.

25.2 The purpose of the policy is to meet two objectives which may, at least in part, be in conflict: firstly the creation and maintenance of a therapeutic environment in which treatment may take place; and secondly, the maintenance of the security of the establishment and the safety of patients, staff and the public.

25.3 The policy may extend to routine and random searching without cause, but only in exceptional circumstances, for example, where the dangerous or violent criminal propensities of patients create a self evident and pressing need for additional security. [R v Broadmoor Special Hospital Authority ex parte S [1998] COD 199]

25.4 In all cases, the consent of the patient should be sought before a search is attempted. If consent is duly given, the search should be carried out with due regard for the dignity of the individual and the need to ensure maximum privacy.

25.5 If consent is refused, the ~~rmo~~ responsible clinician for the patient should first be contacted so that any clinical objection to a search by force may be raised. If no such objection is raised, the search should proceed as set out in para 25.8.

25.6 If a clinical objection is raised by the ~~rmo~~ responsible clinician, but the person empowered to search wishes nonetheless to proceed, the matter should be referred to the medical director of the hospital for decision.

25.7 Any delay in respect of paragraphs 25.5 and 25.6 should be kept to a minimum. While the matter is being resolved, a patient should be kept under observation and isolated from other patients. The patient should be told what is happening and why, in terms appropriate to his understanding.

25.8 If a search is to proceed without consent, it should be carried out with due regard for the dignity of the individual and the need to ensure maximum privacy. The minimum force necessary should be used. A search of a patient's person should be carried out by a member of the same sex unless necessity dictates otherwise.

25.9 If items belonging to a patient are removed, the patient should be given a receipt for the items and informed where they are being kept.

Chapter 26 Visiting patients detained in hospital or independent hospitals ~~registered mental nursing homes~~

The right to be visited

26.1 All detained patients are entitled to maintain contact with and be visited by anyone they wish to see, subject only to some carefully limited exceptions. Maintaining contact with friends and relatives is recognised as an important element in a patient's treatment and rehabilitation. The decision to prohibit a visit by a person whom the patient has requested to visit or agreed to see should be regarded as a serious interference with the rights of the patient and to be taken only in exceptional circumstances. This should only occur after other means to deal with the problem have been exhausted. Any decision to exclude a visitor should be fully documented and available for independent scrutiny by the Mental Health Act Commission. Where the patient has a mental health advocate, meetings with them should be private wherever practicable.

Grounds for excluding a visitor

26.2 There are two principal grounds which may justify the exclusion of a visitor:

a. Restriction on clinical grounds

It will sometimes be the case that a patient's relationship with a relative, friend or supporter is anti- therapeutic (in the short or long term) to an extent that discernible arrest of progress or even deterioration in the patient's mental state is evident and can reasonably be anticipated if contact were not to be restricted. Very occasionally, concern may centre primarily on the potential safety of a particular visitor to a disturbed patient. The grounds for any decision by the ~~rmo~~ responsible clinician, taken after full discussion with the patient's multi- disciplinary care team, should be clearly documented and explained to the patient and the person concerned, orally and in writing.

b. Restriction on security grounds

The behaviour of a particular visitor may be, or have been in the past, disruptive to a degree that exclusion from the hospital ~~or mental nursing home~~ is necessary as a last resort. Examples of such behaviour include: incitement to abscond, smuggling of illicit drugs/ alcohol into the hospital~~,~~ ~~mental nursing home~~ or unit, transfer of potential weapons, or unacceptable aggression or unauthorised media access. A decision to exclude a visitor on the grounds of his or her behaviour should be fully documented and explained to the patient orally and in writing. Where possible and appropriate the reason for the decision should be communicated to the person concerned.

Visiting of patients by children

26.3 All inpatient mental health services must have policies and procedures relating to children visiting inpatients, as set out in *Guidance on the Visiting of Psychiatric Patients by Children* (HSC, 1999/222: LAC(99)32 to NHS Trusts. Additional guidance has been provided for high security hospitals. Mental health practitioners must consider the needs of children whose parent or relative is an inpatient – whether formal or informal – in a mental health unit, and make appropriate arrangements for them to visit if this is in the child's best interests. ~~Hospitals should have written policies on the arrangements about the visiting of patients by children, which should be drawn up in consultation with local social services authorities. Although it is important to maintain parent/child relationships, a A visit by a child should only take place following a decision that such a visit would be in the child's best interests. Decisions to allow such visits should be regularly reviewed.~~

Facilitation of visiting

26.4 The hospital ~~or mental nursing home~~ should be sufficiently flexible to enable regular visits to the patient, if he or she wishes. Ordinarily, inadequate staff numbers should not be allowed to

deter regular visiting. The facilities provided for visitors should be comfortable and welcoming, and for children, child-friendly. Consideration should be given to meeting the needs of visitors who have travelled long distances.

Other forms of communication

26.5 Every effort must be made to assist the patient, where appropriate, to make contact with relatives, friends and supporters. In particular patients should have readily accessible and appropriate day time telephone facilities and no restrictions should be placed upon dispatch and receipt of their mail over and above those referred to in section 134 of the Act.

Hospital Managers

26.6 Hospital Managers should regularly monitor the exclusion from the hospital ~~or mental nursing home~~ of visitors to detained patients.

Chapter 27 After-care

27.1 While the Act defines after- care requirements only in very broad terms, it is clear that a central purpose of all treatment and care is to equip patients to cope with life outside hospital and function there successfully without danger to themselves or other people. The planning of this needs to start when the patient is admitted to hospital as part of the CPA planning and review process.

27.2 These objectives apply to all patients receiving treatment and care from the specialist psychiatric services, whether or not they are admitted to hospital and whether or not they are detained under the Act. They are embodied in the Care Programme Approach (CPA) set out in Circular HC(90) 23/ LASSL(90) 11

The CPA was revised in the 1999 policy document The key elements of the CPA are:

- systematic arrangements for assessing ~~people's health and social care needs~~ and managing the health and social needs of people accepted into specialist mental health services;
- the formulation of a care plan which identifies the health and social care required from a variety of providers ~~addresses those needs~~;
- the appointment of a ~~key worker~~ care co-ordinator to keep in close touch with the patient and monitor and co-ordinate care;
- regular reviews and ~~if need be~~ where necessary, agreed changes to the care plan.

27.3 Section 117 of the Act requires ~~Health Authorities~~ PCT's and local social services authorities, in conjunction with voluntary agencies, to provide after-care for certain categories of detained patients. This includes patients given leave of absence under section 17 (if they would otherwise qualify when leaving hospital permanently) and patients going onto SCT. The after-care of detained patients should be included in the general arrangements for implementing the CPA, but because of the specific statutory obligation it is important that all patients who are subject to section 117 are identified and records kept of them. There is a section 117 after- care entitlement when the patient stays in hospital informally after ceasing to be detained under the Act, and also when a patient is released from prison, if they have spent part of their sentence detained in hospital. There are special considerations to be taken into account in the case of patients who are subject to restrictions under Part III of the Act (see Chapter 29). Note that section 117 provides that after-care must be provided for SCT patients throughout the period that they are subject to SCT.

27.4 NHS Managers and Directors of Social Services should ensure that all staff are aware of the CPA and related provisions. Further guidance on the discharge of mentally disordered people and their continuing care in the community is given in HSG(94) 27/ LASSL(94) 4. The relationship between the CPA, section 117 after- care and local authority arrangements for care management is more fully explained in "Building Bridges - A Guide to arrangements for inter-agency working for the care and protection of severely mentally ill people" (DH 1995).

27.5 Before the decision is taken to discharge or grant leave to a patient, or place a patient onto SCT, it is the responsibility of the ~~rmo~~ responsible clinician to ensure, in consultation with the other professionals concerned, that the patient's needs for health and social care are fully assessed and the care plan addresses them. If the patient is being given leave for only a short period a less comprehensive review may suffice but the arrangements for the patient's care should still be properly recorded.

27.6 The ~~rmo~~ responsible clinician is also responsible for ensuring that:

- a proper assessment is made of risks to the patient or other people and that plans, services and support are available to manage any risks;
- in the case of offender patients, the circumstances of any victim and their families are taken into account;
- consideration is given to whether the patient meets the criteria for ~~after- care under supervision, or under~~ guardianship (see Chapter 13 ~~and 28~~); and
- ~~consideration is given to whether the patient should be placed on the supervision register established in accordance with HSG (94)5.~~

Mental Health Review Tribunals and managers' hearings

27.7 The courts have ruled ~~[R v Ealing District Health Authority, ex parte Fox [1993] 3 All ER 170]~~ that in order to fulfil their obligations under section 117 health authorities and local authority social services authorities ~~must~~ have the power to take reasonable steps to identify appropriate after-care facilities for a patient *before* his or her actual discharge from hospital. The power must be exercised if there is a reasonable prospect of the patient being discharged In view of this, some discussion of after- care needs, including local social services authorities ~~departments~~ and other relevant professionals and agencies, should take place before ~~a~~ the patient has an Mental Health Review Tribunal or managers' hearing, so that suitable after- care arrangements can be implemented in the event of his or her being discharged and the Tribunal can be informed of what after-care arrangements might be made (see Para 22.12).

Who should be involved

27.8 Those who should be involved in consideration of the patient's after- care needs include:

- the patient, if he or she wishes and/ or a nominated representative;
- the patient's ~~romp~~ responsible clinician;
- a nurse involved in caring for the patient in hospital;
- a social worker/ care manager specialising in mental health work;
- the GP and primary care team;
- a community psychiatric/ mental health nurse;
- a representative of relevant voluntary organisations;
- in the case of a restricted patient, the probation service;
- subject to the patient's consent, any informal carer who will be involved in looking after him or her outside hospital;
- subject to the patient's consent, his or her nearest relative; ~~[There are special considerations governing consultation with the nearest relative of a patient subject to after- care under supervision: see Chapter 28]~~
- A representative of housing authorities, if accommodation is an issue.
- A mental health advocate, if the patient has one.

27.9 It is important that those who are involved are able to take decisions regarding their own and as far as possible their agency's involvement. If approval for plans needs to be obtained from more senior levels (for example, for funding) it is important that this causes no delay to the implementation of the care plan.

Considerations for after-care

27.10 Those concerned must consider the following issues:

a. the patient's own wishes and needs, and those of any dependants;

b. the views of any relevant relative, friend or supporter of the patient;

c. the need for agreement with authorities and agencies in the area where the patient is to live;

d. in the case of offender patients, the circumstances of any victim and their families should be taken into account when deciding where the patient should live;

e. the possible involvement of other agencies, eg probation, voluntary organisations;

f. the establishing of a care plan with the service user and others, based on ~~proper~~ a thorough assessment ~~and clearly identified~~ of needs, including: physical health care, day time activities or employment, appropriate accommodation, out-patient treatment, identified risks and safety issues, any parenting or caring needs, social cultural or spiritual needs, contingency plans (should the patient relapse), and crisis contact details, as well as medical and psychological support. ~~counselling, and personal support, assistance in welfare rights and managing finances, a contingency plan should the patient relapse;~~

g. liaison with, or appointment of, a CPA care co-ordinator, or equivalent, who will manage and review the care plan with inpatient staff while the patient is in hospital, and with the community team and services after discharge. ~~the appointment of a key worker (see para 27.2) from either of the statutory agencies to monitor the care plan's implementation, liaise and co- ordinate where necessary and report to the senior officer in their agency any problems that arise which cannot be resolved through discussion~~;

h. the identification of any unmet need.

27.11 The professionals concerned should establish an agreed outline of the patient's needs, taking into account his or her social and cultural background, and agree a time- scale for the implementation of the various aspects of the plan. All key people with specific responsibilities with regard to the patient should be properly identified. Once plans are agreed it is essential that any changes are discussed with others involved with the patient before being implemented. The plan should be recorded in writing.

27.12 The care plan should be regularly reviewed. It will be the responsibility of the ~~key worker~~ care co-ordinator to arrange reviews of the plan until it is agreed that it is no longer necessary. ~~The senior officer in the key worker's agency responsible for after- care arrangements should ensure that all aspects of the procedure are followed.~~

Chapter 28 After-care under supervision

[Paras 113- 140 of the Memorandum]

28.1 After-care under supervision was introduced in April 1996 by the Mental Health (Patients in the Community) Act 1995. In the introductory guidance, HSG (96) 11/ LAC(96) 8, it is referred to as "supervised discharge".

Purpose

28.2 After-care under supervision is an arrangement by which a patient who has been detained in hospital for treatment under the provisions of the Act may be subject to formal supervision after he or she is discharged. Its purpose is to help ensure that the patient receives the after- care services to be provided under section 117 of the Act. It is available for patients suffering from any of the four forms of mental disorder in the Act but is primarily intended for those with severe mental illness.

Criteria for use of supervision

28.3 The Act may be used to ensure after- care is provided for patients who; - have been detained for treatment; - need suitable after- care in respect of their mental disorder to prevent substantial risk of serious harm to themselves or other people, or of serious exploitation. 28.4 Before the patient is discharged, he or she must have a community rmo, who will be responsible for treatment after discharge. The patient must also have an identified supervisor who is a suitably qualified and experienced member of the multi- disciplinary community team. For patients living in England, the supervisor will also fulfil the role of key worker under CPA.

28.5 If a patient needs to receive after- care within a formal structure but he or she does not meet all the criteria for after- care under supervision guardianship under section 7 of the MHA 1983 (see Chapter 13) may be used.

Implementation

28.6 Before the supervision application is made the responsible Health Authority, or the service provider acting for the authority, should meet the responsible local authority and seek to agree the arrangements for providing the after- care, including the requirements to be imposed on the patient under the Act. The procedure for this needs to be agreed as part of local liaison arrangements, which should identify the officer who is to act for the local social services authority. The after- care arrangements will have to be drawn up as part of the normal discharge planning process, following the principles of the CPA in England and the Welsh Office Mental Illness Strategy (WHC(95) 40) in Wales and in accordance with the formal consultation requirements in the Act.

28.7 The rmo who makes the supervision application is responsible for consulting both the current and the proposed future care team about the arrangements for after- care and the requirements to be imposed. The rmo should ensure that agreement about a care plan is reached between all involved. Details of the after- care to be provided must be attached to the supervision application and the rmo must list the requirements to be imposed and name the supervisor and rmo.

Admission to hospital

28.8 After- care under supervision will end completely if the patient is admitted to hospital under section 3 or 37 of the Act. If the patient is admitted to hospital under section 2, or informally, the aftercare will merely be suspended: the patient temporarily ceases to receive after- care and have requirements imposed. The period of after- care under supervision will continue to run whilst the patient is in hospital and if it does not expire it will continue after discharge for the remainder

~~of the period, if any. In the case of an informal patient, if the period of after- care under supervision would expire before the expected date of discharge, the need for renewal should be considered in the normal way and any necessary action taken. In the case of a patient admitted under section 2, if the period expires before discharge it will be deemed to be extended for 28 days after discharge for the purpose of renewal. The same will apply if the period of after- care under supervision has up to 28 days to run after the discharge of a patient detained under section 2.~~

~~Further guidance~~

~~28.9 Further guidance on after- care under supervision can be found in Guidance on Supervised Discharge (After- care under Supervision) and Related Provisions which was published under HSG(96) 11/ LAC(96) 8 and WHC(96) 11 and which remains extant.~~

Chapter 29 Part III of the Act - patients concerned with criminal proceedings

Discharge and supervision

29.1 Those involved in the supervision of a conditionally discharged restricted patient should have copies of and be familiar with 'Supervision and After- Care of Conditionally Discharged Restricted Patients' ~~(HO/ DHSS~~ notes ~~of~~ for the guidance of supervising psychiatrists, revised 2003) and ~~guidance for~~ notes for the guidance of social supervisors (HO/DH/ Welsh Office guidance on the supervision and after-care of conditionally discharged restricted patients) ~~in this series updated in 1997) and Recall of Mentally Disordered Patients subject to restrictions on discharge (HSG(93) 20/ LAC(93) 9).~~

29.1(A) Reports from both the supervising psychiatrist and social supervisor must be submitted one month after the discharge has taken effect, and at regular intervals there after (usually every three months). It is very important that these reports are submitted on time. The Home Office will chase any reports which are not received by the due date.

Recall

29.2 If a conditionally discharged restricted patient requires hospital admission, the Home Office should be informed immediately. The Home Office will consider whether to recall the patient to hospital, taking into account the reasons for the admission and the likely length of admission. If the Home Office decides not to recall the patient, it will keep the admission under close review. The following considerations may be relevant: ~~it will not always be necessary for the Home Secretary to recall the patient to hospital. For example,~~

a. The patient may be willing to accept treatment informally. In these circumstances, however, care should be taken to ensure that the patient's consent is freely given.

b. In some cases it may be appropriate to consider admitting the patient under Part II of the Act as an alternative [R v North West London Mental Health Trust ex parte Stewart].

c. It may not always be necessary to recall the patient to the same hospital from which he or she was conditionally discharged. In some cases recall to hospital with a lesser, or greater, degree of security will be appropriate. However, if an urgent recall is required and no bed can be found elsewhere the Home Office may decide to recall the patient to the hospital from which he was discharged. (HO)

29.3 When a recall is being considered this should be discussed between the doctor, the social supervisor and the Mental Health Unit of the Home Office.

29.4 When a patient is recalled, the person taking him or her into custody should explain that the patient is being recalled to hospital by the Home Secretary and will be given a fuller explanation later. As soon as possible after admission to hospital, and in any event within 72 hours of admission, the ~~rmo~~ responsible clinician or deputy, and an ~~ASW~~ AMHP or a representative of the hospital management, should explain to the patient the reason for the recall and ensure, in so far as the patient's mental state allows, that he or she understands. The patient should also be informed that his or her case will be referred to a Mental Health Review Tribunal within one month.

29.5 The patient's ~~rmo~~ responsible clinician should ensure that: - the patient is given assistance to inform his or her legal adviser (if any); - subject to the patient's consent, his or her nearest relative and/or other relative or friend is told.

~~**Return to court**~~

~~29.6 All professionals concerned with ensuring the return to court of a patient on remand or under an interim hospital order should be familiar with the contents of paras 31- 33 of Home Office~~

~~circular number 71/ 1984 on the implementation of sections 35, 36, 38 and 40(3) of the Mental Health Act. When a patient has been admitted on remand or subject to an interim hospital order, it is the responsibility of the hospital to return the patient to court as required. The court should give adequate notice of the hearing. The hospital should liaise with the courts in plenty of time to confirm the arrangements for escorting the patient to and from hospital. The hospital will be responsible for providing a suitable escort for the patient when travelling from the hospital to the court and should plan for the provision of necessary staff to do this. The assistance of the police may be requested if necessary. Once on the court premises, the patient will come under the supervision of the police or prison officers there.~~

Victims

29.5A The victims of certain mentally disordered offenders have rights to information about that offender (see 29.5B below). In other circumstances mentally disordered offenders should be encouraged to share information that will enable victims and victims' families to be informed about their progress.

Domestic Violence, Crime and Victims Act 2004

29.5(B) The Domestic Violence, Crime and Victims Act 2004 ("the DVCV Act") sets out requirements to provide information to the victim(s) of an offender who:

- is convicted of a sexual or violent offence; and
- receives a restricted hospital order or a hospital and limitation direction, or who is transferred to hospital from prison under a transfer and restriction direction.

Under the DVCV Act, victims may make representations about a patient's conditions of discharge. They are entitled to receive information about whether the patient is to be subject to any conditions in the event of his discharge; to receive details of any conditions of discharge which relate to contact with the victim or his family; and, where the restriction order is to cease to have effect, to be notified of the date on which it ceases to have effect.

Contact with the victim is via the Victim Liaison Officer.

29.5(C) The definition of "victim" includes any person who appears to the local probation board to be, or to act for, the victim of an index offence. This includes a victim's family in a case where the offence has resulted in the victim's death or incapacity, and in other cases where the victim's age or personal circumstances makes it sensible to approach a family member in the first place.

The Act applies only to cases where an order or direction is made on or after 1 July 2005.

29.5(D) Further guidance is available in the note 'Duties to Victims under the Domestic Violence, Crime and Victims Act 2004: Guidance for Clinicians' (http://www.homeoffice.gov.uk/documents/duty-to-victims-guidance).

Requirements of the DVCV Act

29.5(E) The DVCV Act places a duty on the probation board to provide information to the victim, and on the Home Secretary and the Mental Health Review Tribunal to provide information to the Board. It does not place any statutory requirements on clinicians to disclose information.

29.5(F) The information whose disclosure is required under the DVCV Act relates to discharge and conditions of discharge. But there should be liaison between care teams and the VLO in each case where a victim decides that they wish to make representations or receive information under the Act.

29.5(G) Where the court makes an order or direction, the VLO will check whether the victim wishes to make representations or receive information. Where they do, the VLO will make contact with the responsible clinician for the patient concerned. Where a prisoner is transferred to hospital with a restriction direction, the Home Office will notify the relevant offender manager; the VLO concerned will then contact the responsible clinician.

29.5(H) It is for the clinical team and the VLO to decide the level of contact between them eg whether or not the VLO should attend any meetings with the team about the case. It may be helpful for the team to know the views of victim of the offence.

29.5(I) Under the Act, the probation board may also provide “such other information to the victim as the board considers appropriate in all the circumstances of the case”; this is intended to allow the probation board the discretion to give information which will reassure victims. It is not intended to lead to the disclosure of any information which is covered by patient confidentiality.

Liaison with victims outside the DVCV Act

29.5(J) The requirements of the DVCV Act relate to discharge and conditions of discharge. The following guidance, on areas not covered by the DVCV Act, may be helpful regarding the disclosure of information to the VLO.

29.5(K) The Home Office will notify the VLO where a patient is transferred to a different hospital. The VLO will then make contact with the new responsible clinician. VLOs may inform victims of the fact of transfer, on the understanding that they should not inform them of the name or location of the hospital.

29.5(L) Where the Home Office is notified that a patient has absconded, the Home Office may notify the VLO, depending on whether there is any perceived risk to the victim.

29.5(M) 29.5A Where a patient detained under Part III of the Act is both competent and willing to agree to the disclosure of specified information about his or her care, this should be encouraged to enable victims and victims' families to be informed about progress. It can be important to a patient's rehabilitation that victims understand what has been achieved in terms of modifying offending behaviour. Disclosure of such information also serves to reduce the danger of harmful confrontations after a discharge of which victims were unaware. Without prejudice to a patient's right to confidentiality, care teams should be ready to discuss with him or her the benefits of enabling some information to be given by professionals to victims, within the spirit of the Code of Practice for Victims of Crime (http://www.homeoffice.gov.uk/documents/victims-code-of-practice). The patient's agreement to do so must be freely given and he or she will need to understand the implications of agreeing to information being given to the victim (s). Care must be taken not to exert any pressure on the patients or this may bring into question the validity of the consent. If the patient is a restricted patient who has been convicted of a sexual or violent offence, the provisions of the Domestic Violence, Crime and Victims Act may apply (see above)

Chapter 30 People with learning disabilities, autistic spectrum disorders or who are Deaf

30.1 No two patients are alike, and the aim should be to ensure that services, including assessment and examination prior to decisions about use of the Act, are tailored as far as possible to the needs and wishes of each individual. However, the circumstances of certain groups of patients call for particular attention.

People with a learning disability

~~30.1 The guidance given elsewhere in the Code applies to patients with learning disabilities. This chapter gives guidance on a number of particular issues of importance to this group of patients.~~

30.2 Learning disabilities, although defined as mental disorders by the Act, share few features with the serious mental illnesses which are the most common reason for using the Act. Relatively few people with learning disabilities are detained under the Act, and where they are it is not usually because of their learning disability itself, but may well be the result of another mental disorder. ~~Where people with learning disabilities fall within the legal definition of mental disorder they may be considered for admission under section 2 and detention under sections 5, 135 and 136. Other admission sections can only be considered if the person falls within the legal definition of mental disorder impairment or severe mental impairment. But admission of a person with learning disability for treatment under the Act may also only be considered if it is associated with aggressive or seriously irresponsible conduct or if he or she also suffers from other mental health problems another form of mental disorder (for example mental illness).~~

30.4a Learning disability is defined in the Act as a state of arrested or incomplete development of mind which includes significant impairment of intelligence and social functioning. For most purposes in the Act (although not admission for assessment under section 2) a learning disability by itself does not count as a mental disorder unless it is associated with abnormally aggressive or serious. "Significant impairment" is not defined in the Act, although an IQ below 70 is an internationally agreed feature of the diagnosis of learning disability.

30.5 The identification of an individual with a learning disability ~~who falls within these legal categories~~ is a matter for clinical judgement, guided by current professional practice and subject to the relevant legal requirements. Those assessing the patient must be satisfied that he or she displays a number of characteristics; these are difficult to define in practice. The following is general guidance in relation to the key factors ~~or components of these legal categories~~ in the definition of learning disability for the purposes of the Act:

> *Incomplete or arrested development of mind.* This ~~implies~~ means that the features that determine the learning disability were present ~~at some stage~~ prior to adulthood which permanently prevented the usual maturation of intellectual and social development. It excludes persons whose learning disability derives from accident, injury or illness occurring after that point usually accepted as complete development (although such conditions do fall within the definition of mental disorder in the Act)
>
> *Significant ~~Severe or significant~~ impairment of intelligence*. The judgment as to the presence of this particular characteristic must be made on the basis of reliable and careful assessment.
>
> *Significant ~~Severe or significant~~ impairment of social functioning*. The evidence of the degree and nature of social competence should be based on reliable and recent observations, preferably from a number of sources such as social workers, nurses and psychologists. Such evidence should include the results of one or more social functioning assessment tests.

30.5a The definition encompasses people with a broad range of disabilities. *Valuing People* (the Government's March 2001 learning disability White Paper) emphasises that the presence of a low intelligence quotient, for example an IQ below 70, is not, of itself, a sufficient reason for deciding whether an individual should be provided with additional health and social care support. Valuing People advises that an assessment of social functioning and communication skills should also be taken into account when determining need. Many people with learning disabilities also have physical and/or sensory impairments and Valuing People also covers adults with autism who also have learning disabilities.

30.5b An application for admission for treatment, or for reception into guardianship may only be made on the basis of a learning disability alone where it is associated with two further features:

> *Abnormally aggressive behaviour*. Any assessment of this category should be based on observations of behaviour which lead to a conclusion that the actions are outside the usual range of aggressive behaviour, and which cause actual damage and/ or real distress occurring recently or persistently or with excessive severity.
>
> *Seriously irresponsible conduct* ~~Irresponsible conduct~~. The assessment of this characteristic should be based on an observation of behaviour which shows a lack of responsibility, a disregard of the consequences of action taken, and where the results cause actual damage or real distress, either recently or persistently or with excessive severity.

30.5c These features must also be associated with the learning disability if it is to be the basis of a remand under section 35 or 36, an interim hospital order under s38, a hospital or guardianship order under s37, a hospital and limitation direction under s45A, a transfer direction under s47 or 48, or a hospital order under s51(5).

30.5d Except where urgent action is required, no patient with a learning disability should be diagnosed as meeting these additional conditions ~~under the Act~~ ~~as mentally impaired or severely mentally impaired~~ without an assessment by a consultant psychiatrist in learning disabilities and a formal psychological assessment. This assessment should be part of a complete appraisal by medical, nursing, social work and psychology professionals with experience in learning disabilities, in consultation (where practical and appropriate) with a relative, friend or supporter of the patient.

30.5e All those involved in examining, assessing, treating or taking other decisions in relation to people with learning disability should bear in mind that there are particular issues that people with learning disabilities face:

- assumptions that they do not have capacity to make decisions for themselves and a tendency to be over-protective.
- Over reliance on family members, both for support and for decision-making. This may put families in the difficult position of having to make decisions inappropriately on behalf of the patient.
- a lack of appreciation of the potential abilities of people with learning disabilities, including their potential to speak up for themselves.
- being denied access to decision-making processes: not included in meetings about them, information made inaccessible to them, decisions made in their absence.
- limited life experiences to draw on when making choices.

- problems in understanding what is being explained to them and explaining their views. Moderate levels of anxiety may severely worsen this.

30.5f. Those working under the Act with people with learning disabilities should bear in mind the following general points.

- many people with learning disabilities are able to make their own decisions regarding medical treatment and other areas of their lives. They should be provided with the information and support necessary to do this. In law, capacity must be assumed unless there is evidence to the contrary.
- people with learning disabilities experience prejudice and discrimination in society. Care professionals should have specific skills and awareness of the issues that people with learning disabilities face.
- the needs and wishes of the person with learning disabilities in relation to the role of their family should be afforded the same importance as with any other service user.
- people with learning disabilities may have limited spoken language. Behaviour may replace language as a form of communication. It is important to recognise behaviour that is a communication (for example hitting out because they do not want to go to hospital) rather than a symptom of mental disorder.
- people with learning disabilities may have difficulties managing in environments they find new or frightening such as a medical setting. Every effort should be made to adapt to their needs in order to maximise communication.
- information should be appropriate in format and content for each service user with a learning disability, to make it both relevant and as easy as possible for the patient to understand.
- the most appropriate method of communication for each person with learning disabilities– taking into account how they receive and understand information- should be identified as soon as possible. It is helpful to identify a specific person who will undertake this task
- some people with learning disabilities may prefer to have written material in simple language with images to assist, and reinforced verbally – by personal contact, or other means such as audio tape, CD or video. It can be helpful to repeat information and keep a record of what information has been passed on and how.
- it is important to set aside sufficient time to allow for preparation of suitable information, and for preparation before meetings.
- that people with learning disability will need to be given information about their rights in a form they can understand. In the case of information about the MHRT it will need to be designed to help them understand its role. They may well need support to make an informed decision about whether and when to make an application.

30.5g The examination and assessment of mental disorder in people with learning disabilities is a specialist area. Professionals trained in the mental health of learning disability should be involved wherever practicable. In addition, the approved mental health professional (AMHP) should have training and experience in working with people with learning disabilities. Where the examiners or assessors have limited expertise with this client group it is good practice, wherever possible, to seek advice from the local specialist service, who can provide details of alternatives to compulsory treatment and give advice on good communication – but this should not be allowed to delay action that is immediately necessary. It is desirable that, during examination or

assessment, people with learning disabilities have someone with them who they know well and with whom they have good communication, provided this does not compromise the confidentiality of the examination. The potential of co-morbidity, with mental illness and personality disorder should also be kept in mind, in order that the skills of clinicians and others with appropriate expertise can be brought into play at all points in the assessment, treatment and care pathway.

~~Contact with the specialist hospital units for deafness and mental health may help to forestall deaf people being wrongly assessed as learning disabled. These procedures should also be followed, except in emergencies, where it is proposed that a patient is to be admitted under section 2 on the grounds of mental disorder.~~

Autistic Spectrum Disorders

30.6 The ~~Mental Health~~ Act's definition of mental disorder includes the full range of autistic spectrum disorders, including those existing alongside a learning disability or any other kind of mental health problem. It is possible for someone on the autistic spectrum to meet the conditions for treatment under the Mental Health Act without having any other form of mental disorder, even if it is not associated with abnormally aggressive or seriously irresponsible behaviour, but this is likely to be necessary only very rarely.

30.7 Autistic spectrum disorders are disorders occurring from early stages in development with the person showing marked deficiencies in social skills, having difficulties with transitions or changes and preferring sameness. They may be preoccupied with a particular subject of interest. These disorders are developmental difficulties and not mental illnesses in themselves. However, they may be associated with mental illness such as anxiety and mood disorder. People can become frustrated when they and/or others fail to understand each other or in particular settings and this frustration can occasionally lead to seriously irresponsible or aggressive behaviour if not properly managed. Like people with learning disabilities, it should be borne in mind people with autistic spectrum disorders may also have a personality disorder.

30.8 The examination or assessment of someone with an autistic spectrum disorder requires special consideration of how to communicate effectively with the person being assessed. Whenever possible the AMHP and doctors carrying out assessments should have experience and training in working with people with these disorders. If this is not practicable the AMHP should seek assistance from specialists with appropriate expertise - but this should not be allowed to delay action that is immediately necessary Likewise, if it is decided that the person should be detained the responsible clinician should have relevant specialist expertise. Assessment should wherever possible be part of a complete appraisal by medical, nursing, social work, occupational therapy, speech and language therapy and psychology professionals (as necessary) with relevant specialist experience.

30.9 Where appropriate, someone who knows the service user should be present at an initial examination and assessment, provided it can be done without breaching the person's confidentiality. Knowledge of the person's developmental history and normal behaviour will help prevent someone with an autistic spectrum disorder from being wrongly brought under compulsion.

30.10 A person with an autistic spectrum disorder may have additional sensory and motor difficulties which make them behave in an odd manner and which might be interpreted as a

mental illness but is in fact a coping mechanism. Eccentricity, in anyone, is not in itself a reason for compulsion.

30.11 There can also be a repetitive element to many behaviours, where though the person seems to be making a choice, their range of behaviour is very limited and potentially very harmful. Repetitive behaviour does not in itself constitute a mental disorder.

30.12 People with social and communication disorders can become mentally ill and this mental illness may need compulsory treatment. Where possible a person should be brought under compulsion in a setting which can accommodate his/her social and communication needs as well as treat the mental disorder.

30.13 A person with an autistic spectrum disorder may show a marked difference between their intellectual and their emotional development, leading on occasion to aggressive or seriously irresponsible behaviour. They may be able to discuss an action intellectually and express consent to it, or confirm a desire to not do something, but not have the emotional maturity to carry out their intentions. The therapeutic team should in these circumstances endeavour to help the person to understand their own behaviour, and work with them to minimise it. However, when the person is unable to prevent themselves from causing severe harm to themselves or others, compulsion under the Act may become necessary.

~~30.6 A person who has severe learning disabilities and lacks the capacity to make personal health care decisions may be admitted to hospital on an informal basis if he or she does not object to being an in- patient. In that case the patient's admission and care must in his or her best interests and in accordance with the common law doctrine of necessity (see paras. 2.8 and 15.21).~~

Patients who are Deaf

30.14 An AMHP or clinician examining or assessing a Deaf person should, wherever possible,have had Deaf awareness training, including basic training in issues relating to mental health and deafness. Where required they should also seek assistance from specialists with appropriate expertise in mental health and deafness. This may be available from one of the specialist hospital units for deafness and mental health. Contact with such units may, in particular, help to forestall Deaf people being wrongly assessed as learning disabled.

30.15 When a patient is being assessed with a view to an application under the Act, the AMHP should be responsible for booking and using registered qualified interpreters with expertise in mental health interpreting. Relay interpreters may be necessary, for example when the deaf person has minimal language skills or a learning disability. The use of unqualified interpreters such as family members or health professionals with only limited signing skills should be avoided wherever possible.

30.16 Preverbal deafness may cause delayed language acquisition which may in turn influence social behaviour. An awareness and knowledge of how mental health problems present in pre-verbally deaf people needs to be included in mental health assessments. Cultural issues need to be taken into account for instance in people who are pre-verbally deaf, as they have a visual perspective of the world and may consider themselves to be part of a cultural and linguistic minority. This means that they may behave in ways which are misperceived as mental illness. For

example, animated signing may be misunderstood as aggression, while touching a hearing person to talk to them may be misunderstood as an assault. Deaf people's spoken or written English may be poor, giving rise to a false assumption of thought disorder.

Chapter 31. Children and young people under the age of 18

Introduction

31.1 This chapter provides guidance to mental health professionals working with children and young people with complex mental disorders. A number of statutes make provision relating to the treatment of children suffering from mental disorder and this may lead to some uncertainty. This guidance, therefore, seeks to clarify the legal frameworks and gives practical guidance on dealing with common difficulties. The Code of Practice applies to all patients including children and young people under the age of 18 (referred to in this Chapter as children). This Chapter gives guidance on a number of issues of particular importance affecting children. There is no minimum age limit for admission to hospital under the Mental Health Act (but only a person who has attained the age of 16 can be subject to guardianship ~~or after- care under supervision~~).

The legal framework and legal advice

31.2 The legal framework governing the admission to hospital and treatment of children is complex. It is the responsibility of all professionals, local social services authorities and education authorities and Trusts to ensure that necessary information (including the Code of Practice, the Mental Health Act, the Children Act 1989 and in particular volumes 1, 4, 6 and 7 of the Children Act 1989 Guidance, and the Mental Capacity Act 2005 and the Act's Code of Practice) is available to all those responsible for the care of children. Furthermore, those using this Code of Practice should be aware of, and have access to, the National Service Framework for Children, Young People and Maternity Services Standard 9 (The Mental Health and Psychological Well-being of Children and Young People) which was issued as best practice guidance by DfES and DH in October 2004. It states that "All children and young people, from birth to their eighteenth birthday, who have mental health problems and disorders have access to timely, integrated, high quality, multi-disciplinary mental health services to ensure effective assessment, treatment and support, for them and their families".

31.3 Where it is considered necessary to require a child's residence in a particular place and/ or to require them to undergo medical treatment the choice between the Mental Health Act and the Children Act is not always easy. When considering which provisions to use it is particularly important to identify the primary purpose of the proposed intervention. For example, a seriously mentally ill child may require treatment under the Mental Health Act, whereas the needs of a behaviourally disturbed child may be more appropriately met within secure accommodation under the Children Act. Professional staff who address these questions should:

a. be aware of the relevant statutory provisions and have easy access to competent legal advice,

b. keep in mind the importance of ensuring that the child's care and treatment is managed with clarity, consistency and within a recognisable framework, and

c. attempt to select the option that reflects the predominant needs of the child at that time whether that be to provide specific mental health care and treatment or to achieve a measure of safety and protection. Either way the least restrictive option consistent with the care and treatment objectives for the child should be sought.

Guiding principles

31.4 The guidance set out in Chapter 1 applies equally to children although in the case of children there will be special considerations. In particular:

~~i children should be kept as fully informed as possible about their care and treatment, and their views and wishes ascertained and taken into account, having regard to their age and understanding. It is important to remember, including in the case of older children, that the impact~~

~~of the child's wishes on the parents or other person with parental responsibility should always be considered;~~

~~ii any intervention in the life of a child considered necessary by reason of their mental disorder, should be the least restrictive possible and result in the least possible segregation from family, friends, community and school; and~~

~~iii all children in hospital should receive appropriate education (see joint DH/ DFEE guidance - The Education of Sick Children, DFEE Circular number 12/94, DH circulars LAC(94) 10 and HSG (94) 24, May 1994).~~

a. The best interests of the child and young person must always be considered.

b. The child and young person's views, wishes and feelings should always be ascertained and taken into account having regard to their age and understanding.

c. Children and young people should always be kept as fully informed as possible, and should receive clear and detailed information concerning their care and treatment.

d. Children and young people have the right to share in making decisions about their care and treatment by expressing their views if they have any.

e. Any intervention in the life of a child or young person considered necessary by reason of their mental disorder should be the least restrictive and least stigmatising option consistent with effective care and treatment.

f. Any intervention in the life of a child and young person considered necessary by reason of their mental disorder should result in the least possible separation from family, carers, friends, community and education.

g. All children and young people should receive appropriate educational provision.

h. All children and young people should be accommodated in age-appropriate facilities.

i. The dignity of all children and young people should be respected.

j. The privacy and confidentiality of all children and young people should be respected unless it is necessary to protect them or others from significant harm. See *Working Together to Safeguard Children: A guide to inter-agency working to safeguard and promote the welfare of children* (HM Government, April 2006)

31.5 Additionally the functions of all NHS bodies and the services they contract for are subject to section 11 of the Children Act 2004, which means that they must be carried out having regard to the need to safeguard and promote the welfare of children.

31.6 Whenever the care and treatment of a child under the age of 16 is being considered, the following questions (amongst many others) need to be asked. It may also be appropriate to ask the following questions in the case of the older child:

a. Who has parental responsibility for the child? It is essential that those responsible for the care and treatment of the child always request copies of any court orders for reference on the hospital ward. These orders may include care orders, residence orders, contact orders, evidence of appointment as the child's guardian, parental responsibility agreements or orders under section 4 of the Children Act and any order under wardship;

b. If the child is living with either of the parents who are separated, whether there is a residence order and if so in whose favour. It may be necessary to consider whether it is appropriate to contact both parents;

c. What is the capacity of the child to make his or her own decisions in terms of emotional

maturity, intellectual capacity and mental state? (see Chapter 15 and paras.~~graph~~ ~~31.11~~ 31.9 & 31.13 and the Mental Capacity Act Code of Practice Chapter 12);

d. Where a parent or other person with parental responsibility refuses consent to treatment, how sound are the reasons and on what grounds are they made? Should an application to the court be considered?; and

e. Could the needs of the child be met in a social services or educational placement? To what extent have these authorities carefully considered all possible alternative suitable placements?

Emergency treatment

31.7 In an emergency situation a doctor may undertake treatment if delay would be dangerous (see para.15.25). It is good practice in that situation to attempt to obtain the consent of a parent or other person with parental responsibility. Parental consent may not be appropriate in relation to some children – because the matter is outside the zone of parental responsibility, or because the child is Gillick competent to consent or refuse treatment themselves. [Moved forward from 31.17.]

~~**Informal admission to hospital**~~

~~*Children under 16*~~

~~31.6 The parents or other person with parental responsibility may arrange for the admission of children under the age of 16 to hospital as informal patients. Where a doctor concludes that such a child has the capacity to make such a decision for him or herself (i.e. he or she is of sufficient intelligence and understanding to make that decision - that is to say Gillick competent, see paragraph 31.11) and the child objects to such admission then the consent of the person with parental responsibility may be sufficient authority to enable the child to be admitted against their wishes. Where a Gillick competent child wishes to discharge him or herself as an informal patient from hospital, the contrary wishes of any person who has parental responsibility will ordinarily prevail. In either circumstance consideration should be given to whether the use of the Act, if applicable, would be appropriate. (see also paragraph 31.13)~~

~~31.7 Where a Gillick competent child is willing to be admitted but the parents or other person with parental responsibility object, their views should be seriously considered and given due weight but their objections to such admission will not prevail.~~

~~*16 or 17 year olds*~~

~~31.8 Section 131(2) of the Act provides that any 16 and 17 year old "capable of expressing his own wishes" can admit him or herself as an informal patient to hospital, irrespective of the wishes of his or her parent or guardian. Where a 16 or 17 year old is unwilling to remain in hospital as an informal patient, consideration may need to be given to whether he or she should be detained under the Act.~~

~~31.9 Where a 16 or 17 year old is incapable of expressing his own wishes, the consent of the parents should be obtained or consideration given to the use of the Act.~~

Consent to medical treatment (see Chapters 15 and 16)

~~31.10~~ 31.8 It is normal practice in many cases in relation to the treatment of a child under 16 to obtain the consent of a parent or other person with parental responsibility as an exercise of their parental responsibility. There are circumstances, however, in which the child will decide for him or herself.

Children under the age of 16

~~31.11~~ 31.9 A "Gillick competent" child can give a valid consent to medical treatment. A child should be regarded as "Gillick competent" if the doctor concludes that he or she has the capacity to make the decision to have the proposed treatment and is of sufficient understanding and intelligence to be capable of making up his/her own mind, (Gillick v West Norfolk and Wisbech Area Health Authority and Another [1986] AC 112). ~~(Capacity is dealt with in Chapter 15, paragraph 15.9 et seq. although it is important in assessing whether a child is to be regarded as "Gillick competent" to have regard to the decision of the Court of Appeal in Re R [1992] 1FLR 190. In that case the Court of Appeal stated that "Gillick – competence" is a developmental concept and will not be lost or acquired on a day to day or week to week basis. In the case of mental disability, that disability must also be taken into account, particularly where it is fluctuating in its effect".~~ The question of competence must be assessed each time the question of treatment arises. It can be lost as well as gained. It is always in the particular context that competence is assessed.

~~31.12 The refusal of a "Gillick competent" child to be medically treated can be overridden by the courts or by their parents or other person who has parental responsibility for that child, [Re W [1992] All ER 627].~~

31.10 Where a child is not Gillick competent then it will usually be possible for a person with parental responsibility to consent to treatment on their behalf. Before relying on parental consent in relation to a child under 16 who is not Gillick competent, an assessment should be made of whether the matter is within the zone of parental responsibility (see paras. 31.28-31). A child's views should be taken into account, even if they are not Gillick competent. How much weight the child's views should be given will depend on how mature the child is. Where a child has been Gillick competent to make a decision but then loses competence any views he expressed before losing competence should be taken into account and may act as the parameters limiting the zone of parental responsibility. For example, if a child has an expressed willingness to receive one form of treatment but not another whilst Gillick competent and he then loses competence it might not be appropriate to give the treatment previously refused to the child as an informal patient even if a person with parental responsibility consents.

(Capacity is dealt with in Chapter 15, from paragraph 15.9 although it is important in assessing whether a child is to be regarded as "Gillick competent" to have regard to the decision of the Court of Appeal in Re R [1992] 1FLR 190. In that case the Court of Appeal stated that "Gillick – competence" is a developmental concept and will not be lost or acquired on a day to day or week to week basis. In the case of mental disability, that disability must also be taken into account, particularly where it is fluctuating in its effect").

~~31.13~~ 31.11 It may be appropriate to seek the assistance of the court ~~may be sought, in particular~~ in the following circumstances:

- in the case of a child who is not 16 or Gillick competent where treatment decisions need to be made and the person with parental responsibility cannot be identified or is incapacitated, for example in dealing with a child who is accommodated by a local authority;
- where a person with parental responsibility may not be acting in the best interests of the child in making treatment decisions on behalf of the child or the matter is considered to be outside the zone of parental responsibility.
- in some cases where a child is Gillick competent and is refusing treatment.

~~A child's refusal to be treated is a very important consideration in making clinical judgements and for parents and the court in deciding whether themselves to give consent. Its importance increases with age and maturity of the child.~~

~~31.14~~ 31.12 In cases involving emergency protection orders, child assessment orders, interim

care orders and full supervision orders, the Children Act specifically provides that a child may refuse assessment, examination or treatment. (See respectively Children Act section 44(8), section 43(8), section 38(6) and section 35 and Schedule 3 Part I paragraph 4(4).) However, it may be that the inherent jurisdiction of the High Court can be used to override a child's refusal, where it considers it should do so [South Glamorgan CC v W & B [1993] 18 LR 57].

16 and 17 year olds

~~31.15~~ 31.13 Section 8(1) of the Family Law Reform Act 1969 provides that the consent of a child of 16 years ~~or over may consent~~ "to any surgical, medical or dental treatment which, in the absence of consent, would constitute a trespass to his person, [and the consent] shall be as effective as it would be if he were of full age; and where a minor has by virtue of this section given an effective consent to any treatment, it shall not be necessary to obtain any consent for it from his parent or guardian. ".

~~31.16 Where a 16 or 17 year old is regarded as incapable of consenting to treatment the consent of the parents or other person with parental responsibility should be obtained. The refusal of a competent 16 or 17 year old to be medically treated can be overridden by their parents or other person who has parental responsibility for that 16 or 17 year old or by the court. Consideration should be given to whether the use of the Act, if applicable, would be appropriate.~~

31.14 Where a 16/17 year old is regarded as being unable to make a decision for himself in relation to a matter because of an impairment of, or a disturbance in, the functioning of the mind or brain, the provisions of the Mental Capacity Act will apply (see Mental Capacity Act Code of Practice) unless the treatment amounts to a deprivation of liberty in which case, see below (paras. 31.24-26).

~~Emergency treatment~~

~~31.17 In an emergency situation a doctor may undertake treatment if delay would be dangerous (see para 15.25). It is good practice in that situation to attempt to obtain the consent of the parents or other person with parental responsibility.~~ {Moved forward to 31.7.]

Treatment of Children that might involve deprivation of liberty

31.15 Determining the authority for treating a child or young person who needs treatment for mental disorder that might involve deprivation of liberty can be complicated in view of the different scenarios that can arise. In order to assist practitioners flow charts are appended after 31.26 to use in conjunction with the main text and examples are also provided at para. 31.27.

Competent children under 18

31.16 For children who are Gillick competent or aged 16 years and over, the assumption is that they are able to make their own decisions and clinicians are advised not to rely on the consent of a person with parental responsibility. As a result, children who are Gillick competent or aged 16 years and over (and have the capacity to make a decision on their health care) should be treated in the same way as adults. To put it simply, their decisions to consent to treatment or to refuse treatment should not be over-ridden by a person with parental responsibility. In theory, the High Court could overrule the child's refusal to give consent to treatment. In practice, as there is a statutory route for treating the child against his will, the Mental Health Act (with its inbuilt safeguards), it is considered unlikely that the High Court would be prepared to use its inherent jurisdiction except in very rare cases.

31.17 Where a child who is Gillick competent or is aged 16 years and over (and has the capacity to make a decision on their health care) consents to treatment they should be treated as an informal patient.

31.18 Where a child who is Gillick competent or is aged 16 years and over (and has the capacity to make a decision on their health care) decides that they do not want to consent to treatment for mental disorder, detaining the child in order to administer that treatment would amount to a deprivation of liberty and should therefore only take place if it is within the terms of the compulsory provisions of the Mental Health Act (if they meet all the conditions for it). In the rare cases where the primary issue is not the provision of medical treatment for mental disorder but the deprivation of the child's liberty, it may be appropriate to use section 25 of the Children Act. Section 25 and the Mental Health Act are not straight alternatives. Each should be used where the needs of the child would be best met by using that particular framework (see para.31.3).

Children under 16 lacking competence

31.19 For children aged under 16 years who are not Gillick competent the situation is more complex. The first matter to consider is whether the primary purpose of the intervention is to provide medical treatment for mental disorder.

31.20 If the primary purpose of the intervention is to provide medical treatment for mental disorder, the next matter to consider is whether the decision to consent to detention and/or treatment is within the zone of parental responsibility (see paras. 31.28-31), and, if so, whether the consent of a person with parental responsibility is given.

31.21 If the decision regarding the treatment of a child (including how the child is to be kept safely in one place) is within the zone of parental responsibility and consent is given by a person with parental responsibility, then it will be safe to rely on that consent and treat on that basis as an informal patient. Where it is considered that the child may be treated as an informal patient, the safeguard lies in the need for the responsible clinicians to consider whether it is safe to rely on the parent's consent using this guidance. Where it is, it is considered that it would be appropriate to respect the wishes of a person with parental responsibility as being in the best interests of the child. It would also be possible to treat on the basis of an order made by the court under its inherent jurisdiction or by way of an order made under section 8 of the Children Act.

31.22 If the decision is not within the parental zone of responsibility or parental consent is not given, the Mental Health Act should be used so long as the child meets the conditions.

31.23 In the rare cases where the primary purpose of the intervention is not to provide medical treatment for mental disorder but the intervention does require the restriction of liberty of the child, then the use of Section 25 of the Children Act should be considered. Where section 25 is used to restrict the liberty of the child, treatment may be authorised on the basis of parental consent (where they are prepared to consent to treatment but not detention) or on the basis of a court order using its inherent jurisdiction.

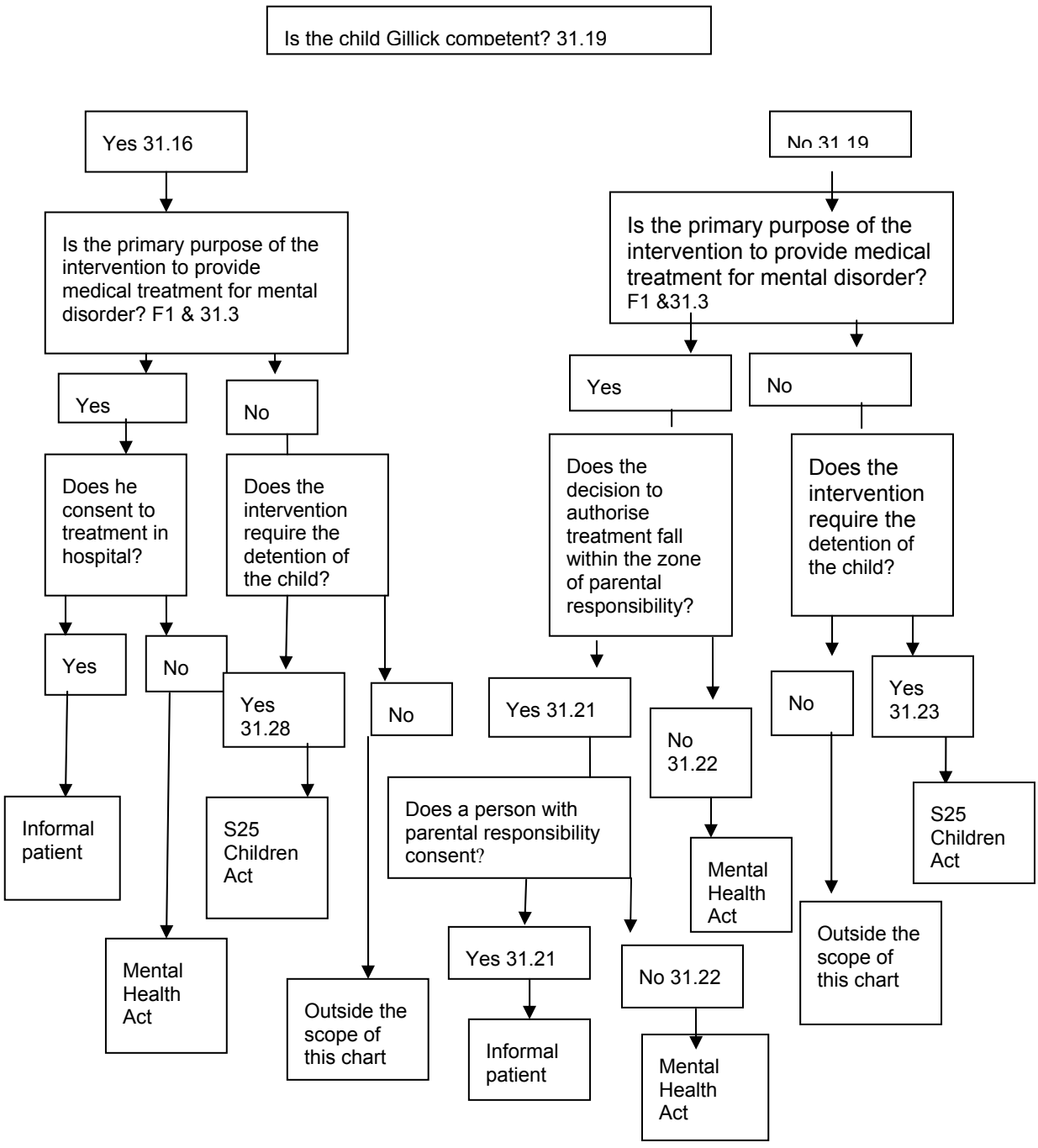
16 and 17 year olds lacking capacity

31.24 For young people aged 16 or 17 lacking capacity the situation depends on whether the primary purpose of the intervention is to provide medical treatment for mental disorder.

31.25 Where detention is required but the primary purpose is not medical treatment for mental disorder (e.g. learning disabled child requiring deprivation of liberty for their own safety or the safety of others) then an application order under section 25 of the Children Act should be considered in order to detain the child.

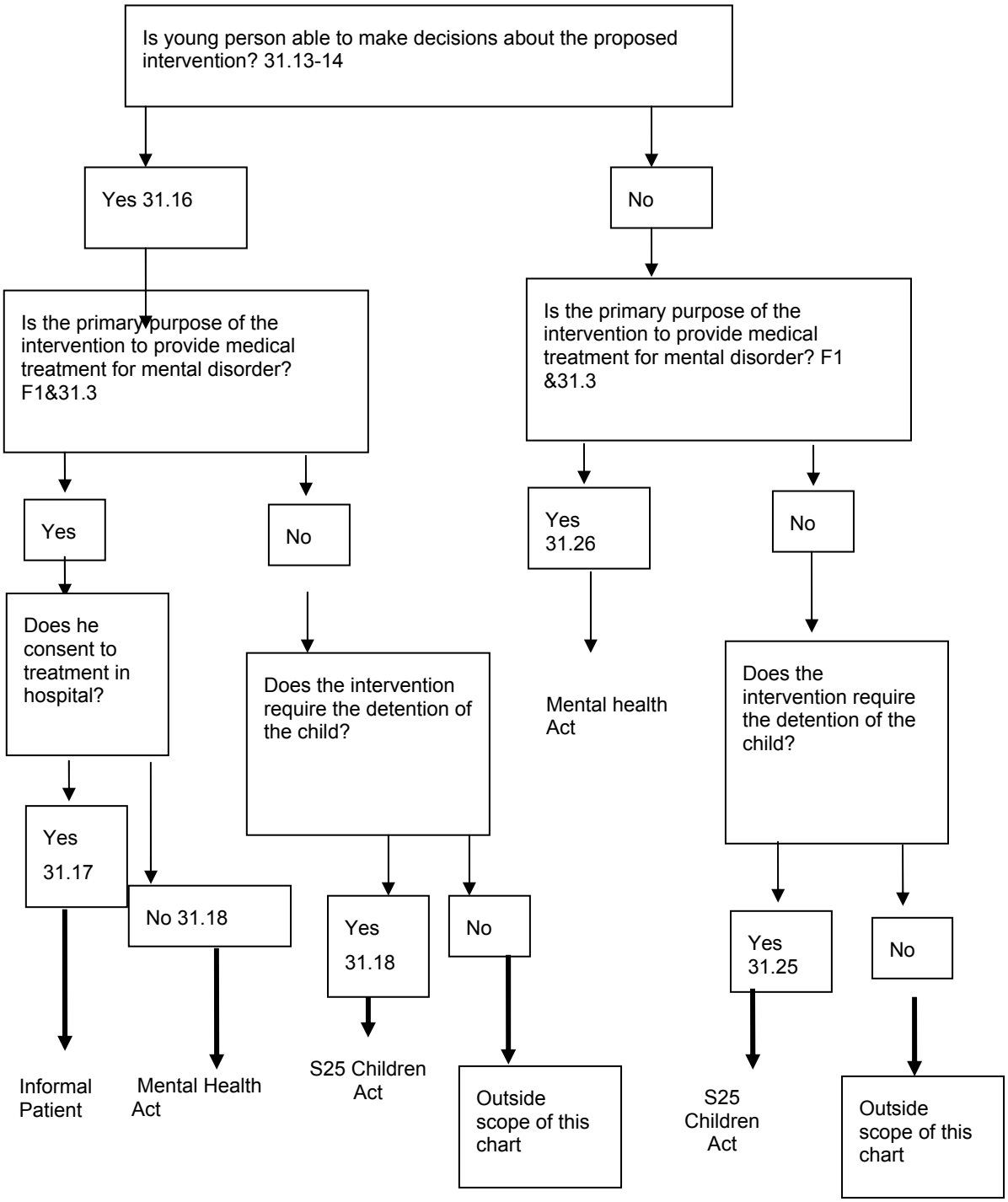
31.26 Where detention in hospital is required and the primary purpose is medical treatment for mental disorder then the Mental Health Act should be used, so long as the conditions are met.

Under 16's – decisions regarding treatment for mental disorder &/or deprivation of liberty



F1 – the treatment may be provided either as part of the assessment under Section 2 or Section 3

16/17s – decisions regarding treatment for mental disorder and/or deprivation of liberty



F1 – The treatment in question may be provided either as part of the assessment under section 2 or section 3

Examples

31.27 The following examples should be read in conjunction with the flow charts.

Example A

A 13 year old child. Assessed as not being Gillick competent. The primary purpose of the intervention is to provide medical treatment for mental disorder. The decision to authorise treatment falls within the zone of parental responsibility as what is proposed is fairly standard, but no person with parental responsibility consents. The child should be admitted to hospital for assessment (s2) or for treatment (s3) under the Mental Health Act if they meet the relevant criteria.

Example B

A 14 year old child. Assessed as not being Gillick competent. The primary purpose of the intervention is to provide medical treatment for mental disorder, but she is severely anorexic and this will involve force feeding. This is likely to take it outside the zone of parental responsibility, so even though a person with parental responsibility consents, the child should still be admitted to hospital for assessment
(s2) or for treatment (s3) under the Mental Health Act if they meet the relevant criteria.

Example C

A 15 year old child. Assessed as being Gillick competent. The primary purpose of the intervention is to provide medical treatment for mental disorder. The child does not consent to treatment in hospital. The child's parents are keen for the child to be admitted to hospital and give their consent. However, it is not considered safe to rely on the parent's consent where a Gillick competent child is refusing. The child should be admitted to hospital for assessment (s2) or for treatment (s3) under the Mental Health Act if they meet the relevant criteria.

Example D

A 16 year old. Assessed as being able to make decisions about the proposed intervention. The primary purpose of the intervention is to provide medical treatment for mental disorder. The young person consents to treatment in hospital. The young person should be treated as an informal patient.

Example E

A 17 year old. Assessed as not having the capacity to make decisions about the proposed intervention. The Mental Capacity Act could be used to authorise treatment if the conditions for its use are met, but the primary purpose of the intervention is not to provide medical treatment for mental disorder but to detain the child. Consideration should be given to using section 25 of the Children Act.

Parental zone of responsibility

31.28 Clinicians will need to determine whether it is appropriate to rely on parental consent. In order for parental consent to be relied upon it should be a decision which comes within the parental zone of responsibility.

31.29 A decision is likely to be within the parental zone of responsibility if it is the sort of decision that a parent would be expected to make, having regard to what is considered to be normal parenting in European society. Where a practitioner feels unease at accepting parental consent for a child's treatment that is probably a good indication that their consent should not be relied upon.

31.30 The parameters of this zone will depend on a number of factors, all of which need to be considered by the registered medical practitioner or approved clinician, as follows –

(i) the nature and invasiveness of what is to be done to the child,

(ii) the age and maturity of the child,

(iii) whether the child is resisting,

(iv) the extent to which the child's liberty will be curtailed,

(v) the extent to which a parent's interest may conflict with those of the child,

(vi) general social standards in force at the time as to the sorts of decisions it is acceptable for parents to make,

(vii) whether what is proposed is unusual for a parent to need to decide, and

(viii) whether there is a risk of conflict between the interests of the parent and of the child. If so, how big is the risk?

31.31 For example, it may be within the zone of parental responsibility for a parent to consent to treatment of a 15 year old child against his will for an eating disorder (where the nature of the illness makes the child unable to consent for himself). However, if force feeding was required by means of invasive treatment in the form of a gastric tube, it might be considered that the extremity of the treatment took it outside the kind of treatment to which a parent could give consent. The child might need to be detained under the Mental Health Act rather than treated as an informal patient.

People with Parental Responsibility

31.32 Those with parental responsibility will often, but not always, be the child's parents. Legally you only need consent from one person with parental responsibility, although clearly it is good practice to involve all those close to the child in the decision-making process. Further guidance on identifying people with parental responsibility and where parents do not agree with each other is contained in *Seeking Consent: Working with Children*, DH, 2001 pages 6-8 & 19.

Children looked after by the local authority

~~31.18~~ 31.33 Where children are looked after by the local authority (see section ~~20~~ 22 of the Children Act 1989), treatment decisions should usually be discussed with the parent or other person with parental responsibility. If a child is voluntarily accommodated by the local authority, the consent of the parent or other person with parental responsibility to the proposed treatment should be obtained if the child is to be treated informally. If the child is subject to a care order, the parents share parental responsibility with the local authority and it will be a matter for agreement/ negotiation between them as to who should be consulted although it should be remembered that local authorities can, in the exercise of their powers under section 33(3)(b) of the Children Act limit the extent to which parents may exercise their parental responsibility.

Parents/ guardians consent

~~31.19~~ 31.34 The fact that a child has been informally admitted by parents or other person with parental responsibility should not lead professionals to assume that they have consented to all components of a treatment programme regarded as "necessary". Consent should be sought for each aspect of the child's care and treatment as it arises. "Blanket" consent forms should not be used.

Assessment

31.35 At least one medical assessment of a person under 18 years of age prior to the imposition

of compulsory treatment should be by a clinician specialising in Child and Adolescent Mental Health Services. See chapter 2 for fuller information on the assessment process.

Responsible clinician and others caring and treating under 18s

31.36 Where possible those involved in the care and treatment of children and young people should be child specialists. Where this is not possible, it is good practice for the clinical staff to have access to a Child and Adolescent Mental Health Services specialist professional for advice and consultation.

Supervised Community Treatment

31.37 There is no lower age limit for supervised community treatment. The number of children and young people whose clinical and family circumstances make them suitable for supervised community treatment is likely to be small but it should be used where appropriate. See chapter 12A for fuller information on supervised community treatment.

ECT

31.38 ECT is only appropriate for a very small number of children and young people. See paragraphs 16.6 and 16.7 for further information on the process to be undertaken when ECT is being considered for a patient.

Advocacy

31.39 Where a child or young person is detained under the Mental Health Act it is particularly important that they are given quick access to an advocate wherever possible.

Mental Health Review Tribunal

31.40 When children are detained under the Mental Health Act they have the same rights as other patients to apply to the MHRT. Hospital managers should actively promote that an application is made to the MHRT by the child, particularly following their initial detention. It is important that children are given assistance so that they get access to legal representation at an early stage. Children under 16 years are additionally safeguarded as hospitals are required to refer the child's case to the MHRT at least once every year after his case was last considered by the Tribunal rather than once every three years for patients 16 years and over.

Information

~~31.20~~ 31.41 The advice concerning the giving of information (see Chapter 14) applies with equal force to children. In particular where such patients are detained under the Act, it is important that assistance is given to enable their legal representation at any Mental Health Review Tribunal.

Confidentiality

~~31.21~~ 31.42 Children's rights to confidentiality should be strictly observed. It is important that all professionals have a clear understanding of their obligations of confidentiality to children and that any limits to such an obligation are made clear to a child who has the capacity to understand them (see paragraphs 4.10 and 4.11 of the DH Guidance on confidentiality.

31.43 A child is entitled to have their consent sought before confidential personal information is disclosed. The validity of that consent depends on their ability to understand the relevant information, retain it, and make a clear choice. The capacity of a child under 16 to give consent is a matter of judgement based on their age, understanding and the complexity of the decision to be made. Where the child or young person lacks capacity to give the necessary consent, someone with parental responsibility may give it on the child's behalf if that decision is within the parental zone of responsibility. It is normally inappropriate to share information regarding a patient aged 16 or 17, without the young person's explicit consent. Such a young person might have an

attorney or deputy under the Mental Capacity Act. Depending on their powers in each case, such a person might be able to consent on behalf of the young person.

31.44 The conditions for disclosure without consent apply to children and young persons with capacity as they do to adults. Legal advice should be sought in difficult cases. See paragraphs 4.10 and 4.11 of the DH Guidance on confidentiality *The Protection and Use of Patient Information, Department of Health, March 1996,* HSG(96)18.

~~Placement~~ Age-appropriate services

~~31.22~~ 31.45 It is usually preferable for children admitted to hospital to be accommodated with others of their own age group in children's wards or adolescent units, separate from adults, and to have access to Child and Adolescent Mental Health Services (CAMHS). If, exceptionally, this is not practicable, discrete accommodation in an adult ward, with facilities, security and staffing appropriate to the needs of the child might provide the most satisfactory solution. Where possible those involved in the care and treatment of children should be child specialists. Where this is not possible, it would be good practice for clinical staff caring for the child to have access to a CAMHS specialist professional for advice and consultation.

Education

31.46 All 16 or 17 year old patients who wish to continue their education should not be denied access to learning merely because they are receiving medical treatment for a mental health condition. The publication *Access to Education for children and young people with Medical needs* (DfES 2001) provides guidance to local authorities on their duty to provide education for children with medical needs, including those in psychiatric in-patient units and also the duties of the Learning and Skills Council to secure provision of proper facilities for education and training for 16-19 year olds. The duties on local authorities are set out in the Education Act 1996 and include powers to make provision for 16-19 year olds who are unable to attend school for medical reasons.

Complaints

~~31.23~~ 31.47 See Chapter 24.

Welfare of certain hospital patients

~~31.24~~ 31.48 Local authorities should ensure that they arrange for visits to be made to:

- children looked after by them whether or not under a care order who are in hospital, and
- those accommodated or intended to be accommodated for 3 months or more by Health Authorities, Trusts, local education authorities or in residential care, nursing or mental nursing homes (see Review of Children's Cases Regulations 1991 S. I. 1991/895 as amended and sections 85 and 86 of the Children Act). This is in addition to their duty in respect to children in their care in hospitals or nursing homes in England and Wales as required by section 116 of the Act. Local authorities should take such other steps in relation to the patient while in hospital or nursing home as would be expected to be taken by his or her parent. Local authorities are under a duty to:
- promote contact between children who are in need and their families if they live away from home and to help them get back together (paragraphs 10 and 15 of Schedule 2 to the Children Act); and
- to arrange for persons (independent visitors) to visit and befriend children looked after by the authority wherever they are if they have not been regularly visited by their parents (paragraph 17 of Schedule 2 to the Act).

31.49 Local authorities should be alerted where the whereabouts of the person with parental responsibility is not known or where that person has not visited the child or young person for a significant period. When alerted to this situation the local authority should consider whether visits should be arranged as under paragraph 31.48.

Chapter 32 A -**ADVANCE STATEMENTS OF WISHES AND FEELINGS**

The first and second guiding principles of this Code are

Participation principle

- care and treatment should be provided in such a way as to promote patients' participation, self determination and personal responsibility to the greatest practicable degree.

Respect for patients principle

- patients should be treated with respect for their qualities as unique individuals, including their wishes and feelings, so far as they are known

32A.1There may be times where, because of their mental disorder, patients are unable or unwilling to express their wishes or participate as fully as they otherwise would. In such cases, patients' past wishes and feelings – so far as they are known – take on a greater significance.

32A.2 Some patients will deliberately state their wishes in advance, about a variety of issues, including their medical treatment, the steps that should be taken in emergencies and the steps that should be taken if particular situations occur. Such wishes should be given the same consideration as wishes expressed at any other time.

32A.3Encouraging patients to set out their wishes in advance will often be a helpful therapeutic tool, encouraging collaboration and trust between patients and professionals. It is also a way in which patients' expertise in the management of crises in their own conditions can be harnessed,

32A.4Where a patient expresses a wish about how they should be treated or ways they would not wish to be treated these should be recorded. If the wish is provided in a written form it should be kept on the patient's file. If the professional to whom the wish is being expressed forms the opinion that, at the time the particular wish was expressed, that the patient lacked capacity to understand the wish they were making this should also be recorded along with the basis for which that opinion was formed.

32A.5 Whenever expressing a wish about their future treatment the patient should be encouraged to identify the circumstances in which they would or would not want such treatment to occur and to provide alternatives when there is particular treatment they would not want used. For example, where restraint is to be used the types of restraint they would prefer over any restraints they would wish were not used. The patient should also be encouraged to provide reasons why they are making any such wish. For example, a particular restraint was used in the past in an assault on the patient or as part of regular abuse.

32A.6 The patient should, however, be made aware of that wishes expressed in advance cannot compel practitioners to act in a particular way, In particular, it is important that patients (and professionals) understand the difference between statements of wishes and advance decisions to refuse treatment (which do have a legal effect, although one which can be over-ridden where patients can be treated without consent under the Act - (see Chapter 16A).

32A.6 The availability of a relevant previously expressed wish should not be seen as satisfying patient consultation where it is also practical to consult with the patient at the time of considering any decision. Where the current wishes of the patient contradicts any previously expressed wish the currently expressed wish should normally prevail as the patient's opinion unless there are reasons to believe that the currently expressed opinion does not represent the patient's true wishes.

Chapter 33A Displacement of the Nearest Relative

33A.1 If the patient decides to make an application to the county court for the displacement of their nearest relative, or to apply for the appointment of a nearest relative where there is none, it will be appropriate for them to seek legal advice.

33A.2 The AMHP, the patient, any relative, or someone living with the patient may apply to the county court to appoint a different person as acting nearest relative on the grounds described in Section 29 Subsection 3 .

33A.3 It will be for the county court to determine what constitutes unsuitability to otherwise act as the nearest relative. However, a nearest relative cannot be rendered unsuitable on the basis that another person is deemed to be more suitable. When determining whether to make an application on the grounds that the current nearest relative is unsuitable, the AMHP should consider the views of the patient and any concerns that the patient has about their nearest relative. The AMHP should distinguish between concerns relating to the person who is the nearest relative, and concerns that relate to the role of the nearest relative - that is, no matter who should undertake that role - or similarly, concerns that relate to how the nearest relative chooses/ may choose to appropriately use his powers.

33A.4 It is desirable for local social services authorities to provide clear practical guidance to help the AMHP decide whether to make an application, and how to proceed. Before producing such guidance, the local social services authority should consult with the county court

Chapter 34A Confidentiality, Information Sharing and Patient's Access to Records

34A.1 Information sharing between professionals can help to protect people from harm. Information sharing on all mentally disordered people who pose a risk to themselves or others can be appropriately done under the Care Programme Approach (CPA).

34A.2 The law on information-sharing and confidentiality is largely based on common law rules, developed through court cases. These have been supplemented by statute law, particularly the Data Protection Act 1998. The NHS Information Governance toolkit is available at: http://nww.nhsia.nhs.uk/infogov/igt/ and the DCA data sharing for service providers is available at: http://www.dca.gov.uk/foi/sharing/toolkit/index.

34A.3 Where a patient is both competent and willing to agree to the disclosure of information or the seeking of views about his or her care, this should be encouraged to enable carers and those with a valid interest in the care and well being of the patient to be informed about progress. A patient's agreement to such contact must be freely given.

34A.4 With regards to patients detained under Part III of the Act such persons with a valid interest can include victims and the families of victims. Guidance on contacting and sharing information with victims can be found at paragraph 29.5A

Confidentiality

34A.5 *What is covered by confidentiality?* People who give information have the right to expect that the recipient will not share it if it is clear from the circumstances that it was meant to be kept confidential. Certain situations, such as discussions with a doctor or social worker, are generally presumed to be confidential.

34A.6 Before considering disclosure of confidential information the individuals consent should always be sought. For consent to be valid, the person must be capable of understanding what is being asked, weighing up the options to reach a decision, and believing the person concerned.

34A.7 *When is it permissible to breach confidentiality?* In the absence of consent, confidentiality can only lawfully be breached if there is –

- some legal obligation to do so where the professional has no choice e.g. a court order requiring disclosure; or
- an overriding public interest in disclosing the information where the professional must exercise judgement.

34A.8 The 'public interest' is not the same as what might be of interest to the public. Public interests could include but are not limited to protecting other from harm and preventing crime. The common law does *not* permit disclosure of someone's personal information in their own interests if they have capacity and refuse consent.

34A.9 The Data Protection Act 1998 regulates the circumstances in which information about an individual, may be gathered, recorded, transferred, deleted and shared. The Department for Constitutional Affairs (DCA) have summarised the conditions for processing personal information in Annex 5 of their legal guidance on 'Public Sector Data Sharing' This document also summarises the legal issues involved in sharing information.

34A.10 As multidisciplinary teams have become more common within mental health, the practice has developed of pooling all information about an individual into a single file which is accessible by all members of the team. This is permissible without the individual's explicit consent *provided* all those who access the file are involved with his or her care or treatment and are bound by a

similar duty of confidentiality as clinicians and the patient understands who will see their details and has not objected. The report "*Still building bridges"* discusses appropriate shared working under the Care Programme Approach.

Service users' access to their own records

34A.11 Mental health service users have the right to see information held about them on personal files, subject to specified restrictions. Access is now covered by the Data Protection Act 1998.

34A.12 Permitting a service user to see their personal files

- encourages the user to participate in their own care,
- reassures the user that information is not being withheld (other than in the circumstances given below),
- helps to identify and correct any errors of fact that have crept into the records, and
- provides an incentive to maintain high standards of record keeping.

34A.13 All hospitals, trusts and social services departments should have policies relating to the disclosure of personal records, which should be drawn up in conjunction with the Caldicott guardian (or equivalent person in an independent hospital or clinic). The Department of Health has also issued guidance which is available at - http://www.dh.gov.uk/assetRoot/04/03/51/94/04035194.pdf

Annex A – D to be updated