



Mental Health Act 1983

# Code of Practice for *Wales*



Llywodraeth Cynulliad Cymru  
Welsh Assembly Government



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# Foreword by the Minister for Health and Social Services

The 'One Wales' agreement, a progressive agenda for the Government of Wales, makes clear the new priority we are placing on providing for mental health for all ages.

My aim is to ensure that mental health services in Wales are of the highest quality. Services must be determined by the needs of those using them, and should treat patients and carers with both dignity and respect.

The Code of Practice to the Mental Health Act 1983 was last revised in 1999. Since then devolution has meant that the Welsh Ministers have become directly responsible for health and social services in Wales. This is the first time that we have had a distinctive and separate Code of Practice for Wales, and it reflects Welsh policy and strategy, and our priority for mental health services in Wales.

The Welsh Assembly Government has worked with stakeholders and consulted widely in drawing up this Code of Practice, and I am grateful to all individuals and organisations who have contributed to this process.

I am sure this Code will be enormously helpful to all practitioners who have to make decisions within the scope of the Mental Health Act 1983, shaping the way that the legislation is put into practice. The Code will also act as a guide to patients and those who support and advise them.

I strongly encourage you to read the Code, and put the guiding principles it sets out into practice.



**Edwina Hart AM MBE**

Minister for Health and Social Services



# Introduction

- i. The Code has been prepared and is issued under section 118 of the Mental Health Act 1983 (the Act) by the Welsh Ministers after consulting such bodies as appeared to them to be concerned, and laid before the National Assembly for Wales. The Code will come into force in November 2008.
- ii. The Welsh Ministers are required to keep the operation of the Code under review.

## Purpose and status of the Code of Practice

- iii. The Code is provided as guidance to registered medical practitioners ('doctors'), approved clinicians, managers and staff of hospitals, and approved mental health professionals on how they should proceed when undertaking functions and duties under the Act. It also gives guidance to doctors and other professionals about certain aspects of medical treatment for mental disorder more generally.
- iv. These people are required to have regard to the Code in carrying out their relevant functions under the Act. Departures from the Code could give rise to legal challenge and a court, in reviewing any departure from the Code, will scrutinise the reasons for the departure to ensure there is sufficiently convincing justification in the circumstances. It is good practice to ensure any such reasons are appropriately evidenced.
- v. It is intended that the Code should be accessible to patients, carers, advocates and others who support them. The Code should also be beneficial to the Mental Health Review Tribunal for Wales, police and ambulance services, and others involved in providing services to people who are, or may become, subject to compulsion under the Act.
- vi. The Code is available in both English and Welsh.

## Presentation

- vii. Throughout the Code, the Mental Health Act 1983 is referred to as 'the Act' or, in some cases, 'the MHA'. Where there are references to other statutes, the relevant Act is clearly indicated.
- viii. The Code takes account of amendments and insertions to the Act made by the Mental Health Act 2007 and other statutes.
- ix. The Act sets out the legal framework, and the Code of Practice provides the principles and guidance on how the Act should be applied in practice. The Code shows, where relevant, the connections between the Act and other legislation, such as the Mental Capacity Act 2005.
- x. It is hoped this 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.

- xi. The Welsh Assembly Government will publish a 'Mental Health Act Reference Guide' in due course. The Guide is intended to provide a description of the provisions of the Act and the regulations, directions and orders that accompany it.
- xii. Finally, a note on some of the terms used in this Code:
- The term 'service user' is often used for people accessing services for care and treatment of their mental disorder. Some people prefer the terms 'survivor', 'client', 'consumer' and 'recipient', but this Code generally uses the term 'patient', in line with the term used throughout the Act.
  - This Code uses the terms 'child' and 'children' for people aged under 18 years, while acknowledging that 'young person' or 'adolescent' might sometimes be more appropriate.
  - There are references throughout this Code to the Mental Capacity Act 2005. The Code assumes that its readers are familiar with the main provisions of that Act as it relates to the care and treatment of people with mental disorder who lack capacity to make particular decisions for themselves. Guidance on the Mental Capacity Act is given in that Act's own Code of Practice.
  - The Code refers in a number of places to the Mental Health Act Commission (MHAC). The Health and Social Care Act 2008 will abolish the MHAC and transfer its functions, in relation to Wales, to the Welsh Ministers. This is expected to take place in April 2009. At that time Healthcare Inspectorate Wales will monitor the operation of the Act in Wales. References to MHAC in this Code are therefore to be read as references to its legal successors at the appropriate time.
  - The Code also refers to the Mental Health Review Tribunal for Wales (or the Tribunal). Subject to Parliament, it is intended that in England the Tribunal will be replaced by a new First-tier Tribunal established under the Tribunals, Courts and Enforcement Act 2007. However, in Wales the Mental Health Review Tribunal will remain, and will be known as the Mental Health Review Tribunal for Wales. There is also intended to be a right of appeal, on a point of law, from both the Mental Health Review Tribunal for Wales and the First-tier Tribunal to a new Upper Tribunal.
  - A list of key words and phrases used in this Code is given at appendix A.



# Chapter 1

## Guiding Principles

- 1.1 This chapter provides a set of guiding principles which should be considered when making decisions about a course of action under the Act. The principles work together to form a balanced set of considerations which should inform decision-making.
- 1.2 All of the chapters of this Code of Practice should be read in light of these principles which are set out from paragraph 1.6 onwards.

### Background to the guiding principles

- 1.3 The Welsh Assembly Government Mental Health Strategy *Adult Mental Health Services for Wales* establishes four underpinning principles to guide everybody involved in planning, commissioning, managing, working in and using mental health services. They are:

- empowerment
- equity
- effectiveness
- efficiency.

While these principles were explicitly set out in the strategy for adults (including older adults), they are sufficiently broad to provide headings for ordering the guiding principles which will inform decision making under the Act across all ages and client specialisms.

- 1.4 The Child and Adolescent Mental Health Services (CAMHS) strategy *Everybody's Business* establishes principles to guide and underpin its implementation. These are referred to in the introduction to chapter 33 and should inform decision-making about children and young people.
- 1.5 The *Statement on Policy and Practice for Adults with a Learning Disability* includes principles to underpin the delivery of services to adults with a learning disability. These are referred to in the introduction to chapter 34 and should inform decision-making regarding adults with a learning disability or autistic spectrum disorder.

## Guiding principles

### The empowerment principles

#### **Patient well-being and safety should be at the heart of decision-making.**

- 1.6 This should also be consistent with ensuring the well-being and safety of others, where necessary. Patients and their carers and other interested parties should be actively involved in assessing the risks posed to the health and safety of the patient and others.
- 1.7 Patients should, wherever practicable, be involved with all relevant agencies in creating and implementing a risk management plan.

#### **Retaining the independence, wherever practicable, and promoting the recovery of the patient should be central to all interventions under the Act.**

- 1.8 Alternatives to avoid the use of compulsory powers should be explored before making an application for admission, and the least restrictive options should be considered. This should include creative approaches to offer choice in service delivery and alternative means of providing treatment and care, subject to the need to prevent harm. This should always be balanced with ensuring patients receive treatment appropriate to their needs and which is aimed at preventing them from harming themselves or others.
- 1.9 Assessment, care and treatment under the Act should draw upon patients' strengths, seeking to enable patients to progress towards recovery and re-establish their independence as soon as is safely practicable.

#### **Patients should be involved in the planning, development and delivery of their care and treatment to the fullest extent possible.**

- 1.10 Professionals must be proactive in ensuring patients receive information in a timely manner and that it is accessible and can be clearly understood by them. Independent advocacy has a significant role to play in empowering patients to be fully engaged in these processes, whether the individual is entitled to independent mental health advocacy as a qualifying patient under the Act, or is able to access other independent advocacy.
- 1.11 Where assessment under the Act is required, patients should be enabled to be as fully involved in the process as they want and to the extent their capacity allows. Mental health professionals undertaking assessments should give due regard to patients' present and past wishes including any advance decisions. Those subject to compulsion under the Act should be encouraged to participate actively in their own care.
- 1.12 Decision-making should be open and transparent, subject to the need to manage information whose disclosure could harm the patient or others.

**Practitioners performing functions under the Act should pay particular attention to ensuring the maintenance of the rights and dignity of patients, and their carers and families, while also ensuring their safety and that of others.**

1.13 This should include careful consideration of the potentially stigmatising effect assessment and admission processes may have on patients, their carers and families, for example the way in which a patient is taken to hospital.

### The equity principles

**Practitioners must respect the diverse needs, values and circumstances of each patient.**

1.14 They must pay due regard to all the legislation relating to equality and non-discrimination, and give due and positive regard to the needs of each patient including their:

- age
- race
- colour
- national, ethnic or social origins
- culture
- language
- gender
- sexual orientation
- disability (if any)
- religious beliefs and practices (if any).

1.15 Assessment, care and treatment must be delivered in a way which avoids unlawful discrimination and complies with all applicable statutory requirements.

**The views, needs and wishes of patients' carers and families should be taken into account in assessing and delivering care and treatment.**

1.16 Particular consideration should be given to the likely impact of clinical decisions on patients' carers and other relevant people.

**Practitioners should ensure that effective communication takes place between themselves, patients and others.**

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

1.18 Welsh speakers should, where reasonably practicable or appropriate in the circumstances, be given the option of assessment, treatment and provision of information through the medium of Welsh. Service providers, who have Welsh language schemes, must act in accordance with their schemes.

- 1.19 If a patient's language is other than English or Welsh, assessment should be delivered using a trained interpreter, who will address issues of both language and cultural interpretation, which includes the use of British Sign Language.

### The effectiveness and efficiency principles

**Anyone made subject to compulsion under the Act should be provided with evidence based treatment and care, the purpose of which should be to alleviate, or prevent a worsening of, their mental disorder, or any of its symptoms or manifestations.**

- 1.20 Treatment should be appropriate to patients' needs, taking account of their individual circumstances, and giving full consideration to any applicable advance decisions.
- 1.21 Decisions under the Act should be taken to minimise the harm done by mental disorder, by ensuring the safety and well-being (mental and physical) of patients and protecting the public from harm.
- 1.22 Patients should be offered treatment and care in environments that are safe (for them and for the public), and supportive, and which enable practitioners to deliver a range of therapies with a focus on patient recovery, and other positive clinical and personal outcomes. Such environments should also be appropriate to the person's age and gender, and to their cultural and religious needs, and should allow for their dignity to be maintained to the fullest possible extent.

**Practitioners should ensure that the services they provide are in line with the Welsh Assembly Government's strategies for mental health and learning disability.**

- 1.23 This will ensure that mental health professionals have a range of options to offer patients and can provide care using the least restrictive option to meet patient's needs and the need for their safety and public safety. This should include consideration of providing treatment subject to compulsion in non-hospital settings as a positive option.
- 1.24 Other legislation and guidance may also be relevant, including that on safeguarding children and adults. Mental health professionals should not view mental health and learning disability guidance in isolation, and should ensure their practice takes account of legislation and guidance in the round.
- 1.25 Care plans should be delivered by practitioners from the appropriate range of statutory and non-statutory agencies working in partnership to meet the needs of the patients and those of their carers. This is particularly important if patients have co-occurring problems such as physical ill health, or learning disability, or substance misuse together with a mental health problem.
- 1.26 Where elements of the care plan are being delivered by carers, mental health professionals should ensure that they work in partnership with those carers.

- 1.27 If patients are in transition from one service to another, for example from adolescent to adult care or from adult to older-adult services, practitioners should ensure that patients receive the most appropriate service and, where practicable, delivered in line with their expressed wishes.
- 1.28 Where patients are subject to compulsory admission, agencies should work together to plan a programme of care that as far as practicable takes account of patients' views and wishes. Care plans should focus on seeking early discharge and providing after-care, if necessary, at the earliest opportunity.

## Using the principles

- 1.29 The principles inform decisions - they do not determine them. Although all of the principles must inform every decision made under the Act, the weight given to each principle in reaching a particular decision will depend on the context. It may be that in making some decisions a greater weight should be given to some principles over others.



# Chapter 2

## Considering admission to hospital or guardianship

- 2.1 In almost all circumstances, two doctors and an approved mental health professional (AMHP) will examine and assess a patient before an application for admission to hospital or reception into guardianship (with the exception of emergency admissions under section 4).
- 2.2 This chapter looks at the roles and responsibilities of AMHPs and doctors when undertaking assessments and examinations to consider whether to make an application or provide a recommendation to support an application, under the Act. It also provides guidance on the approach to be taken during those assessments and examinations and the matters which should be considered.

### General matters

- 2.3 Assessments of the needs of a person with mental health problems, where the assessment may lead to an application for admission to hospital or guardianship, must be carried out in light of the guiding principles set out in chapter 1.
- 2.4 Someone should only be compulsorily admitted if the statutory grounds are met and other relevant factors have been considered as set out in paragraphs 2.19 and 2.22 below. Doctors and AMHPs undertaking assessments must apply professional judgement and reach decisions independently of each other but should cooperate and support each other. Good working relationships require knowledge and understanding of the distinct role and responsibilities of each assessor (see below). It can be helpful for the assessors to see the person together. Chapter 3 of this Code gives guidance on potential conflicts of interest between assessors.
- 2.5 Given the importance of effective communication and cooperation, at least one of the doctors undertaking the medical assessment should discuss the patient's assessed needs with the applicant (whether AMHP or nearest relative), and it is recommended that both doctors do this.
- 2.6 Where practicable, one of the recommending doctors should have previous acquaintance with the patient (section 12(2)), and when planning an assessment, the applicant and doctors should consider whether it is appropriate for the assessment to go ahead if one doctor is not familiar with the patient. They should also consider the most appropriate AMHP to assess the patient, taking into account the AMHP's qualifications and experience in relation to the patient's needs.

2.7 Everyone involved in undertaking assessments should be aware of the need to provide support for colleagues, especially where there is a risk of a patient causing physical harm. Staff should be aware of circumstances where the police should be asked to help, e.g. if the person has a weapon, and how to use that help to minimise the risk of violence.

## Definition of mental disorder

2.8 Mental disorder is defined for the purposes of the Act as 'any disorder or disability of the mind'. Relevant professionals must determine whether a patient has a disorder or disability of the mind in accordance with good clinical practice.

2.9 The fact that someone has a mental disorder is never sufficient grounds for any compulsory measure to be taken under the Act. Compulsory measures are only permitted where specific grounds about the potential consequences of a person's mental disorder are met. There are many forms of mental disorder which are unlikely ever to call for compulsory measures.

2.10 Clinically recognised conditions which could fall within this definition include:

- organic mental disorders such as dementia and delirium (however caused)
- personality and behavioural changes caused by brain injury or damage (however acquired)
- mental and behavioural disorders due to psychoactive substance use (but see below)
- schizophrenia and delusional disorders
- affective disorders, such as depression and bipolar disorder
- 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.

2.11 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.

## Dependence on alcohol or drugs

2.12 A person should not be considered to have a mental disorder or be detained simply because they are dependent on alcohol or drugs; but 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, for example, to detain a person who is dependent on alcohol or drugs if they are also suffering from another mental disorder (whether or not it is linked to their alcohol or drug use), provided all the other relevant criteria in the Act are met.



## Learning disabilities and autistic spectrum disorder (ASD)

- 2.13 Learning disabilities and autistic spectrum disorder are forms of mental disorder as defined in the Act.
- 2.14 Someone with a learning disability and no other form of mental disorder may not be detained for treatment or made subject to guardianship or supervised community treatment unless their learning disability is associated with abnormally aggressive or seriously irresponsible conduct on their part.
- 2.15 The exception above does not apply to ASD (including Asperger's syndrome). It is possible for someone with an ASD to meet the criteria for compulsory measures under the Act without having any other form of mental disorder, even if the ASD is not associated with abnormally aggressive or seriously irresponsible conduct.
- 2.16 Further guidance is given in chapter 34 of this Code.

## Undertaking assessments

- 2.17 The aim of the assessment is to find out whether the criteria for detention under the Act are met, taking into account appropriate alternative means of providing care and treatment. Assessment is also an important consideration of the means to address risk and provide care or treatment.
- 2.18 All those considering a patient's case for possible admission under the Act should ensure they take all relevant factors into account (including those listed at 2.19) and they consider appropriate alternatives to compulsory admission.

## The factors to be taken into account at assessment

- 2.19 An application for admission may not be made in respect of a patient except for one or more of the following reasons:
- for his or her own health
  - for his or her own safety
  - for the protection of other people.

The way these concepts are phrased varies slightly between sections 2, 3 and 7:

### **Applications under section 2**

Someone can only be detained for assessment and treatment under section 2 if:

- the person is suffering from a mental disorder of a nature or degree which warrants their detention in hospital for assessment (or for assessment followed by medical 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 other persons.

### **Applications under section 3**

Someone can only be detained for treatment under section 3 if:

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

### **Applications for reception into guardianship**

Someone can only be received into guardianship if they are 16 years of age or over and if:

- the person is suffering from a mental disorder of a nature or degree which makes it appropriate for them to be received into guardianship; and
- it is necessary in the interests of the welfare of the person or for the protection of other persons that they should be received into guardianship.

2.20 The grounds require consideration of both the nature and degree of a patient's mental disorder. Nature refers to the particular mental disorder from which the patient is suffering, its chronicity, its prognosis, and the patient's previous response to receiving treatment for the disorder. Degree refers to the current manifestation of the patient's disorder.

2.21 Detention under the Act should not be made on the basis of a person's religious, social or political beliefs, unless such beliefs are manifestations of their mental disorder.

2.22 In judging whether the statutory criteria are met and compulsory admission is appropriate, those concerned should take account of matters including:

- the patient's past and present wishes and feelings, which includes the patient's view of their own needs
- the patient's cultural background and social and family circumstances
- the nature of the mental disorder and its likely course
- other forms of potential care or treatment
- the needs of the patient's carers, family and others with whom the patient lives
- the need for others to be protected from the patient
- the effect on the patient and those close to them of a decision to admit or not under the Act.

## The 'health or safety' of the patient

2.23 A patient may be admitted to hospital under sections 2 or 3 of the Act in the interests of their own health or safety even if there is no risk to other people.

2.24 A patient's physical health as well as mental health should be considered when deciding whether admission is necessary, but compulsory admission under the Act is never an option where the person needs treatment only for a physical disorder.

2.25 Those assessing the patient should explore and consider:

- any evidence suggesting that the patient's mental health will deteriorate if they do not receive treatment
- the reliability of such evidence, which may include the known history of the patient's mental disorder
- the views of the patient on the likely course of the disorder and the possibility of it improving
- the views of any carers or close friends or family, especially those living with the patient, on the likely course of the disorder and the possibility of it improving
- the impact that any future deterioration or lack of improvement would have on carers or close friends or family, especially those living with the patient, including an assessment of their ability and willingness to cope
- other possible ways of coping with an expected deterioration or lack of improvement.

## Protection of other persons

2.26 In considering the protection of other people (see sections 2(2)(b) and 3(2)(c) of the Act) it is essential to assess separately the likelihood and nature of the potential risks, taking into account:

- reliability of evidence, such as the patient's clinical history and past behaviours, including contact with other agencies and any relevant criminal convictions
- the degree of risk and its nature (a risk of physical harm or serious persistent psychological harm to others is a significant factor in deciding the need for compulsory admission)

- the willingness and ability to cope with and manage the risk, by those living with the patient, as well as those providing care and support to the patient, and whether there are alternatives available for managing the risk
- the overall acceptability of risk, in terms of likelihood and harm to those involved in the care of the patient and others potentially at risk.

## Informal admission

2.27 Compulsory admission powers should only be exercised if there is no effective alternative way of providing support or treatment available.

### Patients with capacity to consent to admission

2.28 When a patient has capacity and agrees to informal admission, this will normally be the appropriate course of action. However, there may be some circumstances where compulsory admission is justified despite the patient's willingness to be admitted voluntarily. The need for compulsory admission should be carefully considered if a patient's current mental state, together with reliable evidence of past experience, indicates it is very likely that they will have a change of mind about informal admission either before or immediately after admission with a resulting risk to the patient's health or safety or to the safety of other people.

### Patients who lack capacity to consent to treatment or admission

2.29 This section should be read alongside the guidance on treatment for mental disorder in chapters 16 and 17 and the interface with the Mental Capacity Act 2005 (MCA) in chapter 13.

2.30 Where a patient aged 16 or over is not capable of consenting to admission and/or to the treatment that is expected to be required, AMHPs and doctors may consider that the patient can be safely and effectively treated by relying on the provisions of the MCA. However, where it is necessary to deprive someone of their liberty in order to treat them, then the MCA cannot be relied upon unless the treatment has been authorised under that Act (with an authorisation under the deprivation of liberty safeguards (DoLS)<sup>1</sup>). Authorisation under DoLS can be obtained for people of 18 or above who meet the relevant grounds.

2.31 Where a patient can be safely and effectively assessed or treated by relying on the provisions in the MCA, it should not be necessary to use sections 2, 3 or 7 of the Mental Health Act 1983.

2.32 Treatment under the MCA will usually be preferable to detention under the Act where the medical treatment is not assessed as necessary to prevent harm. Detention under the Act will not be appropriate, for example, except in the following circumstances:

- where a person is not capable of making decisions about being in hospital but is objecting to their treatment

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<sup>1</sup> The deprivation of liberty safeguards are expected to come into force from April 2009

- the person is assessed as needing a particular treatment for their mental disorder but has made a valid and applicable advance decision to refuse this treatment (refer to chapter 15)
- some restraint needs to be used which is justified by the risk posed to other people but which, exceptionally, cannot be said to be proportionate to the risk to the patient personally (as required by sections 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 because a patient's capacity to consent fluctuates and the patient is not expected to cooperate when they have capacity
- there is a risk that either a patient or other person could potentially suffer harm, as a result of that patient failing to receive some, if not all, of the elements of a care or treatment package (such as refusing to be admitted to hospital), as a result of which the patient will not receive the care or treatment which they require
- the patient is being considered for detention under Part 3 of the Act in connection with criminal proceedings.

## Individual professional responsibility - the approved mental health professional

### Responsibilities for the assessment process

2.33 It is important to emphasise that an AMHP assessing a patient for possible admission under the Act has overall responsibility for coordinating the process of assessment and, where he or she decides to make an application, for implementing that decision. The AMHP must, at the start of the assessment, identify him or herself to the patient, members of the patient's family, carers or friends present and the other professionals involved in the assessment. The AMHP should explain their role and the purpose of the visit, and ensure that the other professionals have explained their roles. AMHPs should carry documents identifying them as AMHPs and stating which local social services authority (LSSA) has approved them to undertake the role. Where an AMHP is approved by one LSSA but is acting on behalf of another LSSA this should also be identified.

2.34 The AMHP plays a significant part in the assessment process as they should bring a social perspective to a process where the other participants are doctors. This variety of expertise is intended to promote a holistic approach to the consideration of a person's needs. Although acting on behalf of an LSSA by virtue of section 114(10), the AMHP should exercise their own professional judgement based on social and medical evidence when deciding whether it is appropriate to apply for a patient to be detained for assessment or treatment or be made subject to guardianship.

2.35 An AMHP will be a 'public authority' for the purposes of the Human Rights Act 1998 as he or she exercises functions of a public nature.

2.36 The AMHP should interview the patient in a suitable manner, taking account of the guiding principles in chapter 1 and the following points:

- 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. This occasionally occurs when the patient is already in a hospital and is being secluded. In community settings, where direct access to the person is not possible but there is no immediate risk of physical danger, powers in the Act to obtain access (section 135) should be used.
- where the patient is subject to the effects of sedative medication or the short-term effects of drugs or alcohol, the AMHP should consult with the doctor(s) and, unless it is impossible because of the patient's disturbed behaviour and the urgency of the case, wait until the effects have passed before interviewing the patient. If this is not realistic, or the risk indicates that it would not be appropriate to wait, the assessment will have to be based on the information the AMHP can obtain from all reliable sources. This should then be made clear in the AMHP's report (see paragraph 2.75).

2.37 The patient should ordinarily be given the opportunity of speaking to the AMHP alone. If the patient wants or needs another person to be present during the assessment and any subsequent action, then usually the AMHP should help arrange for that other person to attend, although sometimes this may not be appropriate.

2.38 If the AMHP has reason to fear physical harm in carrying out the assessment, they should insist that another practitioner be present or take the necessary steps to secure their safety.

2.39 When an application for admission is to be made, the AMHP should plan how the patient is to be transported and should take steps to make the necessary arrangements (see chapter 9 and the guiding principles in chapter 1).

### **Responsibilities regarding the 'nearest relative'**

2.40 The Act requires the AMHP to try to identify the patient's nearest relative as defined in section 26 of the Act.

2.41 The AMHP should confirm with the patient the identity of their nearest relative as soon as is practical. If relevant, the AMHP should advise the patient of their right to apply for the displacement of their nearest relative (see chapter 23).

2.42 If the patient appears to have no nearest relative, the AMHP should advise the patient of the right to apply to the county court for the appointment of someone to act as their nearest relative.

2.43 The AMHP must consult the nearest relative about a possible application for admission under section 3 or reception into guardianship, unless it is not practicable or would involve unreasonable delay (section 11(4)). The nearest relative need not be informed or consulted, for example, if the AMHP cannot obtain enough information to establish who the nearest relative is or where they are, or if it would need an excessive amount of investigation to find them.

- 2.44 Consulting and notifying the nearest relative is an important patient safeguard, and declining to do so, because it would not be reasonably practicable, should be carefully considered and documented. The AMHP should also consider the likely effect that informing the nearest relative would have on the patient's health and well-being, for example by infringing the patient's rights to respect for their privacy where this cannot be justified by the benefit of that involvement. The AMHP should also consider not consulting if the patient strongly objects and/or if the AMHP considers the potential impact of consultation on the patient to be detrimental; for instance by causing emotional distress, deterioration in his or her mental health, physical harm or some form of financial or other exploitation. It may be that such circumstances suggest that the displacement of the nearest relative could be considered as an option (see chapter 23).
- 2.45 If the nearest relative objects to an application being made for admission for treatment or reception into guardianship, the application cannot proceed at that time. If, because of the urgency of the case, it is thought necessary to proceed with the application, the AMHP must consider applying to the county court for the nearest relative's displacement (section 29) (see chapter 23). Consultation must not be avoided purely because it is thought that the nearest relative might object to the application or as a way of avoiding taking action to displace the nearest relative.
- 2.46 If the AMHP has been unable to consult the nearest relative before making an application for admission for treatment for reasons other than that it not being reasonably practicable to do so, they should still try to inform the nearest relative about the application and about their power of discharge (section 11(3)). If the AMHP has been unable to inform the nearest relative before the patient's admission, they should notify the hospital managers as soon as this has been done. While the duty lies with the AMHP the task of notifying can be carried out by someone else on their behalf.
- 2.47 The AMHP must, where practicable, inform the nearest relative of either their intention to make an application for admission for assessment or that an application has been made, and must consult the nearest relative if admission for treatment is being considered (but see also above). In addition to the requirement regarding the nearest relative in section 11 of the Act, the AMHP should where possible:
- ascertain the nearest relative's views about the patient's needs and the nearest relative's own needs in relation to the patient
  - inform the nearest relative of the reasons for considering an application for admission to hospital or guardianship under the Act and the effects of making an application.
- 2.48 If a nearest relative would find it difficult to undertake their statutory functions, or is reluctant to do so, the *Mental Health (Hospital, Guardianship, Community Treatment and Consent to Treatment) (Wales) Regulations 2008* provide a procedure by which the nearest relative may delegate those functions to someone else. AMHPs should make nearest relatives aware of this procedure.

## Consultation

- 2.49 The value of involving carers and family in the decision-making process is well recognised because it provides a particular perspective of the patient's circumstances and experiences. If the urgency of the case allows, an AMHP applying for the admission of a patient to hospital or guardianship should consult other relevant carers, friends or relatives and should take their views into account.
- 2.50 The AMHP should consult wherever possible others who have been involved with the patient's care in the statutory, voluntary or independent services.
- 2.51 Having decided whether or not to make an application for admission the AMHP should inform (with reasons):
- the patient
  - the patient's nearest relative (whenever practicable)
  - the doctor(s) involved in the assessment
  - the care coordinator if the patient is receiving care under the Care Programme Approach, or other equivalent key worker
  - the patient's general practitioner (GP), if he or she was not involved in the assessment
  - any other relevant person involved in the patient's care.

## **Individual professional responsibility - the doctor**

- 2.52 Each doctor should:
- decide whether the patient is suffering from mental disorder within the meaning of section 1 of the Act and assess its seriousness and the need for further assessment and/or medical treatment in hospital or for reception into guardianship
  - consider the factors set out in paragraph 2.22 above, and discuss them with the applicant and the other doctor involved
  - specifically consider the 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.
- 2.53 If the outcome of the assessment process is that an application for admission is to be made, the doctors should ensure that a hospital bed is made available.

## Medical examination

- 2.54 In addition to following the guidance on assessment provided above, the doctor in carrying out a medical examination should:
- carry out a direct personal examination of the patient's mental state
  - consider all available relevant clinical information including that held by others.



- 2.55 If direct physical access to the patient is not immediately possible, and postponing the examination is not desirable, a doctor should discuss this with the AMHP coordinating the assessment and consider applying for a warrant allowing the police to exercise their lawful power of entry (section 135) (see chapter 7).
- 2.56 It may not always be practicable for the patient to be examined by both doctors at the same time, but they should discuss the patient's case with each other.
- 2.57 It is recommended that both doctors discuss the patient's case with the applicant, and it is essential that at least one of them does so (see paragraph 2.5).

### **The second medical recommendation**

- 2.58 One of the medical recommendations should be provided by a doctor with previous acquaintance of the patient. This should be by a doctor who knows the patient professionally, but it is sufficient for the doctor to have had some previous knowledge of the patient's case. If this is not possible (for example the patient is not registered with a GP) the second medical recommendation should be provided by an 'approved' doctor.

### **A decision not to apply for admission**

- 2.59 Most compulsory admissions to hospital need prompt action to be taken. However the AMHP, in possession of completed medical recommendations, has up to 14 days after seeing the patient to complete an application for admission under sections 2 or 3, and there may be circumstances where it will be in the patient's interests to use this time to make alternative arrangements to avoid detention.
- 2.60 An AMHP or nearest relative does not have to apply for admission just because the statutory grounds are met and two medical recommendations have been made. They have to apply only if they are satisfied that an application is the most appropriate way to provide treatment, taking into account all the circumstances of the case. If they decide not to apply for admission under the Act, the decision should be supported, where necessary, by alternative proposals for care and/or treatment. The decision should also be clearly recorded in the AMHP report of the assessment and the patient's notes, explaining how any accompanying risk of harm is to be managed.
- 2.61 If two medical recommendations are provided but the AMHP decides not to apply for compulsory admission, the AMHP must decide how to implement any alternative actions which they consider necessary - for example, referral to social workers or services within the social services department or a referral for health care. It is particularly important that any care coordinator or key worker concerned with the patient's care be involved as much as possible in these decisions.
- 2.62 Given the role of carers and family members in helping to support people with mental health problems, it is crucial that services work closely with patients and carers, always considering the patient's right to respect for his or her private life under Article 8(1) of the European

Convention on Human Rights. A patient's wishes and feelings about the involvement of family and carers should be recorded and this information shared to help decision making in times of crisis.

- 2.63 The professionals must ensure that, where an application is not made, they, the patient and (with the patient's consent except where section 13(4) applies) their nearest relative and any other closely connected relatives, carers or friends have a clear understanding of any alternative arrangements that are put in place. 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).
- 2.64 Where the AMHP has carried out an assessment at the request of the nearest relative under section 13(4), and has decided not to make an application for admission, the reasons for not doing so must be given to the nearest relative in writing.

### **Particular practice issues - disagreements**

- 2.65 Sometimes there will be differences of opinion between professionals considering a patient's case. Handled properly, disagreements offer an opportunity to safeguard the interests of the patient and the protection of others by widening the discussion about the best way of addressing any risks of harm and of meeting the patient's needs.
- 2.66 Doctors and AMHPs should be ready to consult colleagues (especially care coordinators and other community care staff involved with the patient's care), while retaining the final responsibility for their own decisions. Where disagreements do occur, professionals should ensure that they discuss these with each other.
- 2.67 If there is an unresolved dispute about an application for admission, the professionals should not abandon the patient and the family. Rather, they should explore and agree alternative arrangements, if necessary on a temporary basis, and keep the patient, carer and family informed. Any such plans should include provisions for managing and reviewing identified risks, and should be recorded in writing, with copies made available to all those who need them (subject to the patient's right to confidentiality).

### **The choice of applicant for admission - AMHP or nearest relative?**

- 2.68 The AMHP is usually the right applicant, bearing in mind their professional training, knowledge of the legislation and local resources, and the potential harm that an application by the nearest relative might have on their relationship with the patient.
- 2.69 Where applicable, practitioners should tell the nearest relative about the availability of an AMHP to make an assessment and for the AMHP to make the application. They may also inform the nearest relative of the safeguards set out in section 13(4), and of their right to make an application under the Act.

2.70 Practitioners should never advise the nearest relative to make an application in order to avoid involving an AMHP in an assessment.

## Agency responsibilities - the local social services authority (LSSA)

2.71 Section 13(1) places a duty on an LSSA to arrange for an AMHP to be available to consider the circumstances of a patient in their area where they have reason to believe that admission to hospital or reception into guardianship may be needed. LSSAs may also make arrangements with neighbouring authorities to undertake assessments on patients who are temporarily outside their area, if it is felt that this would result in a better service for the patient. Arrangements should be agreed to enable AMHPs to act on behalf of other LSSAs in this way.

2.72 If the patient is detained under section 2, the LSSA 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 the LSSA has reason to believe that an application for further detention in hospital for treatment under section 3 is required. These duties do not prevent any other LSSA from arranging for an AMHP to consider a patient's case if that is more appropriate. If an application for receipt into guardianship is thought necessary, the LSSA for the area where the person is to be placed should be involved in the assessment.

2.73 LSSAs should ensure that a 24-hour AMHP service is available to ensure that a nearest relative is not put in the position of having to make an application under the Act because an AMHP is unable to attend for assessment.

2.74 LSSAs should plan with their partners in Trusts to train sufficient numbers of AMHPs, and have agreements about training eligible staff who are not their employees.

2.75 Each LSSA should ensure that there is a way of recording decisions by AMHPs and their reasons not to consult with or notify nearest relatives when it is felt impracticable in the circumstances to do so. This information should be provided to the hospital managers.

### Section 13(4) of the Act

2.76 LSSAs are required, if requested by a nearest relative of a patient living in their area, to arrange for an AMHP to consider the patient's case (section 13(4)) and:

- should have policies on how to respond to repeated requests for assessment where the condition of a patient has not changed significantly
- should advise AMHPs on the process for nearest relative requests to be accepted through GPs or other professionals.

## **Emergencies out of hours**

2.77 Arrangements should be made to ensure that information about assessments 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 near future. In such circumstances, the necessary arrangements could, for example, then be made for an AMHP to attend the next day. Making out-of-hours services aware of ongoing situations (such as when there is concern over an individual but no assessment has started or a person has absconded), helps them to respond accordingly.

## **Agency responsibilities - the Local Health Board**

2.78 The Welsh Ministers have delegated to Local Health Boards (LHBs) the function of approving medical practitioners under section 12(2). LHBs should:

- take active steps to encourage doctors in sufficient numbers, including GPs and those working in the health care service for prisoners, to apply for approval
- seek to ensure a 24-hour on-call rota of approved doctors sufficient to cover the area
- maintain a regularly updated list of approved doctors, with contact information and their availability
- ensure that this list and details of the on-call rota are circulated to all concerned parties including GPs, mental health centres and LSSAs.

2.79 Trusts should consider including an obligation to become approved under section 12 in the terms of employment of prospective consultant psychiatrists who have responsibility for providing a catchment area service. Trusts should also include an obligation to keep such approval up-to-date and to take part in the 24-hour on-call approved doctors' rota.

## **Joint agency responsibilities - Local Health Boards/Trusts/local social service authorities**

2.80 LHBs, Trusts and LSSAs should cooperate in ensuring regular meetings take place between professionals involved in mental health assessments to promote understanding, and to provide a forum for clarification of their respective roles and responsibilities. This could also include representatives from the police and ambulance service and should take account of the operation of out-of-hours services.

# Chapter 3

## Conflicts of interest

3.1 This chapter covers possible circumstances that could compromise applications being made by approved mental health professionals (AMHPs) or medical recommendations being given by doctors, because of conflicts of interest.

### Independence of decision-making

3.2 The Act requires an AMHP to take an independent decision about whether to make an application under the Act. If an AMHP believes they are being placed under undue pressure to make, or not make, an application, they should raise this through the appropriate channels - there should be local arrangements in place for dealing with such circumstances.

3.3 The independence of the AMHP is important, but it is equally important to note that the AMHP does not work alone. Supervision, consultation and legal advice play an important role in enabling AMHPs to carry out their duties.

3.4 AMHPs and doctors should come to their own decisions, although in most cases these will take into account the views of others involved.

### Conflicts of interest regulations

3.5 The *Mental Health (Conflicts of Interests) (Wales) Regulations 2008* ('the regulations') explain circumstances where a conflict of interest will arise for the purposes of section 12A of the Act. These regulations prevent an AMHP or a doctor (both called 'assessors' in the regulations) from making a recommendation or application for a patient's admission or guardianship where a conflict of interests arises.

3.6 The potential conflict of interest may concern the assessors' relationships to each other; to the patient, to the nearest relative or to the hospital where the patient is to be admitted. It could be a professional, financial, business or personal relationship.

### Urgent necessity

3.7 If there is a potential conflict of interest, the regulations allow for the assessor to make an application or recommendation in emergency situations if a delay might put the health or safety of the patient or others at serious risk. Any decisions made to proceed despite a potential conflict of interest should be recorded, with reasons, in the case notes. Hospital managers and LSSAs should monitor any such exceptional circumstances.

## Potential conflict of interest for professional reasons

- 3.8 The regulations state that an assessor will have a potential conflict of interest where they are working in a direct line management relationship with another assessor. In such cases, they are prevented from making an applications or providing a medical recommendation, and one of the two should withdraw from the process.
- 3.9 There may also be potential for conflicts of interest where assessors have other professional relationships with each other; such as:
- clinical supervisory relationships
  - relationships relating to professional collaboration (such as education or research)
  - professional or career mentorship
  - when one assessor acts as a referee for another
  - one assessor might be considered professionally senior to another.

In any circumstances where objectivity could appear compromised, one of the assessors should consider withdrawing from the application process.

- 3.10 There will be a conflict of interest if all three assessors (both doctors and the AMHP) come from the same team, and routinely work together for clinical purposes. Such a team may be part of a community mental health team, or a crisis resolution and home treatment team, or may be the staff of an inpatient unit. In these circumstances, only two assessors may come from the same team, and an alternative third assessor must be found.
- 3.11 Where the nearest relative is considering making an application for admission to hospital, the regulations state that:
- a doctor, asked to consider making medical recommendations, should not be under the immediate direction of, or in the employment of, the nearest relative
  - a doctor may not make a recommendation if they employ the nearest relative, or they work under the direction of the other doctor involved.

## Potential conflict of interest for financial reasons

- 3.12 An assessor will have a conflict of interest if they stand to make money from whether or not they make an application or provide a medical recommendation. This does not apply to the payment of any fee to a doctor for considering whether to make a medical recommendation.
- 3.13 If there could be any suspicion that a doctor providing a medical recommendation is doing so for financial gain, arrangements should be made for another doctor to make the recommendation.

3.14 AMHPs will also have a conflict of interest if they have a financial interest in the maintenance of the patient.

### **Potential conflict of interest for business reasons**

3.15 An assessor may be asked to undertake an assessment with another assessor (or the nearest relative if they are the applicant for admission to hospital) with whom they are involved in the same business venture, even one not associated with providing services for the care and treatment of people suffering with mental disorder. In such circumstances, the assessor should withdraw from the application process.

### **Potential conflict of interest for personal reasons**

3.16 If an assessor is related to another assessor, the patient or the patient's nearest relative, the assessor should withdraw from the application process.

3.17 The regulations set out the nature of the personal relationships in view; an assessor is considered to be in a personal relationship with another assessor, the patient or the patient's nearest relative if he or she is:

- related to them in the first degree (parent, sister, brother, son or daughter, including step relationships)
- related to them in the second degree (uncle, aunt, grandparent, grandchild, first cousin, niece, nephew, parent-in-law, grandparent-in-law, grandchild-in-law, sister- or brother-in-law, son- or daughter-in-law, including step relationships)
- related to them as a half-sister or half-brother
- their spouse, ex-spouse, civil partner or ex-civil partner
- living with them as though they were their spouse or civil partner.

References to step relationships and in-laws, above, include those arising from civil partnership as well as marriage.

### **Other circumstances**

3.18 There may be circumstances not covered by the regulations where an assessor considers there is (or could be seen to be) a potential conflict of interest. In such a case the assessor should consider withdrawing from the application process. This would be appropriate if the assessor believes the objectivity and/or independence of their decision is (or could be seen to be) undermined, because of their relationship to the other assessors, patient, nearest relative or hospital.

- 3.19 The regulations do not cover potential conflicts of interest over supervised community treatment (SCT). However, the responsible clinician and the AMHP responsible for making the decision whether to discharge a patient onto SCT, or to revoke a community treatment order should not have any financial interest in the outcome of the decision. Similarly, neither the responsible clinician nor AMHP should be a relative of the patient or of each other in these circumstances.
- 3.20 Other decisions taken under the Act, such as renewal of detention, should be treated the same way.
- 3.21 The regulations do not cover reports made to a court under Part 3 of the Act. Doctors should ensure that any potential conflict of interest in providing the report is set out in that report to the court, and where possible avoided.



# Chapter 4

## Appropriate medical treatment

4.1 This chapter gives guidance on the application of the 'appropriate medical treatment' test in the grounds and criteria for detention and supervised community treatment (SCT) under the Act.

### Purpose of medical treatment for mental disorder

4.2 For the purposes of the Act, medical treatment includes nursing, psychological intervention and specialist mental health habilitation, rehabilitation and care. Habilitation means equipping someone with skills and abilities they have never had, whereas rehabilitation means helping them recover skills and abilities they have lost.

4.3 Section 145(4) of the Act provides that references in the Act to medical treatment for mental disorder are to be taken to mean medical treatment which is for the purpose of alleviating, or preventing a worsening of, the mental disorder; or one or more of its symptoms or manifestations.

4.4 Purpose is not the same as likelihood. Medical treatment may be for the purpose of alleviating or preventing a worsening of mental disorder even though it cannot be shown in advance that any particular effect is likely to be achieved.

4.5 'Symptoms' and 'manifestations' include the way a disorder is experienced by the individual concerned and the way the disorder manifests itself in the person's thoughts, emotions, communication, behaviour and actions. (But it should be remembered that not every thought or emotion, or every aspect of the behaviour of a patient suffering from mental disorder, will be a manifestation of that disorder.)

4.6 Even if particular mental disorders are likely to persist or get worse despite treatment, there may well be a range of interventions which would represent appropriate medical treatment for the person living with them. It should never be assumed that any disorders are inherently or inevitably untreatable. Nor should it be assumed that likely difficulties in achieving long-term and sustainable change in a person's underlying disorder make medical treatment to help manage their condition and the behaviours arising from it either inappropriate or unnecessary.

## Appropriate medical treatment test

- 4.7 The purpose of the appropriate medical treatment test is to ensure that no one is detained (or remains detained) for treatment, or is an SCT patient, unless they are actually to be offered medical treatment for their mental disorder. This treatment must be appropriate, taking into account the nature and degree of their mental disorder and all their particular circumstances, including cultural, ethnic and religious considerations. And, by definition, it must be treatment which is for the purpose of alleviating or preventing a worsening of the mental disorder or its symptoms or manifestations. The test is intended to ensure that detention will be clinically appropriate and not simply preventive detention without the offer of medical treatment.
- 4.8 The appropriate medical treatment test requires a judgement about whether an appropriate package of treatment for mental disorder is available for the individual. Where the appropriate medical treatment test forms part of the grounds for detention, the medical treatment in question is treatment for mental disorder in the hospital in which the patient is to be detained. Where it is part of the criteria for SCT it refers to the treatment for mental disorder that the person will be offered while on SCT.

## Applying the appropriate medical treatment test

- 4.9 The test requires a judgement about whether, in all the circumstances, medical treatment is available to the patient which is appropriate, given:
- the nature and degree of the patient's mental disorder
  - all the other circumstances of the patient's case.

In other words, both its clinical and more general appropriateness must be considered.

- 4.10 The other circumstances of a patient's case might, for example, include:
- the patient's physical health - how it might impact on the effectiveness of the available medical treatment for mental disorder and the impact that treatment might have in return
  - any physical disabilities the patient has
  - the patient's culture and ethnicity
  - the patient's age
  - the patient's gender, gender-identity and sexual orientation
  - the location of the available treatment
  - the implications of the treatment for the patient's family and social relationships
  - its implications for the patient's education or work
  - the consequences of the patient not receiving the treatment available (for mentally disordered offenders about to be sentenced for an offence, the consequence will sometimes be a prison sentence).

- 4.11 Treatment need not be the most appropriate medical treatment that could ideally be made available. Nor does it need to address every aspect of the person's disorder. But the treatment available at any time must be an appropriate response to the patient's condition and situation.
- 4.12 Treatment must actually be available to the patient. It is not sufficient that appropriate treatment could theoretically be provided.
- 4.13 What is appropriate will vary greatly between patients. It will depend, in part, on what might reasonably be expected to be achieved, given the nature and degree of the patient's disorder.
- 4.14 Treatment which aimed merely to prevent a disorder worsening is unlikely, in general, to be appropriate in cases where standard treatment approaches would aim and be expected significantly to alleviate the patient's condition. However, there may be some patients with persistent mental disorders for whom management of the undesirable effects of their disorder is all that can realistically be hoped for.
- 4.15 Although it very often will, appropriate treatment does not have to involve medication or individual or group psychological therapy. There may be patients whose particular circumstances mean that treatment may be appropriate even though it consists only of nursing and specialist day-to-day care under the clinical supervision of an approved clinician in a safe and secure therapeutic environment with a structured regime.
- 4.16 Simply detaining someone - even in a hospital - does not constitute medical treatment.
- 4.17 A patient's attitude towards proposed treatment may be relevant when determining whether the appropriate medical treatment test is met. But an indication of unwillingness to cooperate with treatment generally, or a specific aspect of treatment, does not make such treatment inappropriate. In particular, psychological therapies and other treatments which require the patient's cooperation to be effective are not automatically inappropriate simply because a patient does not currently want to engage with them. Such treatments can potentially remain appropriate and available, so long as it continues to be clinically suitable to offer them and they would be provided if the patient agreed to cooperate.
- 4.18 People called on to make a judgement about whether the test is met, do not have to be satisfied that appropriate medical treatment will be available 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 they must satisfy themselves that medical treatment is available for the time being which is appropriate, given the patient's condition and circumstances as they are currently understood.



# Chapter 5

## Admission to hospital under Part 2 of the Act

5.1 This chapter outlines the factors, which should be taken into account, when deciding which section is most appropriate for admitting a patient to hospital under the provisions of Part 2 of the Act.

### Considering section 2 or section 3

5.2 In deciding whether a person should be detained in hospital under the Act, careful consideration must be given to which section, if any, would be the most appropriate, particularly bearing in mind the principle of least restriction. Professional judgement must be applied in making this decision.

#### **Section 2 pointers:**

- An inpatient assessment must be carried out in order to produce a treatment plan.
- A judgement is required on whether the patient will accept treatment on a voluntary/informal basis after admission.
- A judgement has to be made on whether a proposed treatment, which can only be administered to the patient under Part 4 of the Act, is likely to be effective.
- 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 required.
- The diagnosis and/or prognosis of a patient's condition is unclear.
- It has not been possible to undertake any other assessment in order to formulate a treatment plan.
- The patient has not previously been admitted to hospital and has not been in regular contact with the specialist psychiatric services, and it has not been possible to formulate a treatment plan.

#### **Section 3 pointers:**

- The patient is considered to need compulsory admission for the treatment of a mental disorder, which is already known to his or her clinical team, and has recently been assessed by that team.
- The patient is detained under section 2 and assessment indicates a need for compulsory treatment under the Act beyond the existing period of detention. 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 the existing period of detention.

5.3 Decisions should not be influenced by the possibility that:

- a proposed treatment plan has been formulated but the treatment to be administered under the Act will last less than 28 days
- access to the Mental Health Review Tribunal for Wales may be quicker for a patient detained under section 2, than a patient detained under section 3
- supervised community treatment will only be available if the patient has been admitted under section 3
- a patient's nearest relative objects to admission under section 3.

5.4 A further section 2 application cannot be made if the patient is already in hospital following admission under that section.

### **Admission for assessment in an emergency (section 4)**

5.5 Application for admission for assessment under section 4 can be made by an AMHP or by the nearest relative. Such an application should only be made when the criteria for admission for assessment are met, the matter is urgent and it would be unsafe to wait for a second medical recommendation.

#### **Urgent necessity**

5.6 Section 4 should only be used in a genuine emergency where the patient's urgent need for assessment outweighs the alternative of waiting for a medical examination by a second doctor. The section should never be used for medical or administrative convenience - for example, because it is more convenient for the second doctor to examine the patient as an inpatient, rather than in the community.

5.7 An emergency arises where the mental state or behaviour of a patient cannot be immediately managed. 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 immediate and significant danger of serious harm to property
- and/or the need for physical restraint of the patient.

#### **Availability of the second medical recommendation**

5.8 If the AMHP is considering an application for admission and no second doctor is available, they should discuss the case with the doctor providing the first recommendation, who should help to secure a second doctor to consider the case. If such a problem continues, the AMHP should have access to an officer in the local social services authority (LSSA) who is sufficiently senior to take up the matter with the relevant Local Health Board and NHS Trust as applicable. The LSSA, on whose behalf the AMHP is acting, should make it clear to the AMHP that the matter must be reported to a senior officer.

## Actions to be taken on admission under section 4

- 5.9 An appropriate second doctor should examine a patient who has been admitted under section 4 as soon as possible after admission, to decide whether they should be detained under section 2. Although the further involvement of an AMHP is not necessary at this stage, the LSSA should be informed of the 'conversion' to section 2 so they can inform the patient's nearest relative.
- 5.10 If the second examining doctor decides that the patient meets the criteria for detention under section 3, an application under that section should be considered by the AMHP. The recommendation made in respect of the section 4 admission cannot be used to support an application under section 3. However, the first medical examiner can give a further recommendation if he or she also considers the criteria for detention under section 3 are met.
- 5.11 Patients detained on the basis of emergency applications may not be treated without their consent under Part 4 of the Act, unless or until the second medical recommendation is received. Until then they are in exactly the same position in respect of consent to treatment as patients who are not detained under the Act.
- 5.12 Hospital managers should monitor the use of section 4 and ensure that second doctors are available to visit a patient within a reasonable time after being requested.





# Chapter 6

## Guardianship

6.1 This chapter provides guidance on the purpose of guardianship (under section 7 of the Act), the process for assessment, the components of effective guardianship, the duties of the local social services authority (LSSA) and the powers of the guardian.

### Purpose of guardianship

6.2 The purpose of guardianship is to enable vulnerable, mentally disordered people to receive care in the community when it cannot be provided without the use of compulsory powers. Such care may include specialist medical treatment for mental disorder but only with the patient's agreement. It aims to provide the patient with as independent a life as possible within the community, and is used as part of the patient's overall care and treatment plan.

### Assessment for guardianship

6.3 Approved mental health professionals (AMHPs) and doctors should consider guardianship as a possible alternative to care in hospital. This could be as a package of care in the community or to support a placement in care.

6.4 As with applications for admission to hospital, AMHPs and doctors making recommendations should consider whether the objectives of the proposed application could be achieved in a less restrictive way.

6.5 If the patient lacks capacity to make important decisions about their welfare, an alternative to guardianship will be to rely on the Mental Capacity Act 2005 (MCA). However, guardianship does not give any power to deprive a person of their liberty, and if providing care involves such a deprivation, this should be addressed through the deprivation of liberty safeguards within the MCA<sup>2</sup>.

6.6 Possible situations in which guardianship might be considered 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 there have been long-running or 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 (whether they are able to consent to it, or it is being provided for them under the MCA)
- it appears necessary to use the guardian's power to require a patient to live in a particular place, either in the patient's interests or for the protection of other people

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<sup>2</sup>The deprivation of liberty safeguards are expected to come into force from April 2009

- there is a need to have explicit authority for the person to be returned to the place they are to live (for example, a care home).

6.7 If the relevant criteria are met, guardianship may be considered for a patient who is to be discharged from detention under the Act. However, if it is thought that the patient needs to remain liable to recall to hospital (and the patient is eligible) supervised community treatment is likely to be more appropriate.

## Components of effective guardianship

6.8 An application for guardianship should be accompanied by a comprehensive care and service delivery plan. It should take account of the patient's views, and the patient should be included as fully as possible in drawing it up. The care plan may be used to support applications for guardianship as long as it indicates which powers under the Act are needed to achieve the plan. If no powers are required, guardianship should not be used.

6.9 Key elements of the plan should include:

- suitable accommodation
- access to day care, education and training facilities
- (if there is a private guardian) support from the LSSA for the guardian
- effective cooperation and communication between everyone involved in implementing the care plan.

The guardian should be willing to advocate for the patient when dealing with agencies whose services are needed to carry out the care plan.

6.10 It is important that any LSSA procedures go only as far as needed to ensure the proper use of guardianship. Guardianship should be used positively and flexibly.

## Duties of local social services authorities

6.11 Each LSSA should establish a policy setting out the arrangements for:

- receiving, considering and scrutinising applications for guardianship (see chapter 10), ensuring applications are properly but speedily dealt with
- monitoring the progress of the guardianship including steps to fulfil the authority's obligations relating to private guardians and to arrange visits to the patient (see the *Mental Health (Hospital, Guardianship, Community Treatment and Consent to Treatment) (Wales) Regulations 2008*) - for the purposes of this chapter referred to as 'the regulations')
- authorising an approved clinician to be the patient's responsible clinician
- ensuring any proposed private guardian is suitable and able to carry out their duties, including the appointment of a nominated medical attendant
- ensuring that a patient under guardianship receives information, orally and in writing, as required by the regulations made under the Act

- ensuring that the patient is aware of the right to apply to the Mental Health Review Tribunal for Wales and that a named officer of the LSSA will help them make such an application if assistance is necessary
- ensuring that the patient is aware of the independent mental health advocate (IMHA) service
- ensuring that the nearest relative, where practicable, receives the information detailed in the regulations
- maintaining detailed records about the person under guardianship
- ensuring a review towards the end of each period of guardianship
- discharging the person from guardianship as soon as it is no longer required.

## The powers of the guardian

6.12 A guardian may be the LSSA or someone else approved by the LSSA (known as a 'private guardian'). Section 8 of the Act sets out the three powers of the guardian as follows:

- to require the patient to live at a place specified by the guardian (a patient who is absent without leave from the specified place may be returned within the statutory time limit by those authorised to do so under the Act)
- to require the patient to attend at specified places and times for medical treatment, occupation, education or training (if the patient refuses to attend, the guardian is not authorised to use force, and medical treatment may not be given without the patient's consent)
- to require access to the patient to be given at the place where he or she is living, to a doctor, AMHP or other relevant person (refusing without reasonable cause is an offence under section 129 but no force may be used to secure entry).

6.13 While the reception into guardianship does not affect the continued authority of an attorney or deputy appointed under the MCA, such attorneys and deputies will not be able to take decisions about where a guardianship patient is to reside, or take any other decisions which conflict with those of a guardian.

6.14 Any guardian must act for the welfare of the individual, and appreciate their special disabilities and needs, if any. The guardian should show an interest in promoting the patient's physical and mental health and in providing for their occupation, training, employment, recreation and general welfare in a suitable way.

6.15 The LSSA must satisfy itself that the proposed guardian is capable of carrying out their functions and should help the guardian by providing appropriate advice and facilities.

6.16 If the patient consistently refuses to cooperate with the guardian, there should be a full review of their care. The professionals should consider an alternative care delivery approach, which may include ending the guardianship order.

## General matters

### 6.17 Points to remember:

- Guardianship does not restrict the patient's access to hospital services informally. A patient who needs treatment, but does not need to be detained, may be admitted informally.
- Guardianship can also remain in force if the patient is admitted to hospital under section 2 or 4 but not under section 3.
- It is possible in certain circumstances for a patient liable to be detained in hospital through an application under Part 2 of the Act to be transferred into guardianship, and for someone subject to guardianship under Part 2 of the Act to be transferred into the guardianship of another LSSA or person approved by such authority or to be transferred to hospital. (See section 19 of the Act and the regulations).
- The authority to convey the person to any place named in their care plan is contained in section 18(7).
- Guardianship does not give any power to deprive someone of their liberty.

### 6.18 Particular practice issues:

- Guardianship should not be used to require a patient to stay in hospital except for a very short time while accommodation in the community is being arranged.
- If an adult is assessed as needing residential care, but lacks capacity to make a decision about this, those who are responsible for their care should consider the appropriateness of guardianship as a framework for planning care and treatment in this way (refer also to chapter 13 on the interface with the MCA).
- While the reception of a patient into guardianship does not affect the continued authority of an attorney or deputy appointed under the MCA, such attorneys and deputies will not be able to make decisions about where a person subject to guardianship is to live, nor make other decisions which conflict with those of a guardian.

## Guardianship under section 37

6.19 Guardianship may be used as an alternative to hospital orders by courts where the criteria set out in the Act are met. The court should be satisfied that the LSSA or named person is willing to act as guardian, and the LSSA should be satisfied with the arrangements. The LSSA should be guided by the same principles that apply under Part 2 of the Act. Guardianship under section 37 applies in the same way as guardianship under section 7 of the Act except that the power to discharge is not available to the nearest relative; they may apply to the Mental Health Review Tribunal for Wales.

# Chapter 7

## Places of safety and police powers

7.1 This chapter provides guidance on the police powers to remove a person to a place of safety under provisions in the Act. It also gives guidance on the assessment of a person removed to a place of safety, and any later transfer to another place of safety.

### Understanding the legal framework

#### Section 135: Warrant to search for and remove patients

7.2 Using a warrant from a justice of the peace, a police officer may use powers of entry under section 135(1) or (2) when they need to gain access to a mentally disordered person who is not in a public place and, if necessary, remove them to a place of safety.

7.3 Local authorities should develop guidance for approved mental health professionals (AMHPs) outlining how, and when, they should make applications for a warrant under section 135. The guidance should include advice on the information to include in applications, such as what alternatives to applying for a warrant have been considered. If a suitable place of safety has been identified, this information should also be included. In most cases this would be a hospital, but section 135(6) provides for other places to be used - for example, a frail elderly mentally disordered person might be removed to a place of safety in a care home rather than a hospital.

7.4 In executing a warrant under section 135(1), the police officer must be accompanied by an AMHP and a doctor. Where the warrant is executed on a patient who is liable to detention or recall, the officer may be accompanied by a doctor and/or by any person authorised under the Act to take or retake the patient. It is good practice for the police officer to be accompanied by the patient's responsible clinician.

7.5 Section 135 permits that force may be used in executing the warrant although only where absolutely necessary. The least restrictive means of controlling and restraining the person should always be used and the person should be treated humanely and with due sensitivity. Regard must be shown for the individual's human rights, dignity, privacy and any particular care needs, for example, those associated with their physical health.

#### Section 136: Mentally disordered persons found in public places

7.6 Section 136 allows for any person to be removed to a place of safety if they are found in a public place and appear to a police officer to be suffering from mental disorder and in immediate need of care or control.

- 7.7 Removal may take place if the police officer believes it necessary in the interests of that person, or for the protection of others. An officer may use reasonable force where necessary.
- 7.8 The least restrictive means of controlling and restraining the person should always be used, with the person being treated humanely and with due sensitivity. Regard must be shown for their human rights, dignity, privacy and any particular care needs such as those associated with their physical health.
- 7.9 The purpose of removing the person in these circumstances is so they can be examined by a doctor and interviewed by an AMHP to ensure any necessary arrangements are made for their care and treatment.
- 7.10 Section 136 is not an emergency admission order. It enables an individual to be detained in a place of safety for examination and interview. When that process has been completed within the 72-hour detention period or the doctor has decided that the person is not mentally disordered, the patient must be released, unless he has been admitted to hospital under the Act.

## Local policies on police powers and places of safety

- 7.11 Local Health Boards (LHBs), NHS Trusts, local social services authorities (LSSAs), police forces and the ambulance service should ensure they have jointly agreed policies for the use of section 135 and section 136, as well as agreed places of safety in their areas. The policy should clearly define each agency's responsibility, environmental expectations and risk-management standards, how the operation of the policy will be monitored and the timeframe for its review.
- 7.12 In particular the policy should define responsibilities for:
- planning and providing safe and secure clinical facilities for the containment of a person requiring examination or interview
  - identifying and agreeing the most appropriate place of safety in individual cases
  - providing prompt assessment and, where appropriate, admission to hospital for assessment and/or treatment
  - securing the attendance of police officers where needed to protect a patient's health or safety, or the health or safety of others
  - taking the person to the place of safety, safely and promptly
  - dealing with people who are under the effects of alcohol or drugs
  - dealing with people who are behaving or have behaved violently
  - deciding whether it is appropriate to transfer the person from one place of safety to another
  - returning the person to the local community (where the assessment has not led to admission to hospital or other accommodation).

The policy must ensure due regard is given to the person's individual circumstances, in accordance with the guiding principles set out in chapter 1 of this Code.

- 7.13 Local policies should ensure that police officers know whom to contact before removing someone to a place of safety under section 136.
- 7.14 A person who is removed to a place of safety under section 136 may be subject to supervised community treatment (SCT), conditional discharge, or may be on leave of absence and their recall to hospital may need to be considered. The policy should set out the arrangements, in these circumstances, for contacting the patient's responsible clinician as quickly as possible. Similar provisions in the policy will need to relate to patients who are subject to guardianship.
- 7.15 The policy should include provision for the use of section 136 to be monitored. This will enable checks to be made of how it is being used, including its use in relation to people from black, minority ethnic communities and children, and the parties to the policy to consider any changes in mental health services that might result in reducing its use.
- 7.16 Where local policies establish target times for the start of the examination or interview, NHS bodies and LSSAs should review local practice against these targets.

### Identifying an appropriate place of safety

- 7.17 The process for identifying the most appropriate place of safety must be clearly outlined in the local policy. While this is a matter for local agreement, consideration must be given to the availability and appropriateness of such facilities, depending on individual circumstances. The most appropriate place of safety for children and young people must be considered especially carefully.
- 7.18 A person thought to be suffering from mental disorder should be detained in a hospital if possible. Only in exceptional cases would a police station be the most appropriate place for them to be examined and assessed.
- 7.19 Every effort should be made to ensure that a police station is only used where it is absolutely necessary to provide short-term containment, for example, if the person is considered too violent for the available hospital, or they pose a high risk to other patients or staff.
- 7.20 Save in certain circumstances, it is not acceptable for a police station to be the first option as a place of safety, or an automatic option in cases where more suitable accommodation is not immediately available.
- 7.21 In choosing the place of safety, the professionals should consider the impact that the proposed place of safety may have on the person held and on the examination and interview. Therefore, a police station should be used either in the exceptional circumstances outlined above or when it is considered the safest option for the person, other patients or staff.

7.22 Where someone is removed to a place of safety by the police under section 136, the following are recommended:

- If the place of safety is a hospital, the police should make immediate contact with the hospital and the LSSA before arrival. This will allow the hospital and the LSSA to make arrangements to receive the person and for the examination and interview to begin as soon as practicable.
- If a police station is to be used as the place of safety, health and social care agencies should be contacted to discuss supporting the care and welfare of the person while in police detention. Contact should be made quickly with the LSSA and the appropriate doctor (most likely the forensic medical examiner who works with the police). This will enable the examination and interview to begin as quickly as possible, and allow the professionals to consider a transfer to an alternative place of safety as soon as it is safe and appropriate.
- Agencies should work together to ensure no unnecessary delay in the examination and interview process.

7.23 Section 26 and schedule 2 of the Police and Criminal Evidence Act 1984 (PACE) preserves the power to remove under section 136(1) as a power of arrest. This allows for section 32 of that Act to apply which enables a police officer to search a person at a place other than a police station. This power also enables the removed person to be detained under section 136(2) of the Mental Health Act 1983 and for the custody officer to identify what items the detained person has in their possession.

## Examination and interview

7.24 Wherever possible, the examination and interview should be carried out jointly by the doctor and AMHP. There may also need to be an appropriate adult present, particularly if the patient is a child. The examination should begin as soon as possible after arrival at the place of safety.

7.25 Local policies should ensure the doctor undertaking the examination is, wherever possible, approved under section 12(2) of the Act. If the examination has to be carried out by a doctor who is not approved, the reasons should be recorded.

7.26 If, in exceptional circumstances, the doctor has completed the examination before the AMHP arrives and concluded that the person is not mentally disordered within the meaning of the Act, the person can no longer be detained under section 136 and should be immediately released. If the doctor concludes that the person is mentally disordered within the meaning of the Act but does not need to be admitted to hospital, or the person agrees to informal admission, the person should still be seen by an AMHP.

7.27 A consultant psychiatrist in learning disabilities and an AMHP with special experience in learning disabilities should make a joint assessment if it appears the detained person has a learning disability.



7.28 Similarly, if the detained person is under 18, or is known to have only recently moved into adult mental health services, a consultant psychiatrist in child and adolescent mental health services (CAMHS) and an AMHP with special experience in CAMHS should carry out an assessment together.

7.29 The role of the AMHP includes:

- interviewing the person
- contacting any relevant carers, relatives and friends
- finding out if the person has a psychiatric history, through collaboration with other professionals.

7.30 The AMHP should consult the doctor about any arrangements that might need to be made for the person's treatment or care, and the AMHP should:

- consider any possible alternatives to admission to hospital
- or make arrangements for compulsory admission to hospital
- or make any other necessary arrangements.

## Treatment of a person removed to a place of safety

7.31 Parts 4 and 4A of the Act, do not apply to someone detained under section 135 or 136. In other words, they are in exactly the same position in respect of consent to treatment as patients who are not detained under the Act (see also chapter 16).

## Transfer between places of safety

7.32 As a result of changes made by the Mental Health Act 2007, the Act now allows for the person to be transferred between places of safety before the end of the maximum 72-hour period. The maximum period of detention begins from the time of the person's arrival at the first place of safety; this cannot be extended if the person is transferred to another place of safety.

7.33 In the exceptional circumstances where the place of safety is a police station, this should be for as short a time as possible and transfer to a more appropriate place made as quickly as possible.

7.34 The person may be taken to the second or subsequent place of safety by a police officer, an AMHP or a person authorised by either the officer or the AMHP. Matters to be considered in transferring the detained person under these provisions are set out in chapter 9 of this Code.

## Information for people detained under section 136

7.35 If someone has been removed to a place of safety under section 136, they are entitled to have another person, of their choice, informed of the removal and of their whereabouts.

- 7.36 If the place of safety is a police station, the person has a right of access to legal advice. The conditions of detention and treatment of the person must be in accordance with PACE Code C (paragraph 1.10). This requires, among other things, that the person must be told their rights and entitlements orally and in writing. Although section 132 of the Mental Health Act 1983 would not apply to someone in police detention, local policies should require that the same information is given to the person on their arrival as would be given to them if the place of safety were a hospital.
- 7.37 If the place of safety is a hospital, the hospital managers must ensure that the provisions of section 132 of the Act are complied with. They must also provide access to legal advice if requested.
- 7.38 As soon as detention in a place of safety under section 136 ends, the individual must be informed. Where they are free to leave they must be advised of this promptly and clearly.

### **Making ‘necessary arrangements’**

- 7.39 After the examination and interview, the doctor and the AMHP are jointly responsible for considering if any arrangements are necessary to provide for the person’s care and treatment needs.
- 7.40 Where compulsory admission is indicated and hospital is the place of safety, the person should be admitted under section 2 or 3 of the Act. A person detained under section 136 should not have their detention extended by use of sections 5(2) or 5(4) of the Act.
- 7.41 If the police station is the place of safety, compulsory admission to hospital should be under section 2 or 3 as appropriate. It is unlikely that section 4 would be appropriate if there was an urgent need to secure the transfer of the patient to hospital, as the powers of transfer between places of safety should be used.
- 7.42 If the patient is on SCT and compulsory admission is required, the community treatment order should be revoked.

### **Record keeping**

- 7.43 A record of the person’s time of arrival at the place of safety should be made immediately. If the person is later transferred to an alternative place of safety, this should be recorded and the information about their original time of arrival passed to the new place of safety.
- 7.44 Records should also be made of any visitors to the person detained in the place of safety, the purpose of the visit, any interventions necessary and requests made by the person.
- 7.45 A record should be made of the time the period of detention under section 136 comes to an end, and the outcome of the examination and interview.
- 7.46 These records should be subject to monitoring as part of the local policy arrangements.

# Chapter 8

## Holding powers

- 8.1 This chapter provides guidance on the use of holding powers available to doctors, approved clinicians and nurses, and the matters which should be considered when using these powers.
- 8.2 Good practice will be supported by:
- the professionals involved in implementing the holding powers correctly understanding the powers and their purpose
  - hospitals and local authorities 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 approved mental health professional and doctors
  - the hospital managers and local social services authority (LSSA) monitoring the use of the power.

### Use of section 5

- 8.3 Section 5 of the Act provides for applications for admission for assessment or treatment to be made for mentally disordered patients who are already receiving treatment in hospital as informal patients. Section 5 should only be used if, at the time, it is not practicable or safe to take the steps necessary to make an application for detention without detaining the patient in the interim.
- 8.4 Section 5 should not be used:
- as an alternative to making an application under section 2 or section 3, even if it is thought that the patient will need to be detained for 72 hours or less
  - to prolong the detention of a patient where the authority to detain is about to expire (section 5(6))
  - to provide time for an application to be made to the county court under section 29(4) of the Act
  - immediately after section 136 of the Act because there should have already been sufficient time for an assessment to be undertaken. However, a patient initially admitted under section 136 who subsequently agrees to remain an inpatient without compulsion, may later need to be held under the section 5 powers.

## Inpatients

- 8.5 As section 5 may only be used for an informal patient in a hospital, hospital managers should be able to clearly identify what is meant by “informal inpatient”. For the purposes of this Code, an informal inpatient is a patient who has come to the ward and who has not acted to resist (verbally or physically) the admission procedure. A patient remains an inpatient until they have removed themselves (or been removed) from the hospital.
- 8.6 Informal patients should be made aware of how they may discharge themselves from inpatient status.
- 8.7 A patient being treated in an outpatient department, in a day hospital or as a day patient cannot be detained under section 5 of this Act. Admission procedures should not be implemented with the sole intention of then using section 5.

## Doctor and approved clinician’s holding power (section 5(2))

- 8.8 The power may only be used by the doctor or approved clinician in charge of the patient’s treatment, or their nominated deputy. The identity of the person in charge of a patient’s treatment at any time will depend on the particular circumstances. But a professional who is treating the patient under the direction of another professional should not be considered to be in charge.
- 8.9 Section 5(3) of the Act allows the doctor or approved clinician to nominate a deputy to exercise the holding power in their absence. The deputy cannot in turn delegate the power to another. A doctor may delegate another doctor or an approved clinician; an approved clinician may also delegate a doctor or another approved clinician. In both cases the nominated deputy must be on the staff of the hospital in which the patient is currently an inpatient.
- 8.10 The deputy may find it useful to consult a senior colleague before exercising the power under section 5, but any decision to apply the holding power should be their own. The nominated deputy should report the use of section 5(2) to the person for whom they are deputising as soon as practicable.
- 8.11 To ensure that there is appropriate cover in case it is necessary for section 5(2) to be used, there should be an identified deputy for every duty period. Deputies may be nominated by title, rather than by name, for example the junior doctor on call for particular wards, provided that it can be determined with certainty who the nominated deputy is at any given time.
- 8.12 It may occasionally be necessary to make a report under section 5(2) on a patient who is not in a psychiatric hospital or the psychiatric wing of a general hospital. Where such a patient is receiving treatment for mental disorder (in addition to inpatient treatment for other illnesses or disorders) the doctor or approved clinician for the purposes of section 5(2) will be the person in charge of the patient’s treatment for the mental disorder. But where the patient is not receiving treatment for mental disorder (for example they are receiving treatment for a

physical health problem only), the doctor in charge of the patient's treatment would have the power to make the report. In these cases there would not be an approved clinician in charge of their treatment.

- 8.13 In all cases doctors and approved clinicians should use the power only after having personally examined the patient.
- 8.14 The period of detention under section 5(2) starts at the moment the report of the doctor or approved clinician (or their deputy) is furnished to the hospital managers (e.g. when it is handed to an officer authorised by the managers to receive it, or when it is put in the hospital's internal mail system).
- 8.15 The use of the power, its start and end dates and times should be accurately recorded in the patient's case notes.
- 8.16 Arrangements for an assessment to consider the use of section 2 or section 3 should be put in place as soon as the report is furnished to the hospital managers.
- 8.17 Detention under section 5(2) will end if:
- the result of the assessment is a decision not to make an application under section 2 or 3
  - or the power has been invoked by a nominee under section 5(3) and the doctor or approved clinician in charge decides that no assessment for possible detention needs to be carried out
  - or an application under section 2 or 3 is made
  - or the patient is discharged for clinical reasons before an assessment can be undertaken (for example, the patient's violent conduct leads to an arrest and removal to police custody).

The maximum period a patient may be held under section 5(2) is 72 hours, which will include any time the patient is held under section 5(4) of the Act.

- 8.18 The patient should be informed once he or she is no longer held under section 5(2) and advised of the reasons why. If this is because section 2 or section 3 was not applied, the patient should be informed they are free to leave the hospital.

## **Nurses holding power (section 5(4))**

- 8.19 A nurse of a prescribed class (see below) may use section 5(4) of the Act to detain an inpatient who is receiving treatment for mental disorder for a period of not more than six hours. This section may be used only where it is immediately necessary to prevent the patient leaving the hospital and it is not practicable for a practitioner or clinician to attend immediately and make a report to the hospital managers under section 5(2) of the Act.

- 8.20 A nurse of the 'prescribed class' is defined in the *Mental Health (Nurses) (Wales) Order 2008* as a nurse registered in sub-part 1 or 2 of the nurse's part of the Register of the Nursing and Midwifery Council, with a recordable qualification in mental health or learning disability nursing.
- 8.21 The decision whether to use this power is entirely at the discretion of the nurse. The nurse cannot be instructed to exercise this power by anyone else.
- 8.22 A patient cannot be made subject to section 5(4) if he or she does not meet the criteria set out in that sub-section. Therefore, before using this power the nurse should assess:
- (a) the likely arrival time of the doctor or approved clinician, against the likely intention of the patient to leave. It may be possible to persuade the patient to wait until a doctor or approved clinician arrives to discuss their case further. Where this is not possible the nurse must assess the impact of any delay upon the patient;
  - (b) the consequences of a patient leaving hospital immediately, including the harm that might occur to the patient or others, taking into account:
    - the patient's expressed intentions including the likelihood of the patient harming themselves or others
    - any evidence of disordered thinking
    - the patient's current behaviour and in particular any changes in usual behaviour
    - the likelihood of the patient behaving violently
    - any recently received messages or information from relatives or friends
    - any recent disturbances on the ward
    - any relevant involvement of other patients
    - any known unpredictability on the patient's part
    - and any other relevant information from other members of the multi-disciplinary team.
- 8.23 Formal structured assessment should normally take place before any action on the part of the nurse, but in extreme circumstances it may be necessary to use the power after a briefer assessment. The suddenness of the patient's determination to leave and the urgency with which they attempt to do so should alert the nurse to potentially serious consequences if the patient were to be successful in leaving.
- 8.24 The patient may be detained from the moment the nurse makes the necessary record. The record must then be sent to the hospital managers. Entries should also be made in the patient's case notes of the use of this power; the reasons and the expiry date and time.
- 8.25 A nurse using section 5(4) may use the minimum force necessary to stop the patient leaving the hospital.

- 8.26 During the detention under section 5(4), the doctor or approved clinician in charge of the patient's treatment (or their nominated deputy) should attend as soon as possible, and within the six hours of the power, and examine the patient to consider making a report under section 5(2). All discussions, including attempts to contact the doctor or approved clinician should be recorded in the patient's notes.
- 8.27 The use of section 5(4) is an emergency measure and the doctor or approved clinician with the power to use section 5(2) should take steps to arrive as soon as possible. The doctor or approved clinician should not wait six hours before attending, simply because this is the maximum duration of the holding power. Hospital managers should set target times for responses, which should be as short as practicable.
- 8.28 If no doctor or approved clinician has attended within six hours, the patient must be released and may leave the hospital if not prepared to stay voluntarily. The failure to attend should be considered as a serious failing, and reported and investigated locally.
- 8.29 The six hours of the power is a maximum, which cannot be renewed or extended. Any detention under section 5(4) will end after the six-hour period, or on the arrival of the doctor, approved clinician or their deputy entitled to make a report under section 5(2). The power does not continue if a report under section 5(2) is not made.
- 8.30 The details of any patient who remains subject to the power at the time of a shift change must be given to staff coming on duty.

## Statements of intent

- 8.31 Although entries into notes which appear to limit the discretion of the doctor/approved clinician or deputy must be avoided (for example 'For section 5(2) if he tries to leave'), the doctor or approved clinician in charge may make an entry to the effect that the use of powers under section 5(2) should be considered if the patient tries to leave. It is not acceptable to record 'not to leave the ward' or 'ntlw' in an informal patient's case notes.

## General points regarding section 5

### Information

- 8.32 The patient should be told about the provisions and effects of the use of section 5, and the reasons for using it. Where a patient has been held under section 5(4) but has subsequently been detained under section 5(2), this change and its effect should be explained to the patient.

### Medical treatment of patients

- 8.33 Part 4 of the Act does not apply to a patient detained under section 5. In other words, they are in exactly the same position in respect of consent to treatment as patients who are not detained under the Act.

## Transfer to other hospitals

- 8.34 Patients detained under section 5 cannot be transferred to another hospital under section 19 of the Act, because they are not detained through an application made under Part 2 of the Act. This includes transfer between hospitals that are managed by the same hospital managers.
- 8.35 If a patient leaves hospital, while held under this power; they cannot be retaken once the period of detention has passed - for section 5(4) this is 6-hours, for section 5(2) this is 72-hours.

## Recording the end of detention

- 8.36 The time at which a patient ceases to be detained under section 5 should be recorded, together with the reasons for it and the outcome.
- 8.37 Section 5 cannot be renewed, but it is recognised that circumstances may arise after the patient's reversion to informal status where the use of the holdings powers may be considered again.

## **Hospital managers' responsibilities**

- 8.38 Hospital managers should ensure that there are suitably qualified, experienced and competent nurses available on all wards where there is a possibility of section 5(4) being used, particularly acute admission wards, and wards where there are acutely disturbed patients, or patients needing intensive nursing care.
- 8.39 Hospital managers should also ensure that the staff who may need to consider using section 5(2) or section 5(4) are familiar with the chapters of this Code concerned with the management of behaviours that challenge (chapter 19) and information for patients (chapter 22).
- 8.40 Hospital managers should monitor the use of section 5, including how quickly a patient is assessed for detention, and/or discharged from the holding power. They should also monitor the attendance times of doctors and approved clinicians after the use of section 5(4), together with outcomes following their attendance.



# Chapter 9

## Conveyance of patients

9.1 This chapter provides guidance on conveying patients from one place to another in the circumstances set out in the Act.

### Authority to convey

9.2 The Act allows for patients to be conveyed from one place to another in several circumstances. The guidance in this chapter will apply whether this conveyance is to enable:

- admitting people to be assessed or treated
- transferring patients liable to be detained between hospitals
- transferring patients who have been received into guardianship to the community
- transferring people to and between places of safety (sections 135 and 136)
- returning patients liable to be detained to hospital if they are absent without leave
- returning people to hospital if they are on supervised community treatment (SCT), or conditional discharge, and have been recalled
- transferring patients between hospital, court and prison.

9.3 The following table explains who is responsible for coordinating conveyance.

Reason for conveyance	Legal authority	Responsibility for co-ordinating conveyance
Admission to hospital	Section 6(1)	The applicant (i.e. the AMHP or nearest relative)
Transfer between hospitals	Section 19 and associated regulations	Hospital managers
Conveyance into guardianship, or between places for guardianship	Section 18(7)	The applicant (i.e. the AMHP or nearest relative) or guardian
Transfer between places of safety	Section 135(3A) or section 136(3)	Police or AMHP or person authorised by them, depending on place of safety
Return of patients absent without leave	Section 18	Police, AMHP, hospital staff or hospital manager
Recall from SCT or conditional discharge	Sections 17E & 17F or section 42(3) (as applicable)	Responsible clinician
Transfer to hospital from prison/court	Sections 35(9)(a), 37(4), 38(4), and 40(1)	Court
Return to court or prison	Sections 35(9), 36(8), 50(1)(a), 51(3) and (4), and 53(2)	Responsible clinician or hospital manager

## General matters

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

- a clear statement of the roles and obligations of each authority and its staff
- the form of any authorisation to be given, for example by the approved mental health professional (AMHP) to ambulance staff
- guidance on powers relating to conveying patients
- responsibility for conveying patients outside authority areas.

9.5 Those responsible for taking patients from one place to another must 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 factors to be taken into account when deciding the most appropriate method for conveyance include:

- the guiding principles in chapter 1
- the wishes and views of the patients, including any relevant care plan or advance statement
- the nature of the mental disorder and its course
- any physical disability the patient has
- the impact that any particular transport will have on the patient's relationship with the community to which he or she will return
- the availability of various transport options
- the distance to be travelled
- the patient's need for support and supervision during travel
- the availability of transport to return home those who accompany the patient (including whether the professionals will need to return to their own vehicles)
- the risk of the patient absconding and the risk of harm in the event of the patient absconding before admission to hospital.

## Conveying to hospital for admission

9.6 A duly completed application for admission under the Act (which includes the required medical recommendations) gives the applicant, whether an AMHP or nearest relative, the authority to take the patient to hospital.

9.7 If an AMHP is the applicant, he or she must ensure that all the necessary arrangements are made for the patient to be taken to hospital.

9.8 If the nearest relative is the applicant and they need help to ensure the safe transport of their relative, the local social services authority (LSSA) should ensure the availability of an AMHP to help them. If this is not possible, other professionals should help.

- 9.9 If the 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). For further guidance on removing patients under warrant see chapter 7 of this Code.
- 9.10 The task of conveying the patient may be delegated, for example, to ambulance staff, and help may be sought from the police. The AMHP (or other authorised person) is ultimately responsible for ensuring the patient is transported in a lawful and humane way and should give guidance to those asked to help.
- 9.11 The patient should not normally be transported by car unless the AMHP is satisfied that they do not present a danger to themselves or others and that this is the most appropriate method. In these circumstances there should always be an escort for the patient in addition to the driver.
- 9.12 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 the police may be asked to provide a suitable vehicle. Although the police may have to exercise their duty to protect people or property while the patient is being conveyed, they should, where possible be guided by any advice provided by the AMHP.
- 9.13 If the patient is taken by ambulance, the AMHP may go with the patient and, where requested by the AMHP, the ambulance authority should make the necessary arrangements for this to happen. The patient may be accompanied by another person, provided the AMHP is satisfied that this will not increase the risk of harm to the patient or others.
- 9.14 The AMHP should telephone the receiving hospital to ensure that the patient is expected and give the likely time of arrival.
- 9.15 The AMHP must ensure that the admission documents are provided to the receiving hospital at the same time as the patient arrives. If the AMHP is not travelling with the patient, the documents should be given to the person authorised to take the patient, with instructions for them to be presented to the officer authorised to receive them.
- 9.16 If the 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. The AMHP 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 AMHP should stay in the hospital with the patient until satisfied that the patient has been detained properly.
- 9.17 The AMHP should leave a 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. LSSAs and NHS Trusts should develop and use a common form on which AMHPs can make this report. The report should also be included in any community case records, if these are not shared with hospital case records.

- 9.18 There may be circumstances where the receiving hospital is a considerable distance from the area where the AMHP operates, which would make it impracticable for the AMHP to go to hospital with the patient. In these circumstances, the information referred to in paragraph 9.17 may be delivered by telephone, facsimile or other electronic means that comply with local or national procedures for passing confidential information.
- 9.19 A patient who has been sedated before being taken 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.

## Conveying patients recalled from supervised community treatment (SCT)

- 9.20 The responsible clinician will be responsible for coordinating the patient's recall. Their decision to recall a patient on SCT provides the legal authority for the patient to be taken to hospital by the responsible clinician, or any AMHP, officer on the staff of the hospital, police officer or person authorised in writing by the responsible clinician.
- 9.21 The way to achieve the patient's return to hospital will need to be considered after assessing any risk, the need for urgency, the factors outlined in paragraph 9.5 above, and any other practical considerations.
- 9.22 If the person being recalled might be violent or dangerous, the police should be asked to help. In these circumstances an ambulance may be the preferred transport, unless the assessed level of risk indicates that a police vehicle should be used. Although the police may have to exercise their duty to protect people or property while the person is being conveyed, they should bear in mind any professional guidance given by the person authorised to take the person to hospital.

## Conveying patients between hospitals or places of safety

- 9.23 Given patients taken to a place of safety under sections 135 and 136 can be moved between places of safety, it is important that the reasons and justification for the transfer are clearly thought through (see chapter 7).
- 9.24 When transporting patients between hospitals or places of safety, it is necessary to consider the most appropriate method of securing the transfer, taking into consideration the patient's views as well as the need to manage any risks to the safety of the patient or others.
- 9.25 It is not always necessary for transport to be by ambulance but where this is most appropriate, an ambulance should be provided.

# Chapter 10

## Receipt and scrutiny of prescribed forms

- 10.1 This chapter provides guidance on receiving and scrutinising the forms prescribed by the *Mental Health (Hospital, Guardianship, Community Treatment and Consent to Treatment) (Wales) Regulations 2008* (referred to in this chapter as 'the regulations'). These forms give authority for compulsion (including guardianship) and treatment under the Act, and it is essential that systems are in place to ensure that the completion of the forms meets the legal requirements.
- 10.2 Applications and recommendations do not have to be completed on original statutory forms, and photocopies of an original form or a computer-generated form may be used. However, the wording of the forms must meet the requirements in the regulations.
- 10.3 There is a difference between 'receiving' forms and 'scrutinising' them. Receipt involves physically receiving the forms and recording that receipt; scrutiny is the study of those forms to ensure that the requirements of the Act and the regulations have been met. Scrutiny includes both administrative and medical scrutiny (see paragraph 10.10 below). Reference to 'receipt' in this chapter means the formal receipt of forms by or on behalf of the hospital managers.
- 10.4 Forms should be scrutinised as soon as they are received or as soon after as possible.

## Receipt and scrutiny of guardianship applications

- 10.5 The local social services authority (LSSA) should prepare a checklist to guide those delegated to receive forms, to identify errors that can be corrected within 14 days of receipt (see section 8(4)) or that might make the application invalid. When someone is being received into guardianship, the person 'receiving' the forms on behalf of the LSSA should check their accuracy with the approved mental health professional (AMHP) or nearest relative making the application.
- 10.6 The LSSA should ensure that the medical recommendations (required under section 7(3)) are scrutinised by someone with appropriate clinical expertise to check that the reasons given appear sufficient to support the conclusions shown in them. The scrutiny of the medical recommendations should be carried out at the same time as the administrative scrutiny.

## Receipt and scrutiny of applications for admission to hospital

- 10.7 The hospital managers should formally delegate their duties to receive and scrutinise admission forms to a limited number of officers who have been suitably trained and understand the requirements of the Act. Depending on the type of unit to which patients

are admitted, it may be appropriate to ensure that there is 24-hour cover for receiving and scrutinising forms. A manager of appropriate seniority should take overall responsibility on behalf of the hospital managers for the proper receipt and scrutiny of forms.

- 10.8 The hospital should have a checklist to guide those delegated to receive forms, to detect errors that might invalidate applications, or that can be corrected within 14 days of receipt (refer section 15).
- 10.9 When a patient is being admitted on the application of an AMHP, the person receiving the admission forms should check their accuracy with the AMHP. The person receiving the forms should have access to a manager for advice, especially outside normal working hours.
- 10.10 Where the person delegated to receive the forms is not a person authorised by the hospital managers to agree to the correction of errors in an admission form, the forms should be scrutinised by an appropriately authorised person immediately on the patient's admission - or during the next working day if the patient is admitted out of hours.
- 10.11 Forms should be scrutinised for accuracy and completeness and to check that they do not reveal any failure to comply with the procedural requirements of the Act and regulations. The medical recommendations should also be scrutinised by someone with appropriate clinical expertise to check that the reasons given appear sufficient to support the conclusions shown in them. This scrutiny should be carried out at the same time as the administrative scrutiny of the forms.

## Rectifiable and non-rectifiable errors

- 10.12 Those delegated to scrutinise forms must be clear about the kind of errors on application forms and medical recommendations which can and cannot be corrected.
- 10.13 Sections 8(4) and 15 of the Act allow for the correction of 'incorrect' or 'defective' applications or medical recommendations for guardianship or admission to hospital, within 14 days of these being received by or on behalf of the hospital managers or the LSSA.
- 10.14 There is no equivalent power of rectification for orders issued by a court, reports made under section 5, forms given in support of a transfer under section 19 or to the renewal of detention, or forms relating to supervised community treatment (SCT). However, hospital managers and LSSAs should ensure that these forms are scrutinised to ensure that they have been duly and correctly completed.
- 10.15 Rectification, or correction, is mainly concerned with inaccurate recording, and it cannot be used to enable a fundamentally defective application to be retrospectively validated. It also cannot be used to cure a defect which arises because an element of the procedural process leading to the detention has simply not taken place at all. Therefore a form may be 'incorrect', for example, if names, dates or places are mis-stated, but which, if corrected, would not make

the decision to admit a patient an unjustified one, and it may be 'defective' if the signatory has failed to complete all the sections, or delete alternative options. An unsigned form should not be accepted as rectifiable.

10.16 When an AMHP makes an application for detention or guardianship, he or she should carefully check that the medical recommendations prepared by the doctors meet the requirements of both the Act and the regulations. The AMHP should pay particular attention to the correct completion of the medical recommendations and application form. Wherever possible, errors on forms should be corrected before being accepted, with appropriate consultation between the AMHP and the doctor.

10.17 If, after receipt of the admission forms, scrutiny identifies a defect which cannot be rectified under section 15, and is sufficiently serious to make the application invalid, either the hospital managers or the responsible clinician should use their powers under section 23 to discharge the patient from the section. The patient can then only be detained through a new application.

## Monitoring of receipt and scrutiny

10.18 Hospital managers and LSSAs must ensure that patients are detained lawfully; they should therefore monitor the receipt and scrutiny of admission, guardianship and SCT forms regularly.

10.19 Hospital managers remain responsible for their duties even when carried out by those delegated by the hospital managers. Because of this, details of defective admission forms, whether rectifiable or not, and of any subsequent action, should be given regularly to the hospital managers. Similarly, details of defective guardianship forms should be regularly passed to the LSSA. If previously unnoticed errors are found during monitoring, these should be brought to the attention of hospital managers or LSSAs for immediate consideration.

10.20 Hospital managers and LSSAs should ensure that those delegated to receive and scrutinise statutory forms on their behalf are competent to perform these duties, understand the requirements of the Act, and receive suitable training.





# Chapter 11

## Duties of hospital managers

11.1 This chapter explains who the hospital managers are and their role under the Act. Hospital managers may delegate functions and this chapter sets out how they may do this, as well as the governance arrangements for delegations. The chapter also gives guidance on specific powers and duties of hospital managers not covered in other chapters, including those relating to transfers between hospitals, victims of crime, patients' correspondence and references to the Mental Health Review Tribunal for Wales (MHRT for Wales).

### The hospital managers

11.2 Hospital managers have a central role in operating the provisions of the Act.

11.3 For hospitals vested in NHS Trusts, the trust boards are the 'managers'. For a hospital vested in a Local Health Board (LHB), it is the Board members, and for independent hospitals, the person or people in whose name the hospitals are registered under the Care Standards Act 2000 are the managers for the purposes of the Act.

11.4 The hospital managers have the authority to detain patients admitted under the Act. For patients on supervised community treatment (SCT), the hospital managers are those of the responsible hospital - that is the hospital in which the patient was detained immediately before going onto SCT, or the hospital to which responsibility for the patient has subsequently been assigned.

11.5 The hospital managers must ensure that patients are detained only as the Act allows, that their treatment and care fully comply with it, and that the patients are fully informed of, and are supported in exercising, their statutory rights. Hospital managers must also ensure that a patient's case is dealt with in line with other legislation which may have an impact, including the Mental Capacity Act 2005, the Human Rights Act 1998 and the Data Protection Act 1998.

11.6 In practice most hospital managers' decisions are taken by individuals (or groups of individuals) on their behalf. Decisions about discharge from detention or SCT are taken by panels specifically selected for the role. For guidance on powers of discharge see chapter 27.

### Exercising the functions of the hospital managers

11.7 Apart from exercising the hospital managers' power of discharge, hospital managers may arrange for their functions to be carried out on a day-to-day basis, by particular people on their behalf. In certain cases Regulations prescribe that they must do so.

- 11.8 The arrangements for authorising decisions should be set out in a scheme of delegation, approved by a resolution of the body itself.
- 11.9 Regulations<sup>3</sup> permit NHS Trusts and LHBs to delegate functions to committees or sub-committees whose members need not be directors of the Trust or members of the Board. However, the Trust or Board retains the ultimate responsibility for the hospital managers' duties, and the committees and/or sub-committees should, therefore, where possible, include members of the Board.
- 11.10 The hospital managers should ensure that those acting on their behalf are competent to undertake the functions delegated to them by ensuring they are properly informed about the provisions of the Act and receive suitable training. While the hospital managers should determine any necessary arrangements to monitor and review the way functions under the Act are exercised on their behalf, they may authorise a committee, or sub-committee, for this purpose with a process of reporting on findings.

## Specific duties

- 11.11 In this chapter, unless otherwise stated, 'hospital managers' include anyone authorised to take decisions on behalf of the person or body which is formally in charge of the hospital.
- 11.12 The main responsibilities which the Act confers on hospital managers are set out below. This is expanded upon, where necessary, in the relevant chapters of this Code. Hospital managers' powers to discharge patients are dealt with in chapter 27.

## Admission

- 11.13 The hospital managers are responsible for ensuring the grounds for admitting the patient are valid and all relevant admission forms are in order. Any officer delegated with responsibility should be competent to make such a judgement, and to identify any error in the forms which may need rectifying. Guidance on receipt, scrutiny and rectification of prescribed forms is given in chapter 10.
- 11.14 Where a patient is admitted under the Act following an application by their nearest relative, the hospital managers should ask the relevant local social services authority (LSSA) to give them a social circumstances report on the patient as required by section 14.

## Responsible clinicians and approved clinicians

- 11.15 Hospital managers must ensure that patients under their care, who are subject to compulsion, are allocated an appropriate responsible clinician, and should have local arrangements in place for this. For further guidance see chapter 12. Hospital managers should keep a register of approved clinicians employed by or contracted to them.

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<sup>3</sup> See regulation 12 of the Local Health Boards (Constitution, Procedure and Membership) (Wales) Regulations 2003 (SI 2003/149 (W.19)) in relation to LHBs and regulation 15 of the National Health Service Trusts (Membership and Procedure) Regulations 1990 (SI 1990/2024) in relation to Trusts.

## Transfer between hospitals

11.16 Section 19 of the Act, and the *Mental Health (Hospital, Guardianship, Community Treatment and Consent to Treatment) (Wales) Regulations 2008* (referred to in this chapter as 'the regulations') allow the hospital managers to transfer a detained patient from one hospital to another. For restricted patients, the hospital managers' power is subject to the prior agreement of the Secretary of State for Justice.

11.17 Transfers are potentially an interference with a patient's private and family life and should always be made for valid reasons. Officers delegated with this responsibility must consider the reasons for the transfer and the needs and interests of the patient. 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. There could also be social reasons, for example 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 patient's best interests. A transfer may be unavoidable, because the hospital is no longer able to offer the care the patient needs.

11.18 The patient may themselves want to be transferred to another hospital, for example to be close to family or friends. Any request for transfer made by, or on behalf of, the patient should be recorded and given careful consideration. Every effort should be made to meet the patient's wishes.

11.19 Factors that need to be considered when deciding whether to transfer a patient include:

- whether the transfer would give the patient greater access to family or friends
- whether any wish expressed by or on behalf of the patient to be treated by another care team or individual is reasonable and would be helped by a transfer
- the likely effect of a transfer on the course of the patient's disorder or their recovery
- the availability of appropriate beds at the potential receiving hospital
- whether the transfer would be appropriate to enable the patient to be in a more culturally suitable or compatible environment
- where applicable, the views of the commissioner funding care.

Other factors may be relevant in a particular case.

11.20 Before reaching a decision on transfer, there should be discussion with the responsible clinician, the multidisciplinary team responsible for the patient's care and treatment and where practicable, the patient, their nearest relative, and other interested people. The matter should also be discussed with the clinician who would be responsible for the patient at the hospital to which the transfer is proposed.

- 11.21 It is important to explain the reasons for a proposed transfer to the patient and where appropriate, the patient's family, carers or friends, and to record the reasons. If the patient, or someone acting on their behalf, has asked for the transfer, the patient - and the person requesting if different - should be told of the decision and the reasons for it by the hospital managers in writing.
- 11.22 The consent of the patient's nearest relative (if any) is not a statutory requirement; but, unless the patient objects, the nearest relative should normally be consulted about the proposed transfer and must be informed of the transfer, if practicable.
- 11.23 Section 19A allows the responsibility for patients on SCT to be assigned to another hospital. Section 17F of the Act and the regulations enable the hospital managers to transfer a patient on SCT who has been recalled to hospital from one hospital to another. As above, officers delegated with this responsibility must always consider the reasons for the assignment and the needs and interests of the patient.
- 11.24 When a patient is transferred, or responsibility for a patient on SCT assigned, to another hospital, the forms authorising detention - including the authority to transfer - should be sent to the hospital to which the patient is transferred. Copies of these forms should be retained by the transferring hospital.

### Transfers into/from guardianship

- 11.25 Section 19 of the Act, and the regulations also allow the hospital managers to transfer a patient who is liable to be detained in hospital into guardianship, and a guardianship patient may be transferred to hospital. As with transfers between hospitals, people acting on behalf of the hospital managers and the LSSA should fully consider the reasons for any transfer and the needs and interests of the patient.

### Responsibilities under SCT

- 11.26 When a responsible clinician indicates that SCT is appropriate for a patient, those authorised to act on behalf of the hospital managers must liaise with the relevant authorities, usually the LSSA, to ensure arrangements are put in place for suitable after-care services.
- 11.27 When a patient is recalled from SCT, the patient may only be detained for a maximum of 72 hours. The period begins at the time the patient's detention in hospital following the recall notice begins. The hospital managers and those acting on their behalf must ensure no patient is detained on recall for longer than 72 hours without having their community treatment order (CTO) revoked. Arrangements should be put in place to ensure the time of recall is recorded and the length of stay monitored.
- 11.28 The hospital managers have a duty to ensure a patient is referred to the Mental Health Review Tribunal for Wales as soon as is practical if the CTO is revoked. Officers authorised to perform this function may do so on their behalf.

## Information for patients and relatives

- 11.29 Sections 132, 132A and 133 and the regulations require the hospital managers to give certain information to detained patients, community patients and patients' nearest relatives. Guidance is given in chapter 22.
- 11.30 Hospital managers also have the duty to inform certain qualifying patients, including community patients and those liable to be detained, that support is available to them from an independent mental health advocate (IMHA) and how that support can be obtained. For guidance on the role of IMHAs see chapter 25.

## Correspondence of patients

- 11.31 Section 134 allows the hospital managers to withhold outgoing mail from a detained patient if the addressee has requested this in writing to them, the patient's responsible clinician or the Welsh Ministers. The fact that mail has been withheld must be recorded in writing and the patient must be informed, in accordance with the regulations.
- 11.32 Hospital managers should have a written policy for the exercise of these powers, which may include guidance on other forms of correspondence and communication (for example mobile phones or electronic mail) which are outside the provisions of section 134. There are no powers to withhold the mail of patients who are not liable to be detained, and any policy prepared by the hospital managers should reflect this.

## Mental Health Review Tribunal for Wales

- 11.33 Hospital managers should ensure that support is given to patients who want to make an application to the MHRT for Wales.
- 11.34 Hospital managers must refer cases to the MHRT for Wales where patients have not exercised their right to apply for a tribunal hearing (or been referred by the Welsh Ministers or the hospital managers), in the circumstances set out in section 68 of the Act. It is important that hospital managers (or the officers to whom the function is delegated) have appropriate systems in place to alert them of the need to make a reference in good time. Officers exercising this function should be familiar with the requirements of the MHRT for Wales and its procedural rules.
- 11.35 Where a tribunal hearing has been arranged, the hospital managers should inform the relevant LHB and LSSA so they can consider the need for a section 117 after-care planning meeting before the tribunal takes place and, if necessary, to compile a report for the tribunal. Although the requirement to put in place after-care arrangements does not arise before the tribunal's decision, the hospital managers should consider whether it is necessary to start planning before the hearing.

## Referrals by the Welsh Ministers

11.36 The Welsh Ministers may at any time refer the case of a Part 2 patient (including a patient on SCT) or an unrestricted Part 3 patient to the MHRT for Wales. Anyone may request such a referral and the Welsh Ministers will consider each request on its merits.

11.37 Hospital managers should always consider asking the Welsh Ministers to exercise their power of referral for a patient whose rights under Article 5(4) of the European Convention on Human Rights might otherwise be at risk of being violated, because they are unable (for whatever reason) to have their cases considered by the MHRT for Wales speedily, following their detention or at reasonable intervals afterwards. The hospital managers should normally seek a reference in any case where:

- a patient's 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
- a patient lacks capacity to request a reference
- a patient's case has not already been considered by the MHRT for Wales (or First-tier Tribunal if the patient has transferred from England), or a significant period has passed since it was last considered.

## Discharge

11.38 Hospital managers' powers to discharge patients are dealt with in chapter 27 below.

## Victims

11.39 Hospital managers will be notified by the local probation board of a victim's wish to receive information and make representations (in line with the relevant provisions within the Domestic Violence, Crime and Victims Act 2004) in relation to certain unrestricted Part 3 patients.

11.40 In such circumstances the duties of the hospital managers include:

- Forwarding any representations made by a victim to the relevant people and bodies responsible for making decisions on discharge or SCT and for passing any information received from those people or bodies to the victim.
- Informing the victim if the patient's discharge is being considered or if the patient is to be discharged.
- Informing the victim who has asked to receive information whether the patient is to be discharged onto SCT and, if so, telling them of any conditions relating to contact with them or their family. This will extend to any subsequent variation of the conditions and the date on which the order will end. Victims have the right to make representations about the conditions to be attached to CTOs, which hospital managers must forward to the responsible clinician.

# Chapter 12

## Functions of responsible clinicians and approved clinicians

12.1 This chapter provides guidance on the functions of responsible clinicians and approved clinicians and how these should be applied.

### The appropriate responsible clinician

#### Allocation of the responsible clinician

12.2 Every patient must be allocated a responsible clinician. This is the approved clinician who will have overall responsibility for the patient's case.

12.3 Hospital managers should have local protocols in place for allocating responsible clinicians to patients and these should ensure that:

- The patient's responsible clinician is the available approved clinician with the most appropriate expertise to meet the patient's main assessment and treatment needs.
- It can be easily determined who is a particular patient's responsible clinician.
- Any other approved clinicians involved in delivering aspects of the patient's care are also clearly identified.
- There are cover arrangements in place when the responsible clinician is not available.
- There is a system for keeping the appropriateness of the responsible clinician under review.

12.4 Selecting the appropriate responsible clinician should be based on the individual needs of the patient concerned. If the patient's main treatment needs are not immediately clear, it may be necessary to allocate a temporary responsible clinician to ensure that the patient has a responsible clinician promptly upon detention in hospital. Once the patient's main treatment needs are known, a responsible clinician with the expertise most appropriate to address the patient's main treatment needs should be allocated.

12.5 Whenever possible, the responsible clinician for a patient under 18, and the other staff engaged in that care and treatment, should be specialists in child and adolescent mental healthcare (i.e. specialist practitioners who have been trained and who practice in delivering the functions of Tiers 2, 3 and/or 4 in the CAMHS Strategic Framework for Wales). If this is not possible, it is good practice for the clinical staff to have access to such specialist practitioners for advice and consultation.

12.6 Where practicable, the patient's views and any statements of wishes on the selection of the appropriate responsible clinician should be established. This will not override professional decisions on which healthcare professional will be most appropriate to meet the patient's needs, but will allow the patient the opportunity to express any concerns or preferences (for example, on the gender of the clinician).

### Change of responsible clinician

12.7 As the needs of the patient will change over time, it is important that the appropriateness of the responsible clinician is kept under review by the hospital managers. It may be appropriate for the patient's responsible clinician to change during a period of care and treatment if such a change enables the needs of the patient to be met more effectively. For instance:

- During the initial phases of the treatment of a patient with acute psychosis, where there may be an emphasis on pharmacological therapy, it may be appropriate for the responsible clinician to be an approved clinician who is a registered medical practitioner (or a nurse prescriber).
- If psychological therapies are central to the patient's treatment or where psychological expertise is most appropriate to address the main treatment or clinical management needs of the patient, it may be appropriate for a psychologist to be the responsible clinician.
- A nurse may be the most appropriate practitioner to act as the patient's responsible clinician if the care plan emphasises continuing mental healthcare or rehabilitation.
- Where a balance of activities, skills development and vocational rehabilitation form the core of the patient's care plan, it may be appropriate for an occupational therapist to be the responsible clinician.

12.8 With any change of responsible clinician the need for continuity and continuing engagement with the patient are also critical issues to be considered.

12.9 Where a patient's treatment and rehabilitation will require movement between different hospitals or to the community successive responsible clinicians need to be identified in good time to enable that move to take place. An existing responsible clinician is responsible for overseeing the patient's progress through the system. If movement to another hospital is indicated, responsible clinicians should take the lead in identifying their successors, and hospital managers should respond promptly to requests to help in this process.

12.10 Careful consideration should be given to a patient's request for an alternative responsible clinician, which should be facilitated where appropriate or practical.

### Approved clinician in charge of treatment (Parts 4 and 4A of the Act)

12.11 There may be circumstances where the responsible clinician is qualified with respect to the patient's main assessment and treatment needs, but is not qualified to be in charge of a subsidiary treatment that a patient needs, for example, medication which the responsible clinician is not qualified to prescribe. In this situation, the responsible clinician will maintain



their overarching responsibility for the patient's case, but that part of the patient's treatment that they are not qualified to be in charge of will be the responsibility of another approved clinician.

12.12 Where the approved clinician in charge of the treatment is not the patient's responsible clinician, the approved clinician should ensure that treatment decisions are discussed with the responsible clinician in the context of the patient's overall case.

## Delegation by the responsible clinician

12.13 The functions of the responsible clinician (as set out below) cannot be delegated to any other professional, including another approved clinician. In the absence of the responsible clinician (for example, if he or she is on leave or otherwise unavailable), permission can be granted by the approved clinician who is temporarily in charge of the patient's treatment and who is, therefore, temporarily acting as the patient's responsible clinician.

12.14 The exercise of functions by the responsible clinician cannot be fettered by the hospital managers.

## **Functions of the responsible clinician**

### Leave of absence

12.15 Only the patient's responsible clinician may grant a detained patient leave of absence under section 17 of the Act; for restricted patients this requires the approval of the Secretary of State for Justice. A responsible clinician cannot grant leave of absence to patients detained under sections 35, 36 or 38.

12.16 Guidance on leave of absence is given at chapter 28 of this Code.

### Renewal of detention

12.17 Responsible clinicians must decide if a patient's detention should be renewed under section 20 of the Act. That section requires the responsible clinician to examine the patient and decide whether the conditions for detention are met, within the two months leading up to the expiry of the patient's detention. Where responsible clinicians are satisfied that the conditions are met, they must furnish to the hospital managers with a report to that effect.

12.18 Before responsible clinicians can furnish a report to the hospital managers to renew detention, they are required to obtain the written agreement of another professional ('the second professional'). This second professional must be professionally concerned with the patient's treatment and not belong to the same profession as the responsible clinician.

12.19 Apart from that, the Act does not state who the second professional should be. Hospital managers should determine their own local policies for how the second professional should be selected. Policies should be based on the principle that the involvement of a second professional is intended to provide an additional safeguard for patients by ensuring that:

- renewal is formally agreed by at least two suitably qualified and competent professionals who are familiar with the patient's case
- those two professionals are from different disciplines, and so bring different, but complementary, professional perspectives to bear
- the two professionals are able to reach their own decisions independently of one another.

12.20 Accordingly, the second professional should:

- have sufficient experience and expertise to decide whether the patient's continued detention is necessary and lawful, but need not be an approved clinician or approved mental health professional (AMHP), or be qualified to be one
- have been actively involved in the planning, management or delivery of the patient's treatment
- have had sufficient recent contact with the patient to be able to make an informed judgement about the patient's case.

12.21 Second professionals should satisfy themselves, in line with the local policies, that they have sufficient information on which to make the decision. Whether that requires a separate clinical interview or examination of the patient will depend on the nature of the contact that the second professional has with the patient ordinarily and on the circumstances of the case.

12.22 Unless there are exceptional circumstances, the decision of the identified second professional should be respected, even if the responsible clinician does not agree with it. If, in exceptional circumstances, it is decided that the agreement of a different second professional should be sought, that should be drawn to the attention of the hospital managers if, as a result, a renewal report is made.

### Renewal of guardianship

12.23 Where a patient is subject to guardianship (under section 7 or section 37), and that patient's guardian is the local social services authority (LSSA), the patient's responsible clinician should examine the patient and decide whether the criteria for renewal of the guardianship are met. This must take place within the two months before the expiry of the authority of the guardianship. Where responsible clinicians are satisfied that the conditions are met, they must furnish the guardian with a report to that effect.

12.24 In cases where the patient's guardian is not the LSSA, the examination and determination must be made by the nominated medical attendant.

12.25 Although consultation with others who are professionally concerned with the patient would be appropriate, there is no statutory requirement for the formal consultation or agreement of a second professional in the same way as for renewal of detention.

## **Power of discharge (section 23)**

12.26 Section 23 of the Act allows responsible clinicians to discharge most detained patients and all supervised community treatment (SCT) patients and those subject to guardianship by giving an order in writing.

12.27 Because responsible clinicians have the power to discharge patients, they must keep under review the appropriateness of exercising that power. If at any time responsible clinicians conclude that the criteria which would justify renewing the patient's detention or extending the patient's community treatment order (CTO), as the case may be, are not met, they should exercise their power of discharge. They should not wait until the patient's detention or SCT is due to expire.

12.28 The power to discharge a patient by order in writing is not confined to the responsible clinician; see also chapters 23, 26, and 27 of this Code.

## **Supervised community treatment**

12.29 The responsible clinician's functions for making (with an AMHP's agreement) a CTO and for setting conditions are set out in chapter 30 of this Code.

12.30 Only responsible clinicians may extend the period of a patient's CTO. To do so, the responsible clinician must examine the patient and decide whether the conditions for SCT are met, during the two months before the day on which the patient's CTO is due to expire. Where responsible clinicians are satisfied that the conditions are met, they must furnish a report to that effect to the managers of the responsible hospital. The written agreement of an AMHP to extension of the CTO is required.

12.31 The responsible clinician may recall a patient to hospital from SCT, but to revoke the CTO this will also require the agreement of an AMHP. Fuller guidance on these matters is given in chapter 30 of this Code.

## **Reports on patients subject to restrictions**

12.32 The responsible clinician has a duty to examine a patient who is subject to a restriction order (section 41), limitation direction (section 45A), or restriction direction (section 49), and make a report to the Secretary of State for Justice at least annually. The Secretary of State may direct more frequent reporting if necessary, and may also prescribe particular information to be contained in the report. Further information is available from the Mental Health Unit of the Ministry of Justice.

## Reports barring discharge

- I2.33 The nearest relative of a patient who is liable to be detained in a hospital (under Part 2 of the Act) or has been discharged onto SCT may order the discharge of that patient by giving 72 hours' notice to the hospital managers. During that time, the responsible clinician may furnish to those managers a report barring the discharge. The responsible clinician may only make this report if they are satisfied that the patient, if discharged, would be likely to act in a manner dangerous to themselves or others.
- I2.34 The responsible clinician should only make such a report if the prospect of dangerous behaviour can be believed to be a probability, rather than a mere possibility. Such behaviour could include, but is not limited to, serious physical injury or lasting psychological harm. There may also be different levels of risk of danger to the patient harming themselves or others.

## Further guidance

- I2.35 Guidance on the role of the approved clinician in respect of holding powers under section 5(2) and section 5(4) is given in chapter 8 of this Code.
- I2.36 The role of the responsible clinician in respect of performing the functions of the responsible person, within the meaning of the provisions relating to independent mental health advocacy, for a patient who has been conditionally discharged is set out in chapter 25 of this Code.

# Chapter 13

## Interface between the Mental Health Act and the Mental Capacity Act 2005

- 13.1 This chapter provides guidance on the interface between the Mental Health Act and the Mental Capacity Act 2005. Because there are frequent references to both Acts, the respective abbreviations MHA and MCA are used.
- 13.2 Professionals and other paid workers involved in the care of people who lack capacity must have regard of the MCA Code of Practice - this involves being aware of its contents and being able to show how it has been followed. This chapter does not try to describe in detail the way in which the MCA works. For more detailed information, see that Act and its Code of Practice which also contains a chapter on the interface between the two Acts.

### General

- 13.3 A patient subject to detention, guardianship or supervised community treatment (SCT) under the MHA, should not automatically be considered as lacking mental capacity to take decisions about their own mental health care or any other matter.
- 13.4 Similarly, people who lack capacity to make decisions do not stop being protected by the MCA just because they are subject to the MHA.
- 13.5 Everyone involved in treating or making decisions about patients who are (or might be) subject to detention, guardianship or SCT under the Act must be familiar with the key principles of the MCA, including:
- Approved mental health professionals (AMHPs) need to be familiar with the MCA, to evaluate properly and appropriately any possible alternatives to applications for admission and guardianship or to determine whether the making of a community treatment order (CTO) is appropriate; this includes understanding the deprivation of liberty safeguards<sup>4</sup> in that Act.
  - Doctors making recommendations in support of applications similarly need to be familiar with the MCA in order to make appropriate recommendations.

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<sup>4</sup> The deprivation of liberty safeguards are expected to come into force from April 2009

- Responsible clinicians need to be familiar with the MCA in order to exercise their functions properly and appropriately in relation to discharge, renewal and extension of compulsory measures. The same is true of hospital managers in relation to their powers of discharge.
- Approved clinicians in charge of a patient's treatment need to be familiar with the MCA in order to exercise their functions properly under Parts 4 and 4A of the MHA.

13.6 All professionals involved in treating people with mental disorders need to understand the limits and boundaries under the MCA. This is vital to ensure necessary and/or appropriate actions are taken for 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.

## Defining capacity in the Mental Capacity Act

13.7 A person lacks capacity in relation to a matter if, at that time they are unable to make a decision for themselves about the matter because of an impairment of, or a disturbance in, the functioning of the mind or brain - whether permanent or temporary.

13.8 A person is unable to make a decision for themselves if they cannot:

- understand the information relevant to that decision
- retain that information
- use or weigh that information as part of the process of making the decision
- communicate their decision (whether by talking, using sign language, visual aids or any other means).

13.9 In the main, the MCA applies to people subject to the MHA in the same way as it applies to anyone else in relation to decisions about their property, affairs and personal welfare.

## Circumstances where the Mental Capacity Act may not be relied on to give treatment to people subject to the Mental Health Act

13.10 Where treatment is regulated by Parts 4 or 4A of the MHA, section 5 of the MCA may not be relied upon as an alternative legal basis on which to give or consent for such treatment.

13.11 Therefore, if a patient lacks capacity and is detained under a section of the MHA to which Part 4 applies, the MCA cannot be used as an alternative authority to provide electro-convulsive therapy or medication for mental disorder to that patient. Such treatments must be given to such detained patients under the powers (and subject to the safeguards) of sections 58, 58A, 62 and 63 of the MHA.

13.12 Neither can the MCA provide an alternative authority for any treatment regulated by section 57 of the MHA (e.g. neurosurgery for mental disorder). It remains the case that such treatments can only be given to patients who are capable of consenting (whether informal or detained) after statutory certification that the patient has given valid consent and that the treatment should be given.

## Roles and powers of attorneys, deputies and the Court of Protection

13.13 The fact that a person is subject to the MHA does not affect the validity of any Lasting Power of Attorney (LPA), nor the scope of 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 they have the capacity to do so; it does not prevent the Court from appointing a deputy to take decisions for them, when they lack the capacity to make the decisions themselves.

13.14 Attorneys and deputies are therefore able to take any decisions about 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 regulated by Part 4 of the MHA (including neurosurgery for mental disorder and other treatments under section 57).
- They will not be able to make decisions about where a person subject to guardianship is to live, nor make other decisions which conflict with those of a guardian.

13.15 Where conditions are imposed on patients subject to the MHA about leave of absence from hospital, SCT or conditional discharge, a decision by an attorney or deputy on the patient's behalf which goes against one of these conditions would result in the patient being considered to have breached the condition. This might result in the patient being recalled to hospital.

13.16 Attorneys and deputies may 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 lack the capacity to do so themselves. In particular the LPA may authorise personal welfare attorneys and deputies to exercise the patient's various rights to apply to the Mental Health Review Tribunal for Wales or the hospital managers for discharge from detention, guardianship or SCT.

13.17 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, it would be helpful for the two to discuss the issue, perhaps with help from the patient's clinicians or social worker/AMHP. Ultimately an attorney or deputy must act in accordance with their authority and in what they believe to be the patient's best interests. Guidance on nearest relatives is given in chapter 23.

13.18 Where practicable, clinicians and others involved in the assessment and/or treatment of patients under the MHA to try to find out if the person has an attorney or deputy.

13.19 To ensure they are informed, and where relevant consulted, about the patient's care attorneys and deputies should make themselves known either to the clinician responsible for the patient's care or to the managers of the hospital where the patient is detained. In the case of SCT patients, attorneys and deputies should make themselves known to the responsible hospital.

13.20 Attorneys and deputies may find it helpful to use the MHA administrators' office as a useful first point of contact in relation to patients detained or subject to SCT.

## Independent mental capacity advocates

13.21 Under the MCA, NHS bodies or local authorities (as appropriate) are required to instruct independent mental capacity advocates (IMCAs) to represent people who have no family or friends who it would be appropriate to consult, where the NHS body or local authority proposes:

- to provide accommodation for them in a hospital for more than 28 days or in a care home for more than 8 weeks
- or where the NHS body proposes to provide them with serious medical treatment (a term defined in regulations under the MCA).

An IMCA can also be instructed in cases of neglect or abuse of any incapacitated and mentally disordered adult whether or not they have family, and where there are reviews being undertaken of accommodation arrangements.

13.22 The duty to instruct an IMCA does not arise if the serious medical treatment is to be provided under Part 4 or 4A of the MHA. The duty does not apply if the patient is to be required to live in accommodation as a result of an obligation placed on them under the MHA.

13.23 However, a duty to consult an IMCA may arise in connection with serious medical treatment for physical disorder proposed for a patient who is detained under the MHA. Such a duty may also arise in connection with accommodation planned for other people who are to be accommodated as part of the after-care which the NHS and local social services authorities have to provide under section 117 of the MHA.

13.24 Guidance on the potential interface between IMCAs and independent mental health advocates (IMHAs) is given in chapter 25 of this Code.



## Deprivation of liberty authorisations under the Mental Capacity Act 2005

- 13.25 If a person aged 18 or over lacks capacity to consent to admission and/or treatment for mental disorder, the MCA may offer an alternative which makes compulsory admission unnecessary. However, in the case of someone who needs to be detained in hospital for assessment or treatment of their mental disorder, the MCA will only offer an alternative if the patient satisfies the qualifying requirements set out in that Act.
- 13.26 A person can be detained under the Act and subject to a deprivation of liberty authorisation provided they meet the eligibility and other qualifying requirements. Further information about authorisations is given in the supplement to the MCA Code of Practice that is concerned with the deprivation of liberty safeguards.



# Chapter 14

## Care and treatment planning

- 14.1 This chapter aims to provide guidance on care and treatment planning for patients detained under the Act in hospital, discharged onto supervised community treatment (SCT) or received into guardianship.
- 14.2 The starting point for care and service delivery planning in Wales is the Unified Assessment Process (UAP). Guidance was issued by the Welsh Assembly Government in 2002 on this, and the guidance in this chapter is intended to complement this and Welsh Assembly Government guidance on the Care Programme Approach (CPA).
- 14.3 The chapter refers to after-care planning with patients to whom statutory after-care duties (under section 117 of the Act) apply. Further guidance on after-care is given in chapter 31 of this Code.

### Terminology

- 14.4 Personal plans of care, service delivery plans, treatment plans, care programmes, person centred planning, programmes of care, and CPA plans are just some of the terms commonly used to describe a formalised arrangement for delivering care and treatment to a patient. For the purposes of this chapter the term 'care plan' is used and should be read as including 'treatment plans', the term adopted in this Code to describe the formalised arrangements for the delivery of medical treatment to patients under the Act.

### Approach to care planning

- 14.5 Assessment, care and treatment should draw upon the patient's strengths, seeking their recovery and the re-establishment of their independence as soon as is safely practicable.
- 14.6 Patients should be involved in planning, developing and delivering their care and treatment plans. Professionals must ensure patients receive information in a timely manner and that they can clearly understand it. Independent advocacy has a significant role to play in empowering patients to be fully engaged in these processes, whether the individual is entitled to independent mental health advocacy (IMHA) as a qualifying patient under the Act, or can access other independent advocacy.
- 14.7 Care planning is concerned with identifying and recording outcomes from the care provided and the time scales within which it is hoped that the outcomes will be achieved. The key elements of successful care planning are:

- a holistic approach to providing care and treatment, in particular where this follows admission
- involving users and carers in creating and reviewing the care plan
- systematic planning, recording and reviewing the patient's care and support
- clear statements of the objectives of the care plan which set out the nature of services and facilities to meet the identified needs of the person
- appointing someone to take responsibility for coordinating and overseeing the delivery of the care plan (under CPA and UAP this will be the care coordinator)
- flexibility of service provision, responding to the person's changing needs.

14.8 These key elements apply to all patients receiving treatment and care from specialist mental health or learning disability services; for patients who have reached the age of 16 years these are embodied in both the CPA and UAP guidance.

14.9 While the after-care of detained patients should be included in the general arrangements for care-planning, because of the specific obligation under section 117 all patients who are entitled to statutory after-care must be identified and records kept. See chapter 31 of this Code for further guidance.

### **Risk assessments and managing risk**

14.10 In line with the Code's guiding principles, patient well-being and safety should be at the heart of decision-making and where relevant this includes ensuring the well-being and safety of others. Patients and their carers and other interested parties should be actively engaged in assessing the risks to the patient's health and safety and that of others. Managing risks should maximise the patient's strengths and should wherever possible focus on recovery.

14.11 There should be a full assessment of any potential risk(s) to the patient or other people, and professionals must ensure that any tools used for risk assessment have some research-based validity. Subsequent care plans should identify the services and support available to manage any risks.

14.12 Risk assessment and risk management are central to developing a care plan to meet a patient's needs and should be viewed positively as a way of maximising a patient's autonomy within the limits imposed by the Act.

14.13 In the cases of patients under Part 3 of the Act, the circumstances of any victim and their families should be considered in the risk management plan.

14.14 Decisions around risk management should be made in an open and transparent way, subject to the need to manage information where disclosure could cause harm to the patient or others.

## Preparing the care plan

### Involvement in preparing the care plan

14.15 Those who should be involved in preparing the care plan to meet the patient's needs include:

- the patient, if he or she wishes and/or a nominated representative (including, if appropriate, an IMHA or donee of lasting power of attorney (LPA) if the patient lacks capacity and the LPA covers welfare decisions)
- the patient's responsible clinician
- the patient's care coordinator
- the patient's carer (where they will be providing care that is identified in the care plan and subject to the normal procedures for respecting a patient's right to confidentiality)
- members of the inpatient care team (if the patient is in hospital).

14.16 Those who could also be involved in preparing the care plan to meet the patient's needs include:

- a social worker/care manager specialising in mental health work
- the general practitioner (GP) and primary care team
- a community psychiatric/mental health nurse
- an occupational therapist
- a representative of relevant voluntary organisations
- in the case of a restricted patient, the probation service
- subject to the patient's wishes, his or her nearest relative
- a representative of housing authorities, if accommodation is an issue
- a donee of a relevant LPA, if appropriate
- an independent mental capacity advocate (IMCA), if appropriate.

14.17 Those involved in making decisions, particularly about after-care planning, must be empowered to make commitments on behalf of their agency's involvement. If approval for plans needs to be obtained from more senior officials (for example, for funding) it is important that this does not delay implementing an after-care plan.

14.18 If a different responsible clinician is to take over responsibility for a patient being discharged onto SCT, it will be essential to liaise with that clinician, and the community team, at an early stage.

14.19 For patients placed in services away from their home area, services from their home area should remain involved in their care through attending formal care planning meetings, and regular involvement in other discussions.

## Considerations for care planning

I 4.20 When the care plan is being prepared, account should be taken of:

- the patient's own wishes, needs and aspirations, and those of any dependents
- the views of any relevant relative, friend or supporter (including an IMHA) of the patient
- the need for agreement with all other authorities and agencies in the area where the patient is to live
- in the case of mentally disordered offenders, the circumstances of any victim and their families should be taken into account when deciding where the patient should live
- the patient's carer(s)
- the involvement of other agencies, such as probation or voluntary organisations.

## Elements of the care plan

I 4.21 The development of a fully-agreed care plan should be based on a thorough assessment and clearly identified needs. It should cover the time when the patient is detained in hospital and also preparing for and covering the time after discharge, and should set out the timescales for delivering the different aspects of the care plan.

I 4.22 The professionals concerned should establish an agreed outline of the patient's needs, taking into account their social and cultural background. All professionals with specific responsibilities should be properly identified. Once plans are agreed, any changes should be discussed with all others involved with the patient before being implemented. The plan should be recorded in writing, signed by the patient and a copy given to the patient. If the patient does not agree with the content of the care plan, or the treatment proposed, this should be recorded on the care plan. The intention is not to impose the signing of care plans by patients but to offer the opportunity to express their views.

I 4.23 The care plan should indicate the objectives of the care proposed and anticipated outcomes for the patient. In line with the guiding principles set out in chapter 1 of this Code, the retention of independence, wherever practicable, and promotion of the recovery of the patient should be central to all interventions under the Act. The care plan should reflect this.

I 4.24 Care plans should cover all of the applicable areas identified within the unified assessment process guidance. For patients receiving treatment and care from specialist mental health or learning disability services the areas to be addressed in the written care plan should include:

<b>Areas for inclusion in the care plan</b>	<b>Care and treatment plan for a patient detained in hospital</b>	<b>Care and treatment plan for patients on SCT, guardianship or after-care</b>
Medical treatment (medication etc)	<ul style="list-style-type: none"> <li>information for and discussion with the patient about any proposed treatment</li> </ul>	<ul style="list-style-type: none"> <li>continuing review of the patient's treatment plan on and after discharge, in partnership with the GP where appropriate</li> </ul>
Other forms of treatment, including psychological interventions	<ul style="list-style-type: none"> <li>access to appropriate psychological and other treatments in hospital</li> </ul>	<ul style="list-style-type: none"> <li>continuing access to psychological and other treatments in the community</li> </ul>
Personal care and physical well-being	<ul style="list-style-type: none"> <li>review of all aspects of the patient's general health including medical issues, dentistry, optician and lifestyle issues and how these will be covered in hospital</li> </ul>	<ul style="list-style-type: none"> <li>encouraging appropriate contact with GP and continuing consideration of all aspects of a patient's physical well-being and personal care</li> </ul>
Accommodation, including housing	<ul style="list-style-type: none"> <li>consideration of appropriate accommodation issues inside hospital</li> <li>consideration of the security/maintenance of the patient's home in their absence</li> </ul>	<ul style="list-style-type: none"> <li>preparation of the patient's home for discharge</li> <li>registration of homelessness/referral for supported housing where necessary</li> </ul>
Work and occupation	<ul style="list-style-type: none"> <li>occupational therapy and other structured opportunities in hospital</li> <li>support to maintain contact with an existing employer or to seek vocational guidance</li> </ul>	<ul style="list-style-type: none"> <li>support to maintain existing employment, or</li> <li>support to contact employment agencies, access specialist mental health employment services, seek new job opportunities or to volunteer</li> </ul>
Training and education	<ul style="list-style-type: none"> <li>opportunities for learning in hospital or access to opportunities from hospital</li> </ul>	<ul style="list-style-type: none"> <li>opportunities to take up training or educational courses in the community</li> </ul>
Finance and money	<ul style="list-style-type: none"> <li>support to access benefits or other income, and deal with financial problems or anxieties when in hospital</li> </ul>	<ul style="list-style-type: none"> <li>support with maximising benefits, budgeting and responding to financial anxieties on discharge and at home</li> </ul>

Areas for inclusion in the care plan	Care and treatment plan for a patient detained in hospital	Care and treatment plan for patients on SCT, guardianship or after-care
Social, cultural and spiritual	<ul style="list-style-type: none"> <li>• access to social activities within hospital</li> <li>• support to maintain or build relationship with family, friends and community networks when in hospital</li> </ul>	<ul style="list-style-type: none"> <li>• support to maintain or build a social network and leisure activities in the community</li> </ul>
Parenting or caring relationships	<ul style="list-style-type: none"> <li>• support to maintain links with children</li> <li>• support/consideration of meeting needs of those cared for by the patient</li> </ul>	<ul style="list-style-type: none"> <li>• support to maintain parenting and caring roles within the community</li> </ul>

I4.25 Any unmet needs should be clearly identified and recorded.

I4.26 For all patients their care plan should include contingency and crisis plans, but this is particularly important for patients in the community on leave of absence, or on SCT, or received into guardianship.

I4.27 The contingency plan is aimed at preventing circumstances escalating into a crisis by detailing the arrangements to be used at short notice, whereas the crisis plan specifies the actions to be taken in a crisis. By anticipating the nature of a potential crisis, appropriate action can be taken, and this should be the least restrictive possible. For example, for a patient on SCT, the plan could set out the behaviours or circumstances that could indicate a worsening of the patient's mental health. It could suggest the early involvement of additional support that could be provided in the patient's home, such as the input of a crisis resolution home treatment service which could avoid the recall of the patient into hospital.

### Relationship with after-care (under section 117 of the Act)

I4.28 Before any decision is made to grant leave, discharge absolutely or onto SCT, the responsible clinician must ensure (in consultation with other professionals involved), that the patient's needs have been fully identified, assessed and that the after-care plan addresses them in a way that manages risks positively. If a patient is being granted leave for only a short period, a less comprehensive review may be sufficient, but arrangements for the patient's care should still be properly recorded (see also chapter 31).

### Delivering and monitoring the care plan

I4.29 Care plans should be delivered by practitioners from the appropriate range of statutory and non-statutory agencies working in partnership to meet the needs of the patients and those of their carers. This is particularly important where patients have co-occurring problems such as physical ill-health, or learning disability, or substance misuse together with a mental health problem.



- 14.30 If parts of the care programme are being delivered by carers, mental health professionals should ensure they work in partnership with those carers.
- 14.31 The care plan should be regularly reviewed in accordance with UAP and CPA guidance, to ensure it continues to meet the patient's assessed needs and to check that the outcomes of the interventions are being achieved. Reviews should continue until it is agreed that the patient can be discharged from secondary care services, when the patient's GP should be advised on ongoing management and support in primary care.
- 14.32 The frequency of these reviews will also depend on the patient's circumstances, including whether they are subject to the Act in hospital, discharged from hospital but still under the Act (for example on SCT) or no longer subject to provisions of the Act. These reviews can be at set points and times (for example, at a weekly ward round or a monthly outpatient appointment) but should also take place when a change in the patient's circumstances prompts a review.



# Chapter 15

## Advance statements of wishes and feelings

15.1 This chapter sets out the circumstances where advance decisions made by the patient will be legally binding on the clinician treating that patient. It also explains the importance of ensuring that advanced statements of a patient's wishes and feelings are an integral part of the care-planning and decision-making processes.

### Advance decisions made under Mental Capacity Act 2005 (MCA)

- 15.2 A patient aged 18 years or more who is capable of making a decision ('has capacity') may make an advance decision to refuse treatment at a time when he or she no longer has capacity to refuse or consent to treatment. If the advance decision is valid and applicable in accordance with the MCA, it has the same effect as if the patient makes a decision to refuse treatment at the time. If a clinician treats a patient without consent and that patient has made a valid and applicable advance decision to refuse such treatment, the clinician could face criminal prosecution unless the treatment is authorised under Part 4 or 4A of the Mental Health Act.
- 15.3 If a clinician proposes to treat a patient for a mental disorder under authority of Part 4 or 4A of the Act and the patient has made a valid and applicable advance decision to refuse such treatment, the clinician is not legally bound to act in accordance with that decision. In these circumstances the effect of the advance decision is the same as if the patient had refused their consent at the time. Even if the patient has made an advance decision to refuse their consent then, providing the clinician has the proper authority to do so, treatment may be given.
- 15.4 If a patient who lacks capacity is on supervised community treatment (SCT) but has not been recalled to hospital, the clinician may not treat that patient if the patient has made a valid and applicable advance decision to refuse that treatment unless the treatment is immediately necessary to prevent harm to the patient (see section 64G).
- 15.5 Although the clinician may not be legally bound to act in accordance with the advance decision, he or she should take the decision into account and should, if possible, consider alternative forms of treatment which may have the same benefits. If a clinician gives treatment that the patient has refused in advance then this should be recorded in the patient's notes.
- 15.6 The fact that a clinician may, under Part 4 or 4A, treat a patient for a mental disorder without consent does not mean that the clinician will not be legally bound by an advance decision to refuse other forms of treatment.

## Other advance statements

- 15.7 If an advance statement has been made that does not meet the criteria set out in the MCA, it is not valid and applicable for the purposes of the MCA. However this does not mean that the statement can be ignored. At the very least it must be noted as an expression of the patient's feelings and wishes and should be taken into account in deciding what is in their best interests. In some cases it will be a helpful therapeutic tool to encourage the patient to set out their wishes in advance. This will encourage collaboration and trust between patients and clinicians. It is also a way for patients' expertise and experience in the management of crises in their own conditions to be harnessed to help recovery.
- 15.8 An advance statement will only be relevant where a patient does not have capacity at the time when the treatment is proposed and cannot be consulted. However, even where a patient has made an advance statement and lacks capacity he or she should, as far as is practicable, be involved in the decision process.
- 15.9 Patients' expressions of their wishes about how they should be treated should always be kept or recorded in their case notes so that they are accessible by all treating professionals. If the professional judges that, at the time the wish was expressed, the patient lacked capacity to understand, this should also be recorded along with the professional's reason. If there is more than one set of notes, the views of the patient must be prominent in each set. Similarly good communication between primary and secondary care services will ensure the patient's views are known throughout their healthcare delivery.
- 15.10 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. The patient should also be encouraged to provide reasons.
- 15.11 Some advance statements may express the patient's wishes that a particular course of action should be taken or that they should receive a particular type of treatment if they no longer have capacity. Although health professionals may have a legal duty of care towards their patients, they have no legal obligation to provide a particular treatment because the patient demands it. The decision to treat is ultimately a matter for the professional's judgment, acting in the patient's interests. The patient should be made aware that wishes expressed in advance cannot force practitioners to act in a particular way and that advance refusals of certain treatments may be overridden in certain circumstances (see paragraph 15.3 above).

## Children

- 15.12 Advance statements made by children will not be binding on health professionals but must be taken into account. As with adults, an advance statement made by a child must be treated in the same way as if the child had made the statement at the time. The level of competence that the child had at the time the advance statement was made will be a factor in determining the extent to which their wishes in an advance statement should be followed.

# Chapter 16

## Capacity, competence and consent

16.1 This chapter gives guidance on capacity and competence to consent to treatment, and on consent itself. It covers guidance for people under the age of 16 as well as those aged 16 and over.

### General matters

16.2 Under the common law, valid consent is required before medical treatment can be given. Where a patient will not - or cannot - consent, there must be another explicit legal authority for giving the treatment.

16.3 The Mental Health Act provides a framework of legal authority and safeguards within which treatment for mental disorder may, where necessary, be given to patients who do not wish at the time to receive it. This includes patients who have the capacity to consent to the treatment, but do not do so. It also includes those patients who lack capacity to consent but nonetheless are clear that they do not want to be treated.

16.4 It should not be assumed that a patient subject to the Act will refuse any or all of their treatment, and the patient's consent should be sought for all proposed treatments, even if they may be lawfully given under the Act without consent.

### Medical treatment

16.5 Medical treatment for the purpose of the Act includes nursing and psychological intervention, as well as specialist mental health habilitation, rehabilitation and care. The purpose of medical treatment is to alleviate, or prevent a worsening of, the disorder or one or more of its symptoms and manifestations.

16.6 This includes treatment of physical health problems only to the extent that such treatment is part of, or ancillary to, treatment for mental disorder (e.g. treating wounds self-inflicted as a result of mental disorder). Otherwise, the Act does not regulate medical treatment for physical health problems.

### Capacity to make treatment decisions

16.7 The Act frequently requires healthcare professionals to determine whether a patient has the capacity to consent to or refuse a particular form of medical treatment; and, if so, whether the patient does in fact consent. The rules for answering these questions are the same as for any other patients.

16.8 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 healthcare professional proposing to treat a patient to determine whether the patient has capacity to give valid consent.

### Capacity to consent: people aged 16 or over

16.9 With certain exceptions, the Mental Capacity Act (MCA) applies to any person aged 16 or over. For those people, capacity to consent is defined by the MCA (see box below). The principles of the MCA state (among other things) that:

- People must be assumed to have capacity unless it is established that they lack capacity.
- People are not to be treated as unable to make a decision unless all practicable steps to help them do so have been taken without success.
- People are not to be treated as unable to make a decision merely because they make an unwise decision.

#### **What does the MCA mean by 'lack of capacity'?**

Section 2(1) of the MCA states:

“For the purposes of this Act, 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.”

This means that a person lacks capacity if:

- they have an impairment or disturbance (e.g. a disability, condition or trauma) that affects the way their mind or brain works
- and the impairment or disturbance means that they are unable to make a specific decision at the time it needs to be made.

Section 2(2) states that the impairment or disturbance does not have to be permanent. A person can lack capacity to make a decision at the time it needs to be made even if:

- the loss of capacity is partial
- the loss of capacity is temporary
- their capacity changes over time.

A person may also lack capacity to make a decision about one issue but not about others.

Section 3(1) says that a person is unable to make a decision if they cannot:

- understand information about the decision to be made (the Act calls this 'relevant information')
- retain that information in their mind
- use or weigh that information as part of the decision-making process
- communicate their decision (by talking, using sign language or any other means).

The first three should be applied together. If a person cannot do any of these three things, they will be treated as unable to make the decision. The fourth only applies in situations where people cannot communicate their decision in any way.

For further information see the Code of Practice to the MCA.

16.10 When taking decisions about patients under the Mental Health Act, it should be remembered that:

- Mental disorder does not necessarily mean that a patient lacks capacity to give or refuse consent, or to take any other decision.
- Any assessment of an individual's capacity has to be made in relation to the particular decision being made - a person may, for example, have the capacity to consent to one form of treatment but not to another.
- Capacity in an individual with a mental disorder can vary over time and should be assessed at the time the decision in question needs to be taken.
- Where a patient's capacity fluctuates in this way, consideration should be given, if a decision is not urgently required, to delaying the decision until the patient has capacity again to make it for themselves.
- Not everyone is equally capable of understanding the same explanation - explanations should be appropriate to the level of the patient's assessed ability.
- All assessments of an individual's capacity should be fully recorded in the patient's notes.

16.11 Chapter 17 gives guidance on the interface between section 28 of the MCA and Parts 4 and 4A of the Mental Health Act.

## Care and treatment of children under the age of 16

### Competence

16.12 Legal precedent has established that a child who is under 16 years of age is competent to give valid consent to be treated if he or she has 'sufficient understanding and intelligence to enable him or her to understand fully what is proposed'. In ascertaining whether a child is competent, a healthcare professional should consider factors such as the child's mental and emotional age, intellectual development and maturity, his or her ability to be able to appraise the nature, consequences and implications of the treatment that is being proposed.

16.13 In effect, this requires the healthcare professional to conclude that the child has the capacity to make the particular decision to have the proposed treatment and is of sufficient understanding and intelligence to be capable of making up his/her own mind. Therefore their being competent includes being capacitous, but also goes beyond that concept. Children who are assessed as being competent in the meaning of the word that is adopted in this Code are often referred to as 'Gillick competent'. From now on, this Code simply refers to them as being competent.

16.14 While competence (like capacity) can be lost as well as gained, it 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. This means that the legal position is that, ordinarily, children's competence does not vary rapidly unless some event, events or circumstances affect their competence. These events might include accident and injury, illness, and mental disorder.

### Children under the age of 16 who are competent

16.15 In most instances, decisions about assessment, treatment and hospital admissions of children occur on the basis of them being informal patients who are under the age of 16 years, with the authority for the relevant decision being the consent of the child or a person with parental responsibility. A child may give consent to treatment if they are competent.

16.16 While a person with parental responsibility may give valid consent for a competent child, healthcare professionals are advised not to rely on that consent but to seek consent directly from the child. As a result, the approach taken in these circumstances should be the same for children as for adults. To put it simply, their decisions to consent or to refuse the treatment proposed and/or to be admitted to hospital for treatment should not be overridden by a person with parental responsibility.

16.17 If a child who is competent (and as such has the capacity to make a decision on their healthcare) consents to treatment, they should be treated on the basis of their consent and, if necessary, admitted to hospital as an informal patient.

16.18 A competent child under 16 can consent to treatment, but a person with parental responsibility can overrule their refusal, although this position has not been tested by the courts since the introduction of the Human Rights Act 1998. Clinicians should therefore avoid relying on parental consent in these circumstances, and should exercise extreme caution.

16.19 Where a competent child decides that they do not want to consent to being treated for mental disorder, or to being admitted to hospital, depriving the child of their liberty by detaining them should only take place if it is within the terms of the compulsory provisions of the Mental Health Act (i.e. if they meet all the conditions for compulsion).



16.20 In the rare cases in which the primary issue is not the provision of medical treatment for mental disorder, but deprivation of the child's liberty for other reasons, 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 concerned would be best met by using that particular framework.

### Children under 16 who lack competence

16.21 If a child under 16 is not assessed as being competent, it is usually possible for a person with parental responsibility to consent to treatment on their behalf. If, in the healthcare professional's opinion, it is safe and correct to rely on the parent's consent, it is appropriate to respect the wishes of the person with parental responsibility. However, the power to consent must be exercised in accordance with the 'welfare principle': that the child's 'welfare' or 'best interests' must be paramount.

16.22 Clinical practitioners should also be aware that a person with parental responsibility does not automatically have an absolute right to consent to every type of care or treatment that is proposed for a child. Some procedures, for example, although not unlawful, may require the prior sanction of the court.

16.23 It may also be appropriate to seek the court's help in the following circumstances:

- in the case of a child who has neither attained the age of 16 years nor is competent for which treatment decisions need to be made and the person with parental responsibility cannot be identified, or is incapacitated
- where there is doubt as to whether a person with parental responsibility is acting in the best interests of the child in making treatment decisions on behalf of the child, or the matter is considered to be potentially outside their responsibility as a parent.

16.24 The child should be involved in the decision-making process, and their views should be taken into account, even if they are not competent. How much weight the child's views should be given will depend on that child's level of maturity.

16.25 If consent regarding the assessment and/or treatment of a child (including how the child is to be kept safely in one place) is given by a person with parental responsibility, it will be safe to rely on that consent and treat and/or admit to hospital on that basis as an informal patient. Where the consent of a person who has parental responsibility is not given, the Mental Health Act should be used so long as the child meets the criteria for detention under that Act.

16.26 The fact that a child has been informally admitted to a hospital by parents, or another person with parental responsibility, should not lead professional practitioners and managers to assume that they have consented to all components of a treatment programme that the staff consider necessary. Consent should be sought for each aspect of the child's care and treatment as it arises. Blanket consent and blanket consent forms should not be used.

16.27 In the cases in which 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. If section 25 is used to restrict the liberty of a non-competent child, treatment may be authorised on the basis of parental consent (where they are prepared to consent to treatment, but not to detention) or on the basis of a court order using its inherent jurisdiction.

## Children under 16 years with fluctuating competency

16.28 If a child has been considered to have been competent to make a decision, but later loses that competence, any views they expressed before losing competence should be taken into account and may act as parameters that limit the application of parental responsibility. If, for example, a child has expressed willingness to receive one form of treatment, but not another while competent and he or she 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 to it.

## Consent to treatment decisions

### The basic principles

16.29 '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'.

16.30 A person who lacks capacity to consent does not consent to treatment, even if they cooperate with the treatment or actively seek it.

16.31 Consent will not be valid if the patient has not been given adequate information. All professionals involved in any proposed treatment have a duty to use all reasonable care and skill to give clear and appropriate information to the patient about the treatment and about possible alternatives.

16.32 Simply giving standard information leaflets to the patient will not discharge the duty. The information should be relevant to the particular patient, the particular treatment and the relevant clinical knowledge and practice. The information should be in a language and format that is best understood by the patient, taking account of that patient's ability to retain and understand that information. In every case sufficient information must be given to ensure 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. A record should be kept of information given to patients.

- 16.33 Independent advocates, where available, can help the patient 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. If the patient is a 'qualifying patient' they will be entitled to the support of an independent mental health advocate (IMHA) - see chapter 25.
- 16.34 Patients should be invited and encouraged to ask questions, and professionals should answer fully, frankly and truthfully, particularly if the patient asks about the risks. There may sometimes be a compelling reason, in the patient's interests, for not disclosing certain information. A professional who chooses not to disclose must be prepared to justify the decision. If a professional chooses not to answer a patient's question, he or she should make this clear to the patient.
- 16.35 The patient should be informed that they may withdraw their consent to treatment at any time and that fresh consent is required before further treatment can be given or reinstated. If patients withdraw their consent (or are considering withdrawing it), they should be given a clear explanation of the likely consequences of not receiving the treatment and (where relevant) the circumstances in which the treatment may be given without their consent under the Mental Health Act. A record should be kept of the information given to patients.
- 16.36 Guidance on giving information to patients is set out in chapter 22 of the Code, and further information about the general principles of consent can be found in the Welsh Assembly Government *Reference Guide to Consent to Examination and Treatment*.

### Advance statements and decisions to refuse treatment

- 16.37 Guidance on this area is given in chapter 15 of this Code.

### Treatment where consent is refused

- 16.38 Although the Mental Health Act permits some medical treatment for mental disorder to be given without consent, the patient's consent should still be sought before treatment is given, wherever practicable. It should always be remembered that nothing in the Act authorises treatment without consent, where that treatment is not for mental disorder.
- 16.39 If a patient initially consents, but then withdraws that consent (or loses the capacity to consent), the treatment should be reviewed. The clinician in charge of the treatment must consider whether to proceed in the absence of consent, to provide alternative treatment instead or to give no further treatment.
- 16.40 The patient's consent or refusal should be recorded in their notes, as should the treating clinician's assessment of the patient's capacity to consent.
- 16.41 Clinicians authorising or administering treatment without consent under the Mental Health Act are performing a function of a public nature and are therefore subject to provisions of the Human Rights Act 1998. It is unlawful for them to act in a way which is incompatible with a patient's rights under the European Convention on Human Rights.

16.42 In particular, the following should be noted

- Compulsory administration of treatment, which would otherwise require consent, is invariably an infringement of Article 8 of the Convention (respect for family and private life). However, it may be justified where it is in accordance with law and where 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 can be inhuman treatment (or in extreme cases even torture) contrary to Article 3 of the Convention, if its effect on the person reaches a sufficient level of severity. But the European Court of Human Rights has said that a measure which is convincingly shown to be of therapeutic necessity, from the point of view of established principles of medicine, cannot in principle be regarded as inhuman and degrading.

16.43 Scrupulous adherence to the requirements of the legislation and good clinical practice should ensure that there is no such incompatibility. If clinicians have concerns about a potential breach of a person's human rights they should seek senior clinical and, if necessary, legal advice.

### Emergency treatment

16.44 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 causes an immediate serious danger to him or herself or to other people may be restrained. 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.

# Chapter 17

## Medical treatment under the Act

17.1 This chapter provides guidance on the provisions in the Act which confer, or limit, the authority to treat patients either with or without their consent. The chapter sets out:

- definitions of 'detained patients' and 'Part 4A patients'
- clinicians' responsibilities
- treatments that do not require the patient's consent
- specific guidance on treatment under sections 57, 58 and 58A including withdrawal of consent
- guidance on Part 4A certificates
- guidance on urgent treatments.

17.2 While mention is made, where applicable, of second opinions, more detail is given in chapter 18 of this Code.

### General

17.3 Part 4 of the Act deals mainly with the treatment of people who have been detained in hospital, including supervised community treatment (SCT) patients who have been recalled to hospital. They are referred to as 'detained patients' in this chapter.

17.4 Some patients detained in hospital are not covered by these rules, as set out in the table below. When this chapter talks about detained patients, these patients are not included. There are no special rules about treatment for these patients - they are in the same position as patients who are not subject to the Act at all, and they have the same rights to consent to and refuse treatment.

In this chapter 'detained patients' means patients who are:	Exceptions
Liable to be detained in hospital under any section of the Act (including those on leave of absence or absent without leave) or SCT patients who have been recalled to hospital	Patients detained on the basis of an emergency application under section 4 unless or until the second medical recommendation is received Patients held in hospital under the holding powers in section 5 Patients remanded to hospital for a report on their mental condition under section 35 Patients detained in hospital as a place of safety under section 135 or 136 Patients temporarily detained in hospital as a place of safety under section 37 or 45A, pending admission to the hospital named in their hospital order or hospital direction Restricted patients who have been conditionally discharged (unless or until they are recalled to hospital)

- 17.5 Part 4 also provides specific safeguards to all patients (whether subject to compulsion under the Act or not) in relation to treatments that give rise to special concern.
- 17.6 Provisions affecting medical treatment of SCT patients in the community are found in Part 4A of the Act. Part 4A sets out different rules about treatment for SCT patients who have not been recalled to hospital by their responsible clinician. This includes SCT patients who are in hospital without having been recalled (for example, if they have been admitted to hospital voluntarily). For convenience, this chapter refers to SCT patients who have not been recalled to hospital as 'Part 4A patients'.
- 17.7 The provisions of Parts 4 and 4A are summarised below in the relevant parts of this chapter.

### Interface between Parts 4 and 4A of the Mental Health Act and section 28 of the Mental Capacity Act

- 17.8 In so far as it deals with decisions about medical treatment for people aged 16 or above who lack capacity to consent to treatment, the Mental Capacity Act (MCA) applies to patients subject to the Mental Health Act in the same way as to anyone else, with the exceptions set out in the following table. These exceptions apply only to medical treatment for mental disorder:

Situation	Exceptions to the normal rules in the MCA
Section 57 treatment (neurosurgery for mental disorder etc)	The MCA may not be used to give anyone treatment to which section 57 applies
Section 58A treatment (ECT and related medication)	The MCA may not be used to give detained patients ECT and any other treatment to which section 58A applies
Treatment for detained patients	The MCA may not be used to give detained patients any other medical treatment for mental disorder. Treatment must be given in accordance with Part 4 of the Mental Health Act instead
Treatment for SCT patients who have not been recalled to hospital (Part 4A patients)	The MCA may not generally be used to give these SCT patients any medical treatment for mental disorder; but attorneys, deputies and the Court of Protection may consent to such treatment on behalf of these SCT patients
Advance decisions to refuse treatment (as defined in the MCA)	<p>Where the Mental Health Act allows treatment to be given against the wishes of a patient who has capacity to consent, it also allows treatment to be given despite the existence of a valid and applicable advance decision made under the MCA. But note that, except in emergencies:</p> <ul style="list-style-type: none"> <li>• treatment to which section 58A applies cannot be given contrary to a valid and applicable advance decision</li> <li>• and treatment cannot be given to SCT patients who have not been recalled to hospital (Part 4A patients) contrary to a valid and applicable advance decision.</li> </ul>
Patients who have attorneys or court-appointed deputies under the MCA with authority to take decisions on their behalf about their medical treatment	<p>Attorneys and deputies (acting within the scope of their authority under the MCA) may not:</p> <ul style="list-style-type: none"> <li>• consent to treatment to which section 57 applies on behalf of any patient;</li> <li>• consent to treatment to which section 58A applies - but note that (except in emergencies) they may refuse it on a patient's behalf</li> <li>• consent to or refuse any other treatment on behalf of detained patients</li> </ul> <p>But note that attorneys and deputies may:</p> <ul style="list-style-type: none"> <li>• consent to treatment on behalf of SCT patients who have not been recalled to hospital (Part 4A patients), even if treatment is to be given forcibly</li> <li>• except in emergencies, also refuse treatment on behalf of those patients.</li> </ul>

## Responsibilities for operating Parts 4 and 4A

- 17.9 Promoting the welfare of the patient by the implementation of the requirements under Part 4 and Part 4A and their safeguards requires careful planning and management. Every professional involved in the medical treatment of mental disorder should be familiar with all provisions of the Act, but it is the responsibility of the clinician in charge of the treatment in question to ensure that there is compliance with the Act's provisions relating to medical treatment.
- 17.10 The patient's responsible clinician is 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 professional is in charge of the relevant aspect of the patient's treatment
- 17.11 Overall responsibility for ensuring these provisions of the Act are complied with rests with the hospital managers, who should ensure that proper arrangements are made to enable responsible clinicians and clinicians in charge of treatment to discharge their responsibilities. But all professional staff involved with the implementation of Part 4 and Part 4A should be familiar with the provisions and the procedures set out in the Act and associated regulations.
- 17.12 Patients have a statutory right to be informed about the provisions of Part 4 and Part 4A of the Act as it relates to them. Further guidance is given in chapter 22.

### Clinician in charge of the treatment

- 17.13 This chapter makes reference to the clinician in charge of the treatment. This means the clinician in charge of the particular treatment in question for a patient and need not be the same as the responsible clinician who is in charge of a patient's case overall. In most cases for detained and SCT patients, the clinician in charge of treatment must be an approved clinician, where the treatment is given:

Type of patient	When the clinician in charge of the treatment must be an approved clinician
Detained patients (see definitions at the start of this chapter)	When the treatment is being: <ul style="list-style-type: none"> <li>• given without the patient's consent;</li> <li>• given with the patient's consent, on the basis of a certificate issued under section 58 or 58A by an approved clinician (rather than a second opinion appointed doctor (SOAD));</li> <li>• continued with the consent of an SCT patient who has been recalled to hospital (including one whose community treatment order has then been revoked) to avoid serious suffering to the patient, pending compliance with section 58</li> </ul>



Type of patient	When the clinician in charge of the treatment must be an approved clinician
SCT patients who have not been recalled to hospital (Part 4A patients)	When the treatment is being given to a patient who lacks capacity to consent to it and without the consent of an attorney, deputy or the Court of Protection (unless it is immediately necessary and being given under section 64G)

17.14 The clinician in charge of the treatment need not be an approved clinician where the treatment is given:

- under section 57
- under section 58A to an informal patient who is under 18 years old
- to a patient with capacity under Part 4A.

17.15 Hospital managers should keep a record of approved clinicians who are available to treat patients for whom they are responsible and should ensure that approved clinicians are in charge of treatment where the Act requires it.

### Treatments not requiring patients' consent (section 63)

17.16 Unless sections 57, 58 or 58A apply, section 63 of the Act means that detained patients may be given medical treatment for any kind for mental disorder, either if they consent to it or if they have not consented to it, but the treatment is given by or under the direction of the approved clinician in charge of the treatment in question.

17.17 As well as applying to medication administered in the first three months, section 63 will extend to a wide range of therapeutic activities involving a variety of professional staff, including 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 cooperation. Acceptance in relation to such procedures requires a clear expression of agreement between the patient and the therapist before the treatment begins. The agreement should be expressed positively as willingness to cooperate rather than as an indication of passive submission.

17.18 If sections 57, 58 or 58A apply, detained patients may be given the treatment only if the rules in those sections are followed (see below).

<sup>5</sup> In fact, here and in section 58 and 58A, the Act refers to the patient being 'capable of understanding the nature, purpose and likely effects' of the treatment. However, for all practical purposes this can be understood to mean the same as the test of whether the patient has the capacity to consent (or, if under 16, the competence to do so).

## Section 57 - treatments requiring consent and a second opinion

Quick summary:

- Applies to neurosurgery for mental disorder (sometimes known as 'psychosurgery') and to surgical implantation of hormones to reduce male sexual drive.
- Applies to all patients, whether or not they are otherwise subject to the Act
- Can only be given if the patient consents and three independent people appointed by the Mental Health Act Commission have certified that the patient understands the treatment and has consented to it.

17.19 Where section 57 applies, these treatments can be given only if all three of the following requirements are met:

- The patient consents to the treatment.
- A second opinion appointed doctor (SOAD) and two other people appointed by the Mental Health Act Commission (MHAC) certify that the patient has the capacity to consent and has done so.
- The SOAD also certifies that it is appropriate for the treatment to be given to the patient.

17.20 A decision to provide treatments under section 57 requires careful consideration, given their significance, sensitivity and possible long-term effects. Hospitals proposing to offer such treatments are strongly encouraged to agree with MHAC the procedures which will be followed to implement the requirements of section 57.

17.21 Before referring an individual case to MHAC for a second opinion, the referring professionals should:

- ensure that options for psychological treatments have been fully considered
- satisfy themselves that the patient is capable of giving valid consent and has consented
- advise the patient of their right to independent mental health advocacy (IMHA) services (this applies to patients who are otherwise not detained or on SCT)
- advise the patient and (if the patient agrees) their close relatives, carers, or persons nominated by the patient that the patient's willingness to undergo treatment does not necessarily mean the treatment will be given.

## Section 58 - medication for mental disorder

### Quick summary:

- Concerned with the administration of medication beyond three months.
- These treatments can only be given if the patient consents or a SOAD appointed by MHAC certifies treatment may be given.
- These provisions apply to all detained patients (as defined earlier).

17.22 Section 58 applies only to detained patients who cannot be given medication to which this section applies unless:

- the approved clinician in charge of the treatment, or a SOAD, certifies that the patient has the capacity to consent and has done so
- or a SOAD certifies that the treatment is appropriate and either that the patient does not have the capacity to consent; or the patient has the capacity to consent but has refused to do so.

17.23 Section 58 applies once three months have passed from the day on which any form of medication for mental disorder was first administered whilst the patient is detained under the Act. This is often referred to as the 'three-month period'.

17.24 The three-month period starts irrespective of whether the patient consents to the treatment, and medication does not necessarily have to be administered continuously throughout the three months.

17.25 There can only be one three-month period for such treatment in any continuous period of detention, including during such a period when detention under one section is immediately followed by detention under another section, for example detention under section 2 immediately followed by detention under section 3. A fresh period will only begin if there is a break in the patient's liability to detention, except where the break results from being on SCT. Detention should never be allowed to expire as a means of enabling a new three-month period to start.

17.26 Even though the Act allows treatment to be given without consent during the first three months, the clinician in charge of the treatment 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 clinician in charge of the treatment must consider whether to proceed in the absence of consent, to give alternative treatment or no further treatment.

## Medication after three months

- 17.27 A system should be in place for reminding clinicians in charge of treatment and detained patients at least four weeks before the expiry of the three month period. These systems should be capable of dealing with the possibility that a patient may become an SCT patient, and may also have their community treatment order (CTO) revoked, during the three-month period. A patient's move between detention and SCT does not change the date on which the three-month period ends.
- 17.28 Before the three-month period ends, the approved clinician should personally seek the patient's consent to the administration of medication. A record of their discussion with the patient and of the steps taken to confirm that the patient has the capacity to consent should be in the patient's notes.
- 17.29 Certificates issued under this section must clearly set out the specific forms of treatment to which they apply. All the relevant drugs should be listed, including medication to be given 'as required', either by name or by the classes described in the British National Formulary (BNF). If drugs are specified by class, the certificate should state clearly the number of drugs authorised in each class, and whether any drugs within the class are excluded. The maximum dosage and route of administration should be clearly indicated for each drug or category of drugs proposed.
- 17.30 A copy of the certificate should be 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.

## Section 58A - electroconvulsive therapy (ECT)

### Quick summary:

- Applies to ECT and to medication administered as part of ECT.
- Applies to all detained patients (see earlier definition) and to all patients aged under 18 years (whether or not they are a detained patient).

17.31 Section 58A applies to ECT and to medication administered as part of ECT. It applies to detained patients and to all patients aged under 18 (whether or not they are detained). The key differences from section 58 are that:

- Patients who have the capacity to consent may not be given treatment under section 58A unless they do in fact consent.
- No patient aged under 18 can be given treatment under section 58A unless a SOAD has certified that the treatment is appropriate.
- There is no initial three-month period during which a certificate is not needed (even for the medication administered as part of the ECT).

17.32 A patient who is consenting may not be given treatment under section 58A unless the clinician in charge, or a SOAD, has certified that the patient has the capacity to consent and has done so. If the patient is under 18, only a SOAD may give the certificate, and the SOAD must also certify that the treatment is appropriate. A record of the discussion with the patient and of the steps taken to confirm that the patient has the capacity to consent should be made.

17.33 A patient who lacks the capacity to consent may not be given treatment under section 58A unless a SOAD certifies that the patient lacks capacity to consent and that:

- The treatment is appropriate.
- No valid and applicable advance decision has been made by the patient under the Mental Capacity Act 2005 (MCA) refusing the treatment in question.
- No suitably authorised attorney or deputy objects to the treatment on the patient's behalf.
- And the treatment would not conflict with a decision of the Court of Protection which prevents the treatment being given.

17.34 Records should be made of the discussion with the patient and of the relevant information to support the certificate being made.

17.35 In all cases the certificate should clearly indicate the maximum number of administrations of ECT which it approves, and any medication that may be given relating to the administration of the ECT. A copy of the certificate should be kept in the case notes and with the patient's medicine chart, so as to clearly show the legal basis for the medication and ECT being given.

17.36 For children and young people under 18, a SOAD certificate by itself is not sufficient to authorise the treatment, unless they are detained. Clinicians must also have the patient's own consent or some other legal authority, just as they would if section 58A did not exist.

17.37 Whether or not section 58A applies, patients of all ages to be treated with ECT should be given written information before their treatment starts 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 60 - withdrawal of consent

17.38 A patient being treated under sections 57, 58 or 58A may withdraw their consent to that treatment at any time. Fresh consent for the further administration of treatment will then be required, except where the urgent treatment provisions within section 62 apply.

17.39 Where the patient withdraws consent, he or she should receive a clear explanation:

- of the likely consequences of not receiving the treatment
- and in the case of section 58 treatments 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 power of the clinician in charge of the treatment to begin or continue urgent treatment under section 62, if applicable.

The patient's withdrawal of consent and explanations given to the patient in light of that withdrawal of consent must be clearly documented in the patient's case notes.

## Part 4A treatments

### SCT patients not recalled to hospital ('Part 4A patients') (sections 64B to 64K)

17.40 Part 4A patients who have the capacity to consent to a treatment may not be given that treatment unless they consent. There are no exceptions to this rule, even in emergencies. The effect is that treatment can be given without their consent only if they are recalled to hospital.

17.41 Part 4A patients who lack the capacity to consent to a treatment may be given it if their attorney or deputy, or the Court of Protection, consents to the treatment on their behalf.

17.42 Part 4A patients who lack capacity to consent to treatment may also be given it, without anyone's consent by or under the direction of the approved clinician in charge of the treatment, unless:

- in the case of a patient aged 18 or over - the treatment would be contrary to a valid and applicable advance decision made by the patient
- in the case of a patient aged 16 or over - the treatment would be against the decision of someone with the authority under the MCA to refuse it on the patient's behalf (an attorney, a deputy or the Court of Protection)
- or in the case of a patient of any age - force needs to be used in order to administer the treatment and the patient objects to the treatment.

17.43 In this last case, force means the actual use of physical force on the patient. Where force needs to be used, it is up to the person proposing to give the treatment to decide whether a patient objects to the treatment. The question is simply whether the patient objects - the reasonableness (or unreasonableness) of the objection is irrelevant.

17.44 In deciding whether patients object to treatment, all the relevant evidence should be taken into account, so far as it reasonably can be. In many cases, patients will be perfectly able to state their objection, either verbally or by their dissenting behaviour. But in other cases,

especially where patients are unable to communicate (or only able to communicate 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.

17.45 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 to being treated, but is in fact not directed at the treatment at all. In that case the patient would not be taken to be objecting.

17.46 Whether or not Part 4A patients consent to treatment, there are certain treatments they can only be given if they have been approved by a SOAD on a 'Part 4A certificate'. The Act refers to this as the 'certificate requirement', which is above and beyond the requirements described above, which the Act calls the 'authority' to give treatment. Broadly speaking, the certificate requirement applies to any treatment for which a certificate would be necessary under section 58 or 58A of the Act, were the patient detained instead. Fuller guidance is given below.

### Part 4A certificates

17.47 Part 4A patients may be given certain treatments for mental disorder only if a SOAD has certified that the treatment is appropriate, using a Part 4A certificate. The requirement to have a certificate is in addition to the other rules governing treatment of SCT patients (see chapter 30).

17.48 A part 4A certificate is needed for:

- treatments which would require a certificate under section 58 if the patient were detained - i.e. medication after an initial three-month period ('section 58 type treatment')
- and ECT and any other types of treatment to which section 58A applies ('section 58A type treatment').

However, a certificate is not required for section 58 type treatment during the first month after a patient's discharge from detention onto SCT (even if the three-month period in section 58 has already expired or expires during that first month).

17.49 When giving Part 4A certificates, SOADs do not have to certify whether a patient has, or lacks, capacity to consent to the treatments in question, nor whether a patient with capacity is consenting or refusing. But they may make it a condition of their approval that particular treatments are given only in certain circumstances. For example, they might specify that a particular treatment is to be given only with the patient's consent. Similarly, they might specify that a medication may be given up to a certain dosage if the patient lacks capacity to consent, but that a higher dosage may be given with the patient's consent.

## **SCT patients recalled to hospital - exceptions to the need for certificates under section 58 or 58A**

17.50 In general, SCT patients recalled to hospital are subject to sections 58 and 58A in the same way as other detained patients. There are three exceptions, as follows:

- A certificate under section 58 is not needed for medication if less than one month has passed since the patient was discharged from hospital and became an SCT patient.
- A certificate is not needed under either section 58 or 58A if the treatment in question is already explicitly authorised for administration on recall on the patient's Part 4A certificate.
- Treatment that was already being given on the basis of a pPart 4A certificate may be continued, even though it is not authorised for administration on recall, if the approved clinician in charge of the treatment considers that discontinuing it would cause the patient serious suffering. It may only be continued pending compliance with section 58 or 58A (as applicable) - in other words, while steps are taken to obtain a new certificate.

17.51 As a result, SOADs giving Part 4A certificates need to consider what (if any) treatments to approve, should the patient be recalled to hospital. They must also decide whether to impose any conditions on that approval. Unless they specify otherwise, the certificate will authorise the treatment even if the patient has capacity to refuse it (unless it is a section 58A type treatment).

17.52 The potential advantage of authorising treatments to be given on recall to hospital is that it will enable such treatments to be given quickly without the need to obtain a new certificate. However, SOADs should do so only where they believe they have sufficient information on which properly to make such a judgement.

17.53 The exceptions to the requirement to have a certificate under section 58 or 58A continue to apply if the patient's CTO is revoked, but only while steps are taken to comply with section 58 (where relevant). Responsible clinicians should ensure that steps are put in hand to obtain a new SOAD certificate under section 58 or 58A, if one is needed, as soon as they revoke a CTO.

## **Urgent treatment (sections 62, 64B, 64C and 64E)**

17.54 Sections 57, 58 and 58A do not apply in urgent cases where treatment is immediately necessary (section 62). Similarly, a Part 4A certificate is not required in urgent cases where the treatment is immediately necessary (sections 64B, 64C and 64E).

17.55 In both cases this applies only if the treatment in question is immediately necessary to:

- save the patient's life
- or prevent a serious deterioration of the patient's condition, and the treatment does not have unfavourable physical or psychological consequences which cannot be reversed



- or alleviate serious suffering by the patient, and the treatment does not have unfavourable physical or psychological consequences which cannot be reversed and does not entail significant physical hazard
- or prevent the patient behaving violently or being a danger to themselves or others, and the treatment represents the minimum interference necessary for that purpose, does not have unfavourable physical or psychological consequences which cannot be reversed and does not entail significant physical hazard.

If the treatment is ECT (or medication administered as part of ECT), only the first two categories above apply.

17.56 These are strict tests. It is not enough for there to be an urgent need for treatment or that the clinicians involved believe the treatment is necessary or beneficial.

17.57 Urgent treatment under these sections can continue only for as long as it remains immediately necessary. If it is no longer immediately necessary, the normal requirements for certificates apply.

17.58 Although certificates are not required where treatment is immediately necessary, the other requirements of Parts 4 and 4A of the Act still apply. The treatment is not necessarily allowed just because no certificate is required.

17.59 Hospital managers should monitor the use of these exceptions to the certificate requirements to ensure that they are not used inappropriately or excessively. They are advised to provide a form (or other method) by which the clinician in charge of the treatment in question can record details of:

- the proposed treatment
- why it is immediately necessary to give the treatment
- the length of time for which the treatment was given.

## Status of certificates under Part 4 and Part 4A

17.60 A certificate issued by an approved clinician or by a SOAD is not an instruction to administer treatment.

17.61 The fact that the SOAD has authorised a particular treatment does not mean that it will always be appropriate to administer it on any given occasion, or even at all. Those administering the treatment (or directing its administration) must still satisfy themselves that it is an appropriate treatment in the circumstances.

17.62 They also need to take reasonable steps to assure themselves that the treatment is, in fact, authorised by the certificate, given what is said in the certificate about the patient's capacity and willingness to consent.

17.63 Under sections 61 and 64H, the MHAC may, at any time, direct that a certificate is no longer to approve either some or all of the treatments specified in it from a particular date. However, where the MHAC revokes approval in that way, treatment (or a course of treatment) which is already in progress may continue, pending a new certificate, if the clinician in charge of it considers that discontinuing it would cause the patient serious suffering.

17.64 This exception only applies pending compliance with the relevant requirement to have a certificate - in other words, while steps are taken to obtain a new certificate. It cannot be used to continue treatment under section 57 or section 58A against the wishes of a patient who has the capacity to refuse the treatment, because in those cases there is no prospect of obtaining a new certificate.

## Review of treatment

17.65 All treatments, whether or not sections 61 or 64H of the Act applies to them (see below), should be regularly reviewed and the patient's care and treatment plan should include details of when this will take place. Although the Act does not require the validity of certificates to be reviewed after any particular period, it is good practice for the clinician in charge of the treatment to review them (in consultation with the responsible clinician, if different) at regular intervals.

17.66 The clinician in charge of any treatment given in accordance with a SOAD certificate must provide a written report on that treatment and the relevant patient's condition at any time if requested to do so by MHAC under sections 61 or 64H of the Act. This is in addition to the reports they are automatically required to provide periodically under those sections<sup>6</sup>. Copies of reports should be given to patients.

## Action where treatment is continued pending a new certificate

17.67 Where treatment is continued to avoid serious suffering pending compliance with a certificate requirement, the clinician in charge of the treatment should immediately take steps to ask for a SOAD visit. This applies both to cases where certificates have been withdrawn by MHAC and to cases where the treatment of SCT patients is being continued pending a new certificate after their recall to hospital. If the SOAD visits and decides not to give a certificate for treatment which requires one, the treatment must end immediately.

17.68 As with urgent treatment, hospital managers should monitor the use of these exceptions. They should require clinicians to record details of why it was necessary to continue treatment without a certificate and how long it took to obtain a new certificate.

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<sup>6</sup> At the time of publication, the Mental Health Act Commission expects these reports to be submitted on form MHAC1 which it provides for the purpose

## Other circumstances when certificates cease to be effective

17.69 There are a number of other circumstances in which a certificate will cease to authorise treatment (or a particular treatment). These are summarised in the following table. People administering treatment on the basis of a certificate should always take reasonable steps to satisfy themselves that the certificate remains applicable to the circumstances.

Type of certificate	Circumstances in which the certificate ceases to authorise treatment
Certificate issued by approved clinician under section 58 or 58A	The clinician concerned stops being the approved clinician in charge of the treatment.
SOAD certificate under section 57	<p>The patient no longer consents to the treatment.</p> <p>The patient no longer has capacity to consent to the treatment.</p>
SOAD certificate under section 58 or 58A	<p>The patient has stopped (even if only temporarily) being either a detained patient or an SCT patient - except in the case of section 58A certificates for patients aged under 18.</p> <p>The SOAD specified a time limit on the approval of a course of treatment, and the time limit has expired.</p> <p>The certificate was given on the basis that the patient consented, but the patient no longer consents or has lost the capacity to consent.</p> <p>The certificate was given on the basis that the patient lacked capacity to consent, but the patient now has that capacity.</p>
	<p>(Section 58 only.) The certificate was given on the basis that the patient had capacity to consent but was refusing, and the patient is now either consenting or has lost the capacity to consent.</p> <p>(Section 58A only.) The certificate was given on the understanding that the treatment would not conflict with an advance decision to refuse treatment, but the person giving the treatment has since become aware that there is such a conflict.</p>

Type of certificate	Circumstances in which the certificate ceases to authorise treatment
	(Section 58A only.) The certificate was given on the understanding that the treatment would not conflict with a decision of an attorney, deputy or the Court of Protection, but the person giving the treatment has since become aware that there is such a conflict, or an attorney, deputy or the Court of Protection makes a new decision that the treatment should not be given.
Part 4A certificate	<p>The patient has stopped (even if only temporarily) being either a detained patient or an SCT patient. (But note that a Part 4A certificate authorises section 58 type treatment for a patient whose CTO has been revoked only pending compliance with section 58 itself.)</p> <p>The SOAD specified a time limit on the approval of a course of treatment, and the time limit has expired.</p>

17.70 In all the circumstances listed in the table, treatment cannot be continued while a new certificate is obtained, unless no certificate is needed because the treatment is immediately necessary.

17.71 It is not good practice to use a certificate that was issued to a patient when detained and who has since been discharged onto SCT to authorise treatment, if the patient is then recalled to hospital, even if the certificate remains technically valid. A new certificate should be obtained as necessary.

17.72 Hospital managers should make sure that arrangements are in place so that certificates which no longer authorise treatment (or particular treatments) are clearly marked as such, as are all copies of those certificates kept with the patient's notes and medication chart.

# Chapter 18

## Second opinions under the Act

18.1 This chapter provides specific guidance on the role of second opinions under the Act, and is intended to complement the previous chapter which gave detailed guidance on the provisions in the Act which confer, or limit, the authority to treat patients either with or without their consent.

### Terms used in this chapter

18.2 SOAD means a second opinion approved doctor - this is a registered medical practitioner appointed by the Mental Health Act Commission (MHAC) to approve certain forms of treatment.

18.3 SOAD certificate means a certificate issued by a SOAD approving treatment for a particular patient.

18.4 A 'Part 4A certificate' is also issued by a SOAD, but is issued under Part 4A of the Act in respect of the treatment of a supervised community treatment (SCT) patient.

18.5 The term 'Part 4A patient' has the same meaning given to the term in chapter 17, namely an SCT patient who has not been recalled to hospital. 'Detained patient' also has the same meaning as given in the previous chapter.

### Role of the SOAD

18.6 The role of the SOAD under Parts 4 and 4A of the Act is to provide an additional safeguard to protect patients' rights. The SOAD acts as an individual and must reach his or her own professional judgement on whether the proposed treatment is appropriate in the light of the general consensus about treatment for the condition in question.

18.7 In all cases, the clinician in charge of the treatment remains responsible for deciding 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.

## Arranging and preparing for a SOAD visit

### Requesting a SOAD visit

- 18.8 If a SOAD certificate is required, the clinician in charge of the treatment in question is responsible for ensuring that a request for a second opinion is made.
- 18.9 Clinicians should not normally request a visit from a SOAD in order to obtain a certificate which they could issue themselves confirming that a patient has consented to treatment. They should request a visit for that purpose only if they are genuinely unable to determine for themselves whether the patient has the capacity to consent or whether the patient is consenting.

### Preparing for the visit

- 18.10 SOADs will visit detained patients in hospital. For SCT patients, hospital managers should ensure that arrangements are made for the SOAD to see the patient at a mutually agreed place, e.g. at an outpatient clinic or somewhere that the patient might visit regularly.
- 18.11 Attending for examination by a SOAD is a condition of all community treatment orders (CTOs). If SCT patients fail to attend when asked to do so, they may be recalled to hospital for the examination, if necessary.
- 18.12 Adequate facilities must be made available for the visit.
- 18.13 The hospital managers, in consultation with the clinician in charge of the treatment, are responsible for ensuring the patient is available to meet the SOAD and that the following are available in person when the SOAD visits:
- the clinician in charge of the treatment in question
  - the patient's responsible clinician (if that person is different from the person in charge of the treatment)
  - the statutory consultees
  - any other relevant people, including independent advocates or an independent mental health advocate (IMHA), where appropriate
  - and, where required by section 58A in the case of a patient who lacks capacity to consent, that the following have been given a reasonable opportunity to be available in person
    - any donee or deputy of the patient with appropriate authority related to the patient's treatment with ECT
    - any person who can advise of a patient's advance decision to refuse treatment with ECT where that advance decision is not otherwise documented.
- 18.14 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. If a Part 4A certificate is being requested, the proposal should clearly indicate which (if any) treatments it is proposed should be authorised in the case of the patient's recall to hospital.

- 18.15 During the visit the SOAD will want to satisfy themselves that the patient's detention or SCT papers are in order (where applicable). Copies of the forms relating to the patient's detention under the Act should, therefore, be made available to the SOAD. The patient's case notes including records of the patient's past responses and expressed wishes to the proposed treatment or similar treatments should also be available to the SOAD.
- 18.16 Any advance decisions and advance statements by the patient relevant to the proposed treatment and any court orders (including those of the Court of Protection) regarding it, must be drawn to the SOAD's attention.

## The SOAD visit

- 18.17 During a visit the SOAD will want to interview the patient in private if possible. Others may attend if the patient and the SOAD agree, or if it is thought that the SOAD or others would be at significant risk of physical harm from the patient.
- 18.18 Wherever possible the SOAD will discuss the case with the person in charge of the treatment in question face to face and must consult with two other people professionally concerned with the patient's care as required by the Act (i.e. the 'statutory consultees' - see below). The SOAD should be prepared, where appropriate, to consult a wider range of people 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 independent advocates, including an IMHA, where appropriate.

## Statutory consultees

- 18.19 SOADs are required to consult two people ('statutory consultees') before issuing certificates approving treatment. One of the statutory consultees must be a nurse; the other may not be either a nurse or a doctor. Both statutory consultees must have been professionally concerned with the patient's medical treatment, and neither may be the clinician in charge of the proposed treatment or the responsible clinician (if the patient has one).
- 18.20 The Act does not specify who the statutory consultees should be, but they should be people whose knowledge of the patient and the patient's treatment can help the SOAD decide whether the proposed treatment is appropriate. The patient's care coordinator (if they have one) may be particularly well placed to act as a statutory consultee or, where medication is concerned, a mental health pharmacist who has been involved in any recent review of the patient's medication. Other possible consultees could include a social worker, occupational therapist, psychologist, or psychotherapist.
- 18.21 The statutory consultees whom the SOAD proposes to consult should consider whether they are sufficiently concerned professionally with the patient's care to fulfil the function. If not, or the consultees feel that someone else is better placed to fulfil the function, they should make this known to the clinician in charge of the treatment in question and the SOAD in good time.

18.22 Statutory consultees may expect a private discussion with the SOAD and to be listened to with consideration. Among the issues that the consultees should consider commenting on are:

- the proposed treatment and the patient's ability to consent to it
- the statutory consultees' understanding of the past and present views and wishes of the patient
- other treatment options and the way in which the decision on the treatment proposal was arrived at
- the facts of the case, the patient's progress, the views of the patients' carers
- where relevant, the implications of imposing treatment on a patient who does not want it and the reasons why the patient is refusing treatment.

18.23 All consultees should ensure they make a record of their consultation with the SOAD, which is then placed in the patient's notes

## The SOAD's decision and reasons

18.24 When deciding whether it is appropriate for treatment to be given to a patient, SOADs are required to consider both the clinical appropriateness of the treatment to the patient's mental disorder and its appropriateness in the light of all the other circumstances of the patient's case.

18.25 SOADs should, in particular:

- consider the appropriateness of alternative forms of treatment, not just that proposed
- balance the potential therapeutic efficacy of the proposed treatment against the side effects and any other potential disadvantages to the patient
- seek to understand the patient's views on the proposed treatment, and the reasons for them
- give due weight to the patient's views, including any objection to the proposed treatment and any preference for an alternative
- take into account any previous experience of comparable treatment for a similar episode of disorder
- give due weight to the opinions, knowledge, experience and skills of those consulted.

18.26 The SOAD may not be able to reach a decision at the time of the first visit, in which case the patient should be told of the delay. Once a decision has been reached, the SOAD should record details of the visit and the reasons for the decision they have made.

18.27 The SOAD must provide written reasons in support of their decisions to approve specific treatments for patients. SOADs do not have to give an exhaustive explanation, but should provide their reasons for what they consider to be the substantive points on which they made their clinical judgement. These reasons can be recorded on the certificate itself when it is given, or can be provided to the clinician in charge of the treatment separately as soon as possible afterwards.



- 18.28 A certificate may be acted on even though the SOAD's reasons have yet to be received. If there is no pressing need for treatment to begin immediately, it is preferable to wait until the reasons are received.
- 18.29 When giving reasons, SOADs will need to indicate whether, in their view, disclosure of the reasons to the patient would be likely to cause serious harm to the patient's physical or mental health or to that of any other person.
- 18.30 The clinician in charge of the treatment is personally responsible for communicating the results of the SOAD visit to the patient. This need not wait until any separate statement of reasons has been received from the SOAD. But when a separate statement is received from the SOAD, the patient should be given the opportunity to see it as soon as possible, unless the clinician in charge of the treatment (or the SOAD) thinks it would be likely to cause serious harm to the patient's or anyone else's physical or mental health.
- 18.31 Forms provided by SOADs are a part of - and should be kept in - the patient's notes. The clinician in charge of the treatment should record their actions in providing patients with (or withholding) the reasons supplied by a SOAD.
- 18.32 Every attempt should be made by the clinician in charge of the treatment and the SOAD to reach agreement. A generally sound plan need not be rejected as a whole because of a minor disagreement about one aspect of it.
- 18.33 If SOADs are unable to agree with the clinician in charge of the treatment, they should inform the clinician personally as soon as possible. It is good practice for SOADs to give reasons for their disagreement.
- 18.34 Neither the SOAD nor the approved 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 notes by the clinician in charge of the treatment in question, and the patient's responsible clinician (if different) should be informed.
- 18.35 The opinion given by the SOAD is the SOAD's personal responsibility. There can be no appeal to the MHAC against the opinion.



# Chapter 19

## Managing behaviours that challenge

- 19.1 This chapter relates to interventions which may be considered to ensure the safe, supportive and therapeutic management of patients in hospital whose behaviour presents a risk to themselves or others.
- 19.2 Although this is intended as guidance on the management of patients subject to compulsion, the principles set out in this chapter should apply to all patients under the care of mental health services. Indeed, in some circumstances, there may be legal authority for taking immediately necessary steps in relation to patients who are not subject to the Act.
- 19.3 Nationally recognised guidelines, for example NICE guidance, may be read as a complement to the guidance in this chapter.

### General principles

- 19.4 Individuals in need of care and treatment for mental disorder may present risks to themselves or others. Such risks are usually associated with behaviours that challenge care staff, which might include: hyperactivity, absconding, self-harming, sexual disinhibition, sexually inappropriate behaviour towards others, aggressive and threatening behaviour towards others and physical violence.
- 19.5 When managing such behaviours, staff should aim to support patients in a therapeutic not punitive manner, and in ways that ensure their safety and optimise their privacy and dignity.
- 19.6 On admission, all patients should be assessed for immediate and potential risks of going missing, self-harm, suicide and possible harm to others. Where such risks are identified, individual care plans should include intervention to minimise these risks. A positive risk management plan can often emerge from a structured formal risk assessment, emphasising factors which contribute to the risk from an evidence-based perspective. For guidance on care planning see chapter 14.
- 19.7 Interventions to manage the risks associated with these behaviours should always be undertaken with the principle of 'least restriction' in mind. They should always be carried out in a way that minimises patient distress and discomfort, and never in a way that requires deliberately subjecting patients to physical pain.
- 19.8 When making decisions about any interventions undertaken during the management of a patient's care and treatment, the principles set out in chapter 1 of this code must be taken into consideration. Decisions about interventions should be discussed with the patient as far as possible and where appropriate included in their care plan.

## Prevention

19.9 Prevention should be the priority when managing the risks associated with any behaviour that is likely to challenge care staff. Such preventive approaches should be evidence-based and underpinned by high quality care planning and systematic risk management.

19.10 Effective preventive management of behaviours that challenge care staff depends on staff understanding and addressing the factors that may contribute to such behaviours. These might include:

- poorly treated symptoms
- boredom and lack of stimulation
- over-stimulation
- deficiencies in the environment of care
- overcrowding
- lack of access to external space and fresh air
- frustration, associated with being restricted
- antagonism or provocation on the part of others
- the influence of alcohol or drugs
- a custodial culture within the environment of care
- an unsuitable patient mix within the clinical environment.

19.11 Although individual care planning is fundamental to the appropriate management of behaviours that challenge, problems may be minimised by considering the environment of care, patient involvement in their care, and systematically identifying and managing problem areas. General measures to be taken include:

- providing therapeutic activities for all patients, and providing protected time to enable patients to participate
- identifying a key worker for each patient that is known to them
- encouraging therapeutic relationships between patients and healthcare professionals
- providing each patient with a defined personal space and a secure locker
- ensuring patients have regular access to open space and fresh air
- organising the clinical environment to provide separate: quiet rooms, recreation space, single-sex areas, discrete visitors' rooms and children's visiting facilities
- ensuring patients can make telephone calls in private, wherever possible
- engaging patients and keeping them fully informed of what is happening to them and why, in a way which they can understand
- seeking patients' cooperation with, and encouraging their participation in, their care planning
- identifying those patients in need of special levels of observation
- involving patients in identifying their own trigger factors and early warning signs of disturbed behaviour; and agreeing with them methods of managing disturbed behaviour
- ensuring that patients' complaints are dealt with quickly and properly.

19.12 Effective patient observation is fundamental to the successful prevention of untoward patient-related incidents. Observation must be seen as an integral aspect of patient engagement and all aspects of care management and not simply as a task to be carried out on prescription.

19.13 The employment of preventive and de-escalation strategies and approaches should be central to managing potential violence and aggression. It is recognised that as a last resort, staff may need to employ more restrictive interventions, such as: physical restraint, rapid tranquillisation and seclusion, but these should only be considered if de-escalation and other preventive strategies have failed.

19.14 Such physical interventions must never be used to punish a patient. Where such interventions are deemed necessary, clinical need and the safety of the patients and others should be taken into account.

19.15 When employing such interventions, a balance must be struck between the need to minimise risks to the patient and others, and the need to ensure that the least restrictive approach to caring for the patient is adopted.

19.16 Any interventions employed to manage disturbed behaviour must be seen as reasonable, proportionate and justifiable, taking into account the risks posed by the patient's behaviour or potential behaviour:

19.17 The choice of appropriate restrictive intervention will depend on various factors, but should be guided by:

- patient preference, if known
- the clinical needs of the patient
- obligations to other patients affected by the disturbed behaviour
- the duty to protect other patients, visitors and staff
- the availability of resources within the environment of care.

Options should be discussed with the patient wherever possible and included in their care plan where appropriate.

## Restraint

19.18 Managing aggressive behaviour by physical restraint should be carried out only as a last resort, in an emergency and when there seems to be a reasonable possibility that harm would occur if the intervention were not used.

19.19 If a patient is not subject to compulsory treatment, but care planning and risk assessment indicates that restraint in any form may be necessary during care, consideration should be given as to whether formal detention under the Act might be appropriate.

19.20 If a patient is deprived of their liberty in a hospital by an authorisation under the deprivation of liberty safeguards (DoLS)<sup>7</sup> of the Mental Capacity Act 2005, and restraint is necessary, this may indicate that consideration should be given to whether the patient can and should be detained under the Mental Health Act.

19.21 Interventions used to restrain patients may take several forms, the most common being verbal and/or physical restraint. Clinically acceptable methods of restraint include:

- limiting a patient's disruptive behaviour by giving clear but respectful instructions
- holding techniques
- confining patients to a limited space or closed room.

19.22 In general terms, reasonable grounds for employing any form of restraint as a preventive intervention would include its use to control an immediately life-threatening or dangerous situation or limit a patient's freedom in order to prevent potential harm to the patient or others.

19.23 The use of restraint may be deemed reasonable if employed to deal with various specific situations, including:

- physical assault
- dangerous or destructive behaviour
- non-compliance with lawful treatment
- likely or actual self-harm
- sexually inappropriate behaviour
- extreme and prolonged over-activity on the part of the patient, that is likely to lead to physical exhaustion
- absconding or the risk of absconding.

19.24 Any methods aimed at reducing and eliminating behaviours that challenge should take account of the:

- patient's preference, if known
- patient's needs
- patient's physical condition
- environment of care
- staffing levels and skill mix
- staff's duty to protect all those under their care.

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<sup>6</sup>The deprivation of liberty safeguards are expected to come into force from April 2009

19.25 Any restraint used should:

- be reasonable, justifiable and proportionate to the risk posed by the patient
- apply the minimum, justifiable level of restriction and/or force necessary to prevent harm to the patient or others
- be used for only as long as is absolutely necessary
- be carried out in a way that demonstrates respect for the patient's gender and cultural sensitivities.

19.26 While a physical intervention is being used, relevant Welsh Assembly Government and other national guidance, including NICE guidelines, should be adhered to.

19.27 Service providers should have in place a system of post-incident support and review, which allows the organisation, staff and patients to learn from the experience of using restraint. Such procedures should cater for the needs of:

- patients, including the restrained patient
- staff involved in the incident
- carers and family, where appropriate
- other patients in the clinical environment where the restraint occurred
- independent mental health advocate (IMHA), where appointed
- visitors who witnessed the incident.

19.28 It is recommended that there are arrangements in place to provide support to patients (and others) who have suffered serious assaults in hospital, including where appropriate the involvement of the police.

## Use of medication

19.29 Medication should never be used as a substitute for adequate staffing when managing patients. Other than in exceptional circumstances, behaviours that challenge should only be controlled by rapid tranquilisation after careful consideration, and as part of an agreed treatment plan.

19.30 Local protocols should be in place covering all aspects of rapid tranquilisation. They should be in accordance with legal requirements (in respect of detained patients, the consent to treatment and the emergency treatment powers under the Act) and any relevant Welsh Assembly Government and other national guidance, including NICE guidelines. Such policies should be kept under regular review.

19.31 Restraint may be used 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 never be used unless there is such legal authority.

## Seclusion

19.32 Seclusion is the supervised confinement of a patient in a room, which may be locked.

19.33 At all times, the use of seclusion should be:

- based on patient need
- used as a last resort
- employed for the shortest possible time.

19.34 Seclusion should not be used:

- as a punishment or threat
- as a routine part of a treatment programme
- because of a shortage of staff.

19.35 If it appears necessary to seclude an informal patient, then this should always be taken as an indicator of the need to consider formal detention.

19.36 Service providers should have in place clear written guidelines on the use of seclusion. These should reflect Welsh Assembly Government and other national guidelines, including NICE guidelines.

19.37 If any member of the multidisciplinary team disputes the need for seclusion, the matter should be referred immediately to a senior manager.

19.38 A suitably skilled practitioner should be readily available within sight and sound of the seclusion room at all times throughout the period of the patient's seclusion.

19.39 During the period of seclusion, the aim of observation is to monitor the condition and behaviour of the patient, so ensuring their safety, and to identify when seclusion can be terminated. A documented record of the observation regimen must be maintained and entries made in that record at least every 15 minutes.

19.40 The need to continue seclusion should be reviewed:

- every two hours by two nurses (or other suitably skilled practitioners)
- every four hours by a doctor, or a suitably qualified approved clinician.

19.41 If the patient is secluded for more than 8 hours consecutively, or 12 hours in a period of 48 hours, a multidisciplinary review should be completed by a senior doctor or a suitably qualified approved clinician, who should consult with nurses and other mental health professionals who were not involved in the incident which led to the seclusion. Where an independent multidisciplinary review takes place it is good practice for those involved in the original decision to be consulted in the review.



19.42 Any room used for the seclusion of patients should:

- provide privacy from other patients, but enable staff to observe the patient at all times
- be safe and secure, and 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.

19.43 Staff may decide what a patient may take into the seclusion room, but the patient should always be clothed. Patients should never be deprived of appropriate daytime clothing with the intention of restricting their freedom of movement, neither should they be deprived of other aids necessary for their daily living.

19.44 When managing children and young people who exhibit any of the behaviours that challenge, as referred to in this chapter, staff should always ensure that such interventions are delivered in accordance with best practice guidance relevant to the patient's age.

19.45 There are a small number of patients who exhibit behaviours that challenge that are more sustained and therefore not amenable to short-term seclusion. These patients may benefit from intensive mental healthcare delivered in a discrete clinical area that minimises their contact with the general ward population.

19.46 Services utilising such intervention must have a local policy in place that sets out when it is appropriate to use such an intervention, and how it is to be implemented and kept under review.

19.47 Patients subject to this type of intervention must have a regular multidisciplinary review, undertaken by a senior doctor or a suitably qualified approved clinician, who should consult with nurses and other mental health professionals who are not directly involved in the patient's care. Where such an independent multidisciplinary review takes place it is good practice for those involved in the original decision to be consulted in the review.

## Locked doors

19.48 The principle means of ensuring the security and safety of patients in clinical areas should be patient engagement, underpinned by effective clinical observation. This requires adequate staffing in all environments of care.

19.49 Service providers are responsible for ensuring that it is never necessary to lock patients in clinical areas (including: open wards, individual rooms or any other area) simply because of inadequate staffing levels.

19.50 Local policies on the locking of clinical areas should be clearly displayed in all relevant environments of care, and explained to each patient on admission.

19.51 The professional in charge of a clinical area, during any span of duty, is responsible for the care and protection of patients and staff and for maintaining a safe environment of care, in that clinical area. They must have the authority to lock the doors of the clinical area, if such action can be justified as an acceptable measure to protect patients or others.

19.52 In such circumstances, the professional in charge should:

- inform all staff of why the action is being taken, and how long it will last
- ensure that a notice to that effect is displayed at the entrance to the ward
- inform the patient or patients whose behaviour has led to the ward door being locked of the reason for the action
- inform all other patients that are entitled to leave the ward that they may leave on request at any time, and ensure that someone is available to unlock the door
- inform the relevant line manager or duty manager
- inform the relevant responsible clinicians or nominated deputies
- keep a record of the action, using local incident reporting procedures.

19.53 When handing over to the relieving shift, the practitioner in charge should discuss in detail the reasons for the action taken.

19.54 The safety of informal patients, who would be at risk of harm if they wandered out of a clinical environment at will, should be ensured by adequate staffing levels, positive therapeutic engagement and good observation, not simply by locking the doors of the unit or ward.

19.55 Some informal patients, whether or not they understand the risk, may persistently or purposefully try to leave a ward or hospital. In these cases, consideration must be given to whether they are in fact being deprived of their liberty and, if so, whether authorisation needs to be sought under the DoLS of the Mental Capacity Act. Alternatively, assessment for formal detention under the Mental Health Act should be considered or the person moved to a safer environment.

19.56 If managing entry and exit by permanently locked external doors is considered the most appropriate approach to maintaining patients' safety, there must be a process of regular reviewing this policy, to ensure there are clear benefits for patients of such action, and that it is not simply used for staff convenience.

## Supporting clinical staff

19.57 Service planners and providers should satisfy themselves that relevant policies, procedures, education and training programmes are in place to equip staff to effectively manage patients who exhibit behaviours that challenge.

19.58 Service planners and providers are responsible for ensuring that their staff understand extant legislation and national clinical guidance on these issues, and that they are properly trained to work in the context of locally agreed policies and procedures. These policies should take into account relevant best practice guidance, particularly NICE guidelines and Welsh Assembly Government policy.

19.59 Service planners and the senior management teams of service provider organisations must satisfy themselves that clinical areas in which patients that are likely to present with behaviours that challenge are cared for; have appropriate staffing levels and skill mix at all times.

19.60 In conjunction with clinical staff, service managers should regularly review clinical areas in order to consider the appropriateness of:

- patient mix
- staffing levels
- skill mix
- service capacity
- staff training needs
- clinical supervision for staff
- audit and evaluation processes.



# Chapter 20

## Visiting patients in hospital

20.1 This chapter looks at enabling patients to be visited, and emphasises the importance of maintaining links with family, friends and community networks. There is reference to particular considerations for child visitors, and the chapter also sets out circumstances where it may be necessary to consider excluding visitors.

### The right to be visited

20.2 All patients have the right to maintain contact with, and be visited by, anyone they want to see, subject to carefully limited exceptions. Maintaining contact with friends, relatives and community networks is recognised as an important element in a patient's care, treatment and recovery. Patients' legal representatives, advocates and criminal justice professionals may also need to visit patients.

20.3 Every effort should be made to help the patient, where appropriate, to make contact with relatives, friends and advocates. Patients should have readily accessible and appropriate day time telephone facilities.

20.4 If the patient is meeting their advocate (including an independent mental health advocate (IMHA)), their legal representative or a member of the Mental Health Act Commission, such meetings should in most circumstance be held in private if the patient wishes.

20.5 Restricting visitors to informal patients could amount to a deprivation of liberty and may mean an authorisation under the deprivation of liberty safeguards<sup>8</sup> of the Mental Capacity Act should be considered if the individual lacks mental capacity.

### Facilitation of visiting

20.6 Hospital managers should ensure sufficiently flexible arrangements to enable patients to receive regular visits, if they want. Staff should welcome visitors, and ordinarily, inadequate staff numbers should not be allowed to deter regular visiting.

20.7 The facilities provided for visitors should be comfortable and welcoming, and for children, child-friendly. There may be cases where it is best for children to visit patients on the ward. Hospitals should have policies and procedures which deal with such instances, ensuring that other patients on the ward do not have unsupervised access to the child.

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<sup>7</sup>The deprivation of liberty safeguards are expected to come into force from April 2009

## Children and young people

20.8 It is recognised that for children and young people maintaining contact with relatives, friends and community networks is equally as important as it is for adults. These children and young people could be either:

- those whose parents, guardians or carers are inpatients in hospital (detained and informal)
- or those who are themselves inpatients in hospital (whether or not they are detained).

In both cases the child's rights in relation to private and family life should be protected, and their wishes taken into account in the decision-making process.

20.9 In planning and preparing for visits by children to parents, relatives or carers, mental health professionals must consider the needs of the child and should make appropriate and safe arrangements for them to visit, including appropriate facilities. Although it is important to maintain relationships, a visit by a child should only take place after a risk assessment and full multi-agency agreement that the visit would be in the child's best interests. Decisions to allow such visits should be regularly reviewed.

20.10 Where a child has been admitted to hospital, their wishes about receiving visitors should be taken into account.

20.11 Information about visiting should be explained to children in a way that they are able to understand.

20.12 Hospitals should have written policies on the arrangements for patients being visited by children, which should be drawn up in consultation with local social services authorities (LSSAs). Local policies should be in place between hospitals, LSSAs and Local Safeguarding Children Boards, to assure appropriate safeguarding arrangements.

## Grounds for excluding a visitor

20.13 Prohibiting a visit by anyone the patient has asked to visit and/or agreed to see should be regarded as a serious interference of the patient's rights. There may be circumstances when a visitor has to be excluded, but these instances should be exceptional and occur only after other means to deal with the problem have been exhausted.

20.14 Hospital managers should regularly monitor the exclusion from the hospital of visitors to detained patients. Any decision to exclude a visitor should be fully documented and available for independent scrutiny by the Mental Health Act Commission.

20.15 There are two principal grounds, which could justify restrictions on visiting to a patient, up to and including exclusion of a visitor: clinical grounds and security grounds. Hospitals should have an agreed policy on the clinical or security grounds which may justify restricting visits.

## Restriction on clinical grounds

- 20.16 The clinician responsible for the patient's treatment may decide, after assessment and discussion with the patient and the multi-disciplinary team, that some visits could be detrimental to the safety or well-being of the patient or other patients on the ward. It may be that a patient's relationship with a relative or friend is considered counterproductive to therapy - to an extent that a noticeable halt in progress, or even deterioration, in the patient's mental state is evident and/or can reasonably be anticipated if contact were not restricted.
- 20.17 Access to a patient by a visitor may also need to be restricted if the patient's behaviour is such that the visitor's safety cannot be maintained.
- 20.18 In these circumstances the responsible clinician may make special arrangements for the visit, impose reasonable conditions, or even exclude the visitor. In any of these cases, the grounds for the decision should be recorded and explained to the patient and the person concerned, both orally and in writing.

## Restriction on security grounds

- 20.19 The behaviour of a particular visitor may be, or have been in the past, disruptive to a degree that exclusion from the hospital is necessary as a last resort. Examples of such behaviour could include:
- incitement to abscond
  - smuggling of illicit drugs or alcohol into the hospital or unit
  - transfer of potential weapons
  - unacceptable aggression
  - unauthorised media access.
- 20.20 The decision to exclude a visitor on the grounds of their behaviour should be fully documented and explained to the patient orally and in writing. Where possible and appropriate, the reason for the decision should also be explained to the person being excluded.





# Chapter 21

## Personal searches

21.1 This chapter provides guidance on the approach which should be taken to personal searches, and on the areas which should be included in local policies on searches.

### Objectives for searching

21.2 The objectives for conducting a search are first to create and maintain a therapeutic environment in which treatment may take place and second to maintain the security of the establishment and the safety of patients, staff and the public. These two objectives may sometimes conflict with each other. Necessary and lawful searches of patients and visitors are important for the effective management of inpatient facilities, but unlawful, insensitive or unnecessary searches can disempower patients and affect their dignity.

### Approaches to be taken in undertaking searches

21.3 The general principle is that the use and kind of search undertaken should be proportionate to the risk, and involve the minimum possible intrusion on the individual's privacy. Random searches should only occur in exceptional circumstances, such as potentially violent and/or dangerous situations.

21.4 A search of a patient should be undertaken by a person of the same sex, and conducted with respect for their culture and faith, maintaining as far as possible the individual's dignity and privacy at all times. The patient's consent should be sought before a search is attempted. If consent is refused, the person with overall responsibility for the patient's care and treatment should first be contacted in order that any clinical objection to searching by force may be raised. If a clinical objection is raised, but the person empowered to search still considers it necessary to go ahead with the search, the matter should be referred to the senior manager of the hospital, or their on-call deputy, for a decision.

21.5 If a patient physically resists being searched, physical intervention should only proceed on the basis of a multidisciplinary assessment. After every search undertaken without the patient's consent, there should be a review.

21.6 If it is decided not to proceed with the search, then alternative options should be considered to deal with the situation.

21.7 If a patient's belongings are removed during a search, the patient should be given a receipt and told where the items will be stored.

## Hospital managers' policy

21.8 The hospital managers should ensure that there is an operational policy on searching patients detained under the Act, the patient's belongings, and the environment in which they are being treated, and on searching visitors. When preparing the policy, hospital managers should also consider the position of informal patients.

21.9 The policy should emphasise the purpose of maintaining a safe, secure and therapeutic environment for patients, staff and the public, and should be based on the following approaches:

- all searches will be undertaken with due regard to the patient's dignity and privacy;
- the consent of the person it is proposed to search must always be sought;
- the person being searched should be kept informed of what is happening and why;
- a comprehensive record of every search should be made, including the reasons;
- any consequent risk assessment and risk management plan should be placed in the appropriate records;
- all staff involved in searches should receive appropriate instruction and refresher courses.

21.10 The policy should cover:

- all aspects of personal and environmental searching, from the decision to initiate a search through to the storage, return or disposal of items found (including the lawful disposal of any items such as firearms and illicit drugs)
- the lawful reasons for searches without consent
- circumstances in which a patient physically resists being searched and options available if a decision is made not to proceed
- how to carry out personal searching - particularly the procedure for authorising these without consent
- the searching of staff and visitors
- the routine and random searching of patients without immediate cause as a considered and proportionate response to a continuing problem such as chronic substance abuse on the ward.

21.11 Patients, staff and visitors should be told that there is a policy on searching and have the opportunity to comment on and inform the policy.

21.12 The exercise of powers of search should be audited regularly and the outcomes reported from time to time to the hospital managers. Where indicated, consideration should be given to working with the police on specialised searching for detection of illicit drugs.

# Chapter 22

## Information for patients and nearest relatives

22.1 This chapter sets out the information that is to be given and explained to all detained and community patients and to the patient's nearest relative. It also considers the information that is to be given to patients who have been received into guardianship, as well as informal patients.

### The information to be given to the patient

22.2 There is both information that must be given to all patients upon detention under the Act, and also particular information that should be given relevant to an individual's case. Sections 132(1) and 132A(1) of the Act require that patients who are detained under the Act or discharged onto supervised community treatment (SCT) are informed of the provision of the Act under which they are detained, and of their right to apply to the Mental Health Review Tribunal for Wales (MHRT for Wales). All patients detained under the Act or who are on SCT should also be given the following information where relevant.

### Information on detention, renewal and discharge

22.3 The patient should be informed:

- of the provision of the Act under which they are detained or on SCT and the reasons for their detention or SCT
- that their detention or SCT may be ended at any time if it is no longer required or the criteria for it are no longer met
- that they will not automatically be discharged when the current period of detention or SCT ends
- that their detention will not automatically be extended when their current period of detention or SCT ends
- of their right to have their views about being detained, being discharged onto SCT or discharged absolutely considered before any decision is made
- for SCT patients, they should also be told of the effect of the community treatment order (CTO). This should include the conditions which they are required to keep to and the circumstances in which the responsible clinician may recall them to hospital.

22.4 The patient should be given clear information explaining why they are being detained, so that they can adequately and effectively challenge their detention, if they want to. This information should set out in full the specific reasons for their detention, rather than offering broad reasons why a section may be applied to a person. The patient should receive copies of

the detention or SCT forms (or equivalent court orders, directions from the Secretary of State, or transfers from another jurisdiction). The hospital managers may decide (based on the advice of the authors of the documents) that the information to be disclosed would adversely affect the health or well-being of the patient or others. In these circumstances the information should be withheld, either in part or in full. It may be necessary to remove any personal information of third parties (for example, addresses of assessors) before giving the papers to the patient.

22.5 If the section under which the patient is being detained changes, then the information should again be given in the context of the new section.

### Information on appeal against detention

22.6 The patient should be informed:

- of the role of the MHRT for Wales
- their rights of application and how to apply to the MHRT for Wales
- that free legal aid may be available
- how to contact other organisations and advocates (such as an IMHA) which may be able to help them apply to the MHRT for Wales.

22.7 It is particularly important that patients on SCT, who may not have daily contact with people who could help them make an application to the MHRT for Wales, are informed and supported in this process.

22.8 Where an SCT or conditionally discharged patient is recalled to hospital, they should be told their case will be referred to the MHRT for Wales automatically.

22.9 Patients who are detained or on SCT also have the right to ask the hospital managers to review their detention or SCT with a view to discharge. These patients should be told of this right, and of how to apply, and given help with the application if required.

### Information on consent to treatment

22.10 The patient must be told what the Act says about treatment for their mental disorder. In particular:

- how the proposed treatment fits into their treatment and care plan
- of the nature, purpose, likely and intended effects of the planned treatment
- of their right to withdraw their consent to treatment at any time and of the need for consent before 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.

22.11 A second opinion appointed doctor is required to provide a detained patient who is capable of consenting to treatment, but is refusing to give consent, the reasons for their decision to certify the administration of that treatment to the patient. See also chapter 18.

### Information on the Mental Health Act Commission

22.12 Patients must be told about the role of the Mental Health Act Commission and of their right to meet the Commissioners. Patients should therefore be reminded of the role of the Commission when it visits a hospital or unit.

22.13 Patients may also make a complaint to the Commission, and they should be told how this is done and given help if they need it. They should be given information about the hospital's own complaints system and how to use it.

### Information about independent mental health advocates (IMHAs)

22.14 Information about the IMHA service, including how to obtain this support, should be given to patients who qualify for this support, as soon as practicable. Chapter 25 sets out the person who is responsible for giving this information, and provides further guidance on IMHAs.

22.15 IMHAs have a significant role in supporting and helping qualifying patients to obtain and understand the type of information set out in this chapter, and in supporting them to exercise their rights.

### Additional information

22.16 Patients should also be made aware of this Code of Practice, with particular attention drawn to the guiding principles.

22.17 Where section 134 could apply to a patient, they should also be told of this provision which deals with the withholding of a detained patient's correspondence.

22.18 Patients should be informed of the provisions for making an application to the county court under section 29 of the Act, and given help with the application if they want it. There is further guidance on this in chapter 23 of this Code.

22.19 The Representation of the People Act 2000 widened the franchise to vote to all patients liable to be detained under Part 2 of the Act, or those on remand. Those patients should therefore be informed of their right to vote, and should be helped in voting, where appropriate.

22.20 Under the Data Protection Act 1998 and the Freedom of Information Act 2000, patients have a right of access to information held about them. Hospital managers should ensure that patients are reminded of these rights

22.21 Nothing in the Act prevents professionals from giving information to patients on other matters, such as understanding care planning, admission guidance, and welfare benefits.

## How to deliver and explain information

- 22.22 Hospital managers must take all practicable steps to ensure the patient understands the areas of information set out in section 132 and 132A of the Act. This does not mean simply telling someone about that information - hospital managers must take such steps as are practicable to ensure that the information has been understood.
- 22.23 A patient liable to be detained or discharged onto SCT should be given the reasons for detention or community treatment in simple, non-technical language that can be understood and is culturally sensitive, with the reasons including the essential legal and factual grounds for the use of the Act in their particular case.
- 22.24 Information should be given to the patient both orally and in writing - these are not alternatives. The Welsh Assembly Government has prepared leaflets which can be used as the basis for written information and hospital managers may prepare their own additional documents.
- 22.25 However, merely repeating what is already written on the information leaflets is inadequate, and those providing information to the patient should give full and clear explanations.
- 22.26 In line with the guiding principles of this Code, everything possible should be done to overcome any barriers to effective communication. These barriers may be caused by various factors - for example the patient's first language is not English or Welsh or they may not read and write in English or Welsh; they may have difficulty with technical terms and jargon, or maintaining attention for long periods; they may have a hearing or visual impairment or difficulty reading. There may also be barriers to communication associated with the person's mental disorder; for example, the patient may lack mental capacity.
- 22.27 Members of the multidisciplinary team need to 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 need patience and sensitivity. Specialist help should also be made available to staff as required, either from within the hospital, the local social services authority (LSSA) or voluntary organisation. If an intermediary or interpreter is needed, this should not normally be the patient's relative or friend. Staff should make every attempt to find an interpreter appropriate to the patient's needs, bearing in mind the patient's gender, religion, dialect and age. Professional advocates can be invaluable in helping patients understand the questions and information being presented and in helping them communicate their views to staff.
- 22.28 For children, particular consideration should be given to explaining this information in a way they understand and which is sensitive to their needs for emotional reassurance and advice.

## When information should be delivered and explained

22.29 Information must be provided to a patient as soon as practicable after the start of their detention or SCT.

22.30 Patients should regularly be given an explanation of their rights and restrictions, and a new explanation should also be considered in the following circumstances, among others:

- on applying to the MHRT for Wales, or when the patient again becomes eligible to apply to the MHRT for Wales
- on applying to the hospital managers to consider a discharge
- on changes in consent to treatment status (for example, near the end of the initial three-month period)
- when any change in proposed treatment is considered
- before each care plan review meeting
- when renewal of detention or extension of SCT is being considered, and again if the period of detention or SCT is extended (for patients subject to restriction or limitation orders, where their detention is not 'renewed' by the responsible clinician, this should be on the anniversary of any order or direction being made)
- when it is known that the Mental Health Act Commission will be visiting
- when the reason for being a 'qualifying person' under the IMHA provisions changes.

22.31 When a patient is discharged from detention or SCT, or the authority for detention or SCT expires, this fact should be made clear to them.

## Duty to deliver and explain the information

22.32 The hospital managers have the duty to ensure that a patient has been told about their legal situation and rights, but it is usually more appropriate for staff working with the patient to tell them.

22.33 A patient should never have to rely on other patients for information and explanation.

22.34 A record should be made in the patient's case notes each time an attempt is made to explain information to them, together with the outcome of that explanation and any plans for giving them information again.

## Information for patients subject to guardianship

22.35 The only duty the Act imposes about patients received into guardianship is that the responsible LSSA must ensure patients receive and understand information on the help available to them from an IMHA. However, efforts should be made to ensure that patients also understand how the Act applies, for example, to their rights to apply to the MHRT for Wales.

22.36 More generally LSSAs (and private guardians) should do what they can to ensure that the patient understands why they have been made subject to guardianship and what it means for them.

## Information for informal patients

22.37 While the Act does not impose any duty about providing information to informal patients, these patients should be made aware of their legal position and rights. Hospital managers may consider developing appropriate patient information leaflets for informal patients.

22.38 Local policies and arrangements about patients' movement around the unit, grounds and community should be clearly explained to the patient(s) concerned. Failure to do so could lead to a patient mistakenly believing they are not allowed freedom of movement, which could result in an unlawful deprivation of liberty.

## Information for the nearest relative

22.39 The hospital managers must give a copy of any information required under the Act to be given to the patient in writing (as set out above) to the person appearing to them to be the patient's nearest relative, unless the patient requests otherwise. For guardianship patients, LSSAs must provide similar information to the nearest relative.

22.40 This information should explain how the Act applies to the patient and their rights to apply to the MHRT for Wales, as well as how help is available from an IMHA and how it may be obtained.

22.41 When a patient detained under the Act or discharged onto SCT is given information, he or she should be advised that the written information will also be supplied to their nearest relative, unless they request otherwise.

22.42 The nearest relative should also be told of the patient's discharge from detention or SCT at least seven days beforehand, unless the patient or nearest relative has asked that this information should not be given.

## Information for the patient's children

22.43 In considering the information which young people (and, especially, young carers) should receive about a parent's condition or treatment, practitioners will need to balance the patient's right to privacy, and their wishes and feelings, against the child's interests. Information should be appropriate to the child's age and understanding, and consideration should be given about whether to involve an advocate.



## The hospital managers' information policy

22.44 Hospital managers should implement a system which is consistent with the principles set out in chapter 1 and ensures the following:

- The correct information is given to the patient and their nearest relative.
- The information is given in accordance with the requirements of the Act, the associated regulations, and this Code of Practice, at a suitable time and in an accessible format, including where appropriate with the aid of assistive technologies and interpretive and advocacy services (such as IMHAs).
- The member of staff giving the information has received sufficient training and guidance and is identified in relation to each patient detained under the Act or on SCT.
- A record is kept of the information given, including how, when, where and by whom it was given and how well it was understood.
- A regular check is made that information has been properly given to each patient, and understood by them.
- Information is given to the patient when they are discharged onto SCT and if the order is revoked, as their rights will change.
- Steps are taken to find out whether a patient who lacks capacity has an attorney or deputy with authority to make decisions about their personal welfare (see chapter 13 of this Code). Where there is such a person, that person acts as the patient's agent, and should be kept informed in the same way as the patient (this applies to patients subject to compulsion and guardianship and to informal patients).



# Chapter 23

## The nearest relative

- 23.1 The role of the nearest relative is an important patient safeguard. This chapter explains this role and gives guidance on meeting the obligations of the Act and on seeking the displacement of a nearest relative through the county court.
- 23.2 Guidance on the roles and powers of attorneys and deputies (under the Mental Capacity Act 2005) is given in chapter 13 of this Code. The rights of the nearest relative are not affected because a patient has an attorney or a deputy.

### Identifying the nearest relative

- 23.3 Section 26 of the Act defines 'relative' and 'nearest relative' for the purposes of Part 2 of the Act and also for patients who have been placed under hospital or guardianship orders by a court. A patient's nearest relative is not necessarily the same person as their 'next of kin' - the 'next of kin' has no powers under this Act unless they are also the nearest relative. The identity of the nearest relative may also change over time, for example if a patient enters into a marriage or civil partnership, or their eldest child reaches the age of 18.
- 23.4 A person identified as the nearest relative does not have to act as such - they may find it difficult to undertake the functions defined in the Act, or be reluctant to do so. A nearest relative can authorise any other person (other than the patient or someone who has been disqualified by virtue of section 26(5) of the Act) to perform the functions of the nearest relative; approved mental health professionals (AMHPs) should consider proposing this in appropriate circumstances. Notice of any such delegation of powers must be given to the hospital managers or the responsible local social services authority (LSSA). The procedure for delegation is set out in the *Mental Health (Hospital, Guardianship, Community Treatment and Consent to Treatment) (Wales) Regulations 2008*.
- 23.5 The AMHP should confirm with the patient as soon as possible the identity of the nearest relative.
- 23.6 Where a patient appears to have no nearest relative within the meaning of the Act, the AMHP should tell the patient of their right to apply to the county court to appoint someone to act as their nearest relative. AMHPs should not assume the patient will make an application to the court to have one appointed but should consider doing so themselves.

### The functions of the nearest relative

- 23.7 A nearest relative is the only person other than an AMHP who may make an application for admission for assessment (section 2) or for treatment (section 3), and may make an emergency application for admission (section 4).

23.8 The nearest relative may also request the LSSA where the patient resides to consider making an application for admission to hospital. Where an application is not made, they must be given the reasons for the decision in writing.

23.9 The nearest relative may order the discharge of a patient detained under section 2 or section 3, on SCT or in guardianship. The nearest relative has to give 72 hours notice to the hospital managers or LSSA, or a person authorised by them to receive such a notification, of their intention to discharge the patient. During this 72-hour period the patient's responsible clinician can provide a 'barring certificate' provided that sufficient grounds exist to prevent the discharge. As part of this process the nearest relative may appoint a registered medical practitioner to examine the patient before any order for discharge is made by them.

23.10 The nearest relative can apply to the Mental Health Review Tribunal for Wales (MHRT for Wales) in accordance with section 66 of the Act and will be a party to proceedings under the tribunal, unless the context requires otherwise.

23.11 Points to remember:

- No application for admission for treatment may be made by an AMHP without the nearest relative first being consulted, unless consultation is not reasonably practicable or would cause unreasonable delay.
- The nearest relative will receive information from the hospital managers in writing about, among other things, their rights of discharge and of application to the MHRT for Wales - see chapter 22.
- The nearest relative of a ward of court needs the court's permission to exercise their functions under the Act (see section 33(2)).

## Guidance for professionals

23.12 Chapter 2 of this Code gives guidance to AMHPs and others on consulting and informing the nearest relative during the assessment process.

23.13 Chapter 22 of this Code gives guidance to hospital managers and others on the duty to provide nearest relatives with statutory information, including information about the qualifying patient's right to help from an independent mental health advocate (IMHA) (see also chapter 25).

## Displacing the nearest relative

23.14 There are circumstances in which the nearest relative can be displaced by the county court, which may direct that the nearest relative's functions are carried out by another person or by an LSSA.

### Applicants for seeking displacement

23.15 The application may be made by any of the following people:

- the patient
- any relative of the patient
- anyone with whom the person is living (or was living with before admission)
- an AMHP.

23.16 LSSAs should ensure they provide clear practical guidance to help the AMHP decide whether to make an application, and how to proceed. The LSSA should consult the county court in developing this guidance.

23.17 Where the applicant is the patient, support should be provided to them by the hospital managers and the LSSA - this may include ensuring they have access to an advocate (including an IMHA where applicable) or are able to access appropriate legal advice if required. Support should also be available to enable the patient to attend the court, as appropriate, provided this does not conflict with any requirements under section 17 of the Act.

23.18 Some patients may want to displace their nearest relative but may be deterred by the need to apply to the county court. In such cases the AMHP should consider whether the grounds for seeking displacement are met, and if so, to consider making an application themselves.

### Grounds for seeking displacement

23.19 The grounds for making an application to the court for displacement of the identified nearest relative are:

- The nearest relative is incapable of acting as such because of mental disorder or other illness.
- The nearest relative is believed to be unreasonably objecting to an application for admission for treatment or a guardianship application.
- The nearest relative has used, or is likely to use, their right to discharge without due regard to the welfare of the patient or the interests of the public.
- The nearest relative is otherwise not a suitable person to act as such.

23.20 Where there is no identified nearest relative, the grounds for making an application to the court are that:

- There is no nearest relative within the meaning of the Act.
- It has not been reasonably practicable to find out where the nearest relative is, or who that relative is.

23.21 The effect of a court order appointing an acting nearest relative is to displace the person who would otherwise be the patient's nearest relative.

23.22 When making an application, an AMHP may want to seek legal advice from their LSSA, which could include advice on the nature of the evidence required and whether the application is contested.

- 23.23 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 the patient has about their nearest relative. The AMHP should distinguish between concerns of the patient about the person who is the nearest relative and concerns the patient may have about the role of the nearest relative. The AMHP should also seek to understand any concerns of the patient about how the nearest relative chooses or may choose to use his or her powers.
- 23.24 In the case of children, it may be necessary to make an application to the county court to have the nearest relative displaced if that person's interests and the best interests of the child are thought to have parted company.
- 23.25 An applicant needs to be able to show the county court that the grounds were met not only at the date of application but also at the date of the hearing, for the court to make an order.
- 23.26 Any applicant to the county court will need to nominate someone to become the acting nearest relative should the application be successful. LSSAs should provide clear practical guidance to help the AMHP decide whom to nominate in these circumstances, which should encourage AMHPs to seek the views of the patient. Although not a legal requirement, it would be appropriate to seek the agreement of the proposed nominee before an application is made. The nominated person does not have to be a person mentioned at section 26(1) of the Act, and could be a friend of the patient where appropriate.

### Effect of an application

- 23.27 Although applications to the county court should be dealt with quickly there may be occasions when the matter takes some time to be resolved. During this period the nearest relative retains their power of discharge. The court may make an interim order when they are considering an application and hospital managers may rely on this interim order for the purposes of admission and detention of a patient.
- 23.28 If the patient is detained for assessment and an application for displacement has been made, the authority for detention is extended until the application is finally disposed of. In such cases, the hospital managers should always consider asking the Welsh Ministers to refer the patient's case to the MHRT for Wales (see also chapter 26).

### The displaced nearest relative

- 23.29 The displacement of a nearest relative does not remove their legitimate interest in the patient's welfare, and authorities should consider this when deciding about and arranging for the patient's care.
- 23.30 A displaced nearest relative has a right to make an application to the MHRT for Wales (section 66) once within each year after the court's order.

# Chapter 24

## Involvement of carers

24.1 This chapter re-emphasises the references in this Code to the importance of ensuring that unpaid carers are appropriately involved in planning and delivering care and treatment for patients, and outlines the matters which should be considered in this involvement.

### Identifying carers

24.2 The Welsh Assembly Government defines carers as ‘people who look after relatives, friends or neighbours who are frail, sick, disabled or vulnerable’; the term ‘carers’ in this Code means informal carers - family carers, friends and other unpaid carers.

24.3 Some carers do not see themselves as carers, but primarily as a parent, child, wife or husband, partner, friend or neighbour. Some live with the person they care for; others live nearby and visit regularly or live further away and visit less often. Their ages and backgrounds vary.

24.4 Throughout this Code there are consistent messages that professionals must involve carers in care planning and treatment.

### Involving carers in care planning and treatment

24.5 At each level of assessment (including risk assessment), and through care, treatment, and after-care (where applicable) professionals should seek the views of the patient’s carers.

24.6 More specifically, carers can provide relevant, detailed and up-to-date information about the patient and their needs, wishes and lifestyle, which may not always be apparent or available to professionals. This can help in identifying and targeting particular needs.

24.7 Helping carers to take part in decision making, may be achieved through:

- inviting them to appropriate meetings
- involving them in deciding the main objective(s)
- participating in deciding the best way to achieve those objectives
- identifying any potential barriers and solutions
- monitoring and reviewing the progress of the care plan
- evaluating outcomes.

24.8 To ensure carers can fully participate in the above, it is important that they are given:

- practical and emotional help and support in order for them to participate and to continue to care for the patient

- timely access to comprehensive, up-to-date and accurate information about the patient's current and proposed care and treatment plans.

24.9 Professionals should also bear in mind their duties under the Mental Capacity Act 2005 and, in particular, their duty when deciding on best interests to consult anyone engaged in caring for the patient or interested in their welfare, where the patient lacks capacity for making decisions about their own care and treatment.

24.10 Carers have a vital role in care planning. In consulting carers, professionals should try to address their concerns and accommodate their wishes, provided that this does not conflict with the best interests of the patient.

24.11 In engaging with carers, professionals should:

- consider if the carer can provide new information and/or perspectives
- consider what role the carer may need to undertake in the patient's care and treatment
- seek to understand and minimise any risks to carers
- ensure carers are not just involved in minor matters (and thus avoid 'tokenism')
- address any concern about the carer's ability to contribute, including matters such as transport to meetings and other commitments
- be aware of any additional pressure on carers, through their involvement
- provide any support necessary
- be aware that carers may lack experience in these processes
- be aware that carers may need training or other support to undertake their caring role
- provide information to enable informed participation
- minimise barriers to communication, which should include limiting the use of jargon.

## Carers' assessments

24.12 Carers have a right to an assessment of their own needs even if the person cared for has refused an assessment for, or the provision of, community care services. More detailed guidance on carers' assessments is in the Unified Assessment Process guidance. The Carers (Recognition and Service) Act 1995 and the Carers (Equal Opportunities) Act 2004 place a duty on local authorities to tell carers of their right to an assessment, and require carers' assessments to consider whether the carer works or is undertaking education, training or other leisure activity, or wants to do these things. The Carers (Equal Opportunities) Act also provides for better cooperation between statutory agencies in providing services for carers.



# Chapter 25

## Independent mental health advocacy

- 25.1 Independent mental health advocates (IMHAs) provide an important safeguard for certain patients treated under the compulsory powers of the Act. This chapter provides guidance about the role and functions of IMHAs.
- 25.2 Importantly, this service is not a substitute for independent advocacy as practised in the health and social care sectors, but builds on good practice in the advocacy sector. IMHAs specifically provide specialist advocacy within the framework of mental health legislation.

### The role of the independent mental health advocate (IMHA)

- 25.3 The IMHA provides support to qualifying patients to ensure they understand the Act and their own rights and safeguards. This may include support in obtaining information about any of the following:
- the patient's rights under the Act
  - the provisions of the Act under which the patient qualifies for an IMHA
  - any conditions or restrictions which affect the patient
  - the medical treatment the patient is receiving, or which is being proposed or discussed, and the reasons for this
  - the legal authority for providing such treatment
  - the requirements of the Act which apply to treatment.
- 25.4 The IMHA will:
- ensure that the patient's voice is heard by supporting the patient to articulate their views and to engage with the multi-disciplinary team
  - support patients to access information, and to understand better what is happening and what is planned, and to understand better the options available to them
  - support patients in exploring options, making better-informed decisions and in engaging with the development of their care plans
  - support the patient to ensure they are valued for who they are
  - support the patient to counteract any actual or potential discrimination.
- 25.5 IMHAs also support the patient to exercise their rights under the Act, including by representing them.
- 25.6 IMHAs may also support patients in other ways to ensure they can participate in decisions about care and treatment, including:

- attending meetings with the patient to discuss their care and treatment; supporting patients by attending meetings at their request on their behalf, but subject to the consent of the mental health professional who is convening the meeting
- supporting the patient in exploring alternatives to the proposed treatment
- supporting the patient in understanding their rights of appeal
- supporting the patient in applying to and obtaining legal representation for the Mental Health Review Tribunal for Wales (MHRT for Wales) or hospital managers' hearings, and in attending these if requested
- supporting the patient in understanding and following up the decisions or directions made by the MHRT for Wales or hospital managers
- supporting the patient in understanding their rights regarding their nearest relative
- supporting the patient in understanding, applying to and obtaining legal representation for county court hearings
- supporting the patient in raising concerns or in accessing the relevant complaints process about any aspect of their hospital or supervised community treatment (SCT) experience
- supporting the patient in accessing relevant records
- supporting the patient over the provision of appropriate after-care
- signposting other services to the patient and vice versa.

25.7 The involvement of an IMHA will not affect a patient's legal rights to seek independent advice from a solicitor or to legal aid.

25.8 It may be necessary, where the patient's language is other than English or Welsh, to have the support of a trained interpreter, alongside the involvement of the IMHA to ensure that the patient is fully supported.

## Qualifying patients for IMHA

25.9 The following patients are entitled to receive support from an IMHA:

- all patients liable to be detained under the Act - excluding those subject to sections 4, 5(2), 5(4), 135 or 136
- patients discharged onto SCT
- patients subject to guardianship.

25.10 The right to IMHA support also applies to:

- informal patients who discuss, with a registered medical practitioner or approved clinician, the possibility of being given a form of treatment to which section 57 treatment applies
- informal patients under the age of 18 who discuss, with a registered medical practitioner or approved clinician, the possibility of being given a form of treatment to which section 58A applies.

## Patients' rights to an IMHA

25.11 A qualifying patient may ask for the support of an IMHA at any time. Certain professionals have a duty to tell qualifying patients that independent mental health advocacy is available and how they may obtain it. Patients may want to consider accessing an IMHA in the following circumstances:

- as soon as practicable after their arrival in hospital under one of the relevant sections of the Act
- before the initial discussion with their clinician about the proposed treatment plan
- when the use of electroconvulsive therapy (ECT) is being considered
- when an application has been made or is being considered to the MHRT for Wales or to the hospital managers
- when they choose not to be legally represented at a tribunal hearing
- when they want to make, or have made, a complaint
- when they want to discuss any aspect of their care or treatment
- when they want to apply to displace their nearest relative (see chapter 23)
- when they are consulted about the conditions to be attached to a community treatment order (CTO)
- when a CTO is renewed, revoked, or its conditions are varied
- when a meeting is held to discuss after-care.

25.12 A patient who qualifies for the support of an IMHA because of a discussion about the possibility of treatment to which section 57 - or, if under 18, section 58A - applies, must be told that such advocacy is available. Any professional discussing the possibility of such treatment with a patient should not assume that the patient is already aware that they are eligible to receive IMHA support and should, where appropriate, inform them.

## Providing information about the service

### The 'responsible person'

25.13 Qualifying patients should be informed, as soon as practicable, that support is available from an IMHA and how that support can be obtained. The person responsible for informing qualifying patients is set out in the table below:

<b>Qualifying patient</b>	<b>Person responsible for informing the qualifying patient (the 'responsible person')</b>
Patient liable to be detained <sup>9</sup>	The hospital managers
A patient who is liable to be detained but has been conditionally discharged <sup>10</sup>	The responsible clinician (for the patient)
Patient subject to guardianship	The responsible local social services authority
A community patient	The hospital managers (for the responsible hospital)
A patient for whom treatment under section 57 is proposed, if they do not already fall under one of the categories above	The registered medical practitioner or approved clinician with whom the patient first discusses the possibility of such treatment
A patient under 18 years for whom treatment under section 58A is proposed, if they do not fall under one of the categories above	

## The role of the 'responsible person'

25.14 The responsible person must ensure that they tell the patient, both orally and in writing, that support is available to them from an IMHA, and how they can obtain that support.

25.15 If a patient has a nearest relative, the responsible person should, unless the patient requests otherwise, provide a copy of the same information, in writing, to the nearest relative.

25.16 Further guidance on giving information to patients and their nearest relative is given in chapter 22 of this Code.

25.17 As well as telling people about the availability of independent mental health advocacy, the responsible person must also ensure that the patient has the opportunity of making use of IMHA support.

25.18 If the patient would like an IMHA, the responsible person should support them in making contact - for example, they might make arrangements for the patient to meet the IMHA if the patient would otherwise be unable to do this, but they should not at this stage disclose any personal information about the patient to the IMHA service.

25.19 The responsible person should record in the patient's medical records the steps taken to tell that patient about IMHA support. Other people who support the patient should also be informed about whether the patient would like support from an IMHA, and any follow-up action required, if the patient has agreed to such information being shared.

25.20 If a patient has been fully informed about IMHA support, and chooses not to involve an advocate in their case, the responsible person should:

<sup>9</sup> Otherwise than by virtue of sections 4, 5(2), 5(4), 135 or 136 of the Act

<sup>10</sup> By virtue of sections 42(2), 73 or 74 of the Act

- record in the patient's medical records that the patient was informed about independent mental health advocacy and did not want it
- check with the patient again at a later date in case they have changed their mind
- tell the patient that legal representation is available and how to access it.

## IMHAs and patient confidentiality

25.21 IMHAs are expected to follow an agreed confidentiality policy. Under this, any information a patient shares with an IMHA should remain confidential unless the patient wants it to be disclosed, or the IMHA has reasons to disclose it.

25.22 In most circumstances the IMHA will tell the patient all the information they have received on their behalf. However, if there is information that clinicians or other members of the multi-disciplinary team believe it is inappropriate to share with the patient, it should not be disclosed to the IMHA for fear of compromising their relationship with the patient.

## Supporting the role and work of the IMHA

25.23 Patients should have access to a telephone to speak to an IMHA in private.

25.24 The IMHA has the right to:

- visit and interview the patient in private
- visit, interview and get the views of anyone professionally concerned with the patient's medical treatment.

Hospital managers and local social services authorities (LSSAs) should ensure there are systems and provisions in place to support this.

25.25 It is good practice for the IMHA to meet the patient in private, unless the patient requests otherwise. However, there are circumstances which might dictate against a meeting in private. These include:

- when a patient is under close observation
- when the patient is held in seclusion
- when clinicians or other members of the multi-disciplinary team advise against a meeting in private for reasons of safety.

25.26 When it is not advisable to hold the meeting in private, the IMHA may:

- offer to postpone the meeting until it is convenient to meet in private
- continue with the meeting, in the presence of staff, with the patient's consent
- or continue the meeting on, for example, an open area of the ward, with the patient's consent.

25.27 The IMHA's right to visit and speak to anyone professionally concerned with the patient's medical care and treatment is important for the support of the patient. Supporting patients and professionals in communicating is a significant part of the advocacy role as it can impact positively on the patient's ability to be involved in their care planning. Although the IMHA has the right to speak to a professional concerned with the patient's medical care and treatment without that patient's consent, consent from the patient is required before the professional can disclose confidential information to the IMHA.

25.28 IMHAs should be enabled, as appropriate, to:

- have access to the unit and ward where the patient under detention is staying
- have access to facilities in the community where the patient is a community patient
- attend relevant meetings and ward rounds when asked to do so by the patient.

25.29 Information on independent advocacy should be displayed in public areas, on wards and community facilities, as well as in forms which can be handed out to patients, their carers and others, such as leaflets.

25.30 Hospital managers and LSSAs should have an IMHA policy which ensures that:

- all relevant staff are aware of the patient's right to independent mental health advocacy, its role, the legal requirements about IMHA under the Act and of best practice
- all relevant staff know when they need to give information about an IMHA
- all relevant staff know how to access an IMHA
- all relevant staff record an IMHA's involvement in a case and any information they provide to support decision-making
- records show how a decision-maker considered the IMHA's information as part of their decision (including reasons for disagreeing with that advice, if relevant)
- all relevant staff give access to the IMHA of any relevant health or social care records when asked under section 130B(3) of the Act
- the IMHA gets information about changes that may affect the support and representation they provide
- all relevant people are informed when an IMHA is working to support a qualifying patient.

## Access to records

### Relevant records

25.31 Subject to conditions, the IMHA has a right to access and inspect the patient's relevant records, including any records:

- about the patient's detention or treatment in any hospital or registered establishment
- about any after-care services provided to the patient under section 117
- of or held by an LSSA about the patient.

25.32 The following conditions must be met for access to be granted:

- if the patient can consent, they do consent
- or if the patient is not capable of consenting, the decision to allow access does not conflict with a decision made by a 'donee' or deputy or the Court of Protection
- and the holder of the records thinks it is appropriate and the records in question are relevant to the support to be provided by the IMHA.

25.33 When seeking access to records for a patient who is not capable of consenting, the advocate will be asked to declare why they are seeking access and the nature of the information being requested.

25.34 Record holders should bear in mind the principle of respect for the patient's past and present wishes and feelings, when considering the request for access to records.

## Ending the IMHA's involvement

25.35 The purpose of independent mental health advocacy is to provide support on specific issues about the use of compulsory powers of detention and treatment for qualifying patients. Once all issues have been addressed, the IMHA will close the case, but patients can request IMHA support later provided they remain a qualifying patient.

## Interface with independent mental capacity advocacy

25.36 Under the Mental Capacity Act 2005, NHS bodies or local authorities must instruct independent mental capacity advocates (IMCAs) to represent people who are otherwise without support, if 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.

25.37 They do not have to instruct an IMCA if the serious medical treatment is to be provided under authority of Part 4 or 4A of the Mental Health Act 1983, or if the patient is to be required to live in the accommodation as a result of an obligation placed on them under that Act, for example as a condition of leave of absence, SCT or conditional discharge from hospital or a requirement imposed by a guardian.

25.38 However, they may have to instruct an IMCA in connection with serious medical treatment for a physical illness or disorder proposed for a patient who happens to be detained under the 1983 Act. Such a duty may also arise in connection with accommodation being planned for other people who are to be accommodated as part of the aftercare the NHS and LSSAs must provide under section 117 of the 1983 Act for people who have been detained under certain sections of the Act.





# Chapter 26

## The Mental Health Review Tribunal for Wales

26.1 This chapter outlines the purpose of the Mental Health Review Tribunal for Wales (the tribunal or MHRT for Wales) and provides guidance to all those involved in the process of applications, preparing reports and attending hearings<sup>11</sup>.

### Purpose of the tribunal

26.2 The MHRT for Wales is an independent judicial body. Its main purpose is to review the cases of detained or conditionally discharged patients or those who are on supervised community treatment (SCT). It also considers applications for discharge from guardianship and it can direct the discharge of any of these patients if it thinks appropriate.

26.3 The MHRT for Wales provides a significant safeguard for patients who have had their liberty curtailed under the Act. It is for those who believe that a patient should continue to be liable to detention or remain an SCT patient to prove their case - not for the patient to disprove it. They will therefore need to present the tribunal with sufficient evidence to support the continued use of the Act. Clinical and social reports form the backbone of this evidence.

26.4 Those giving evidence at hearings should do what they can to enable tribunal hearings to be conducted in a professional manner, which includes having regard for the patient's wishes and feelings and ensuring that the patient feels as comfortable with the proceedings as possible.

### Informing the patient of their rights of application

26.5 Hospital managers and local social service authorities (LSSAs) must ensure patients know about and understand their rights to apply to the MHRT for Wales. Patients should also be told that they are entitled to free legal advice and representation. Unless the patient requests otherwise, the information should normally also be given to their nearest relative. It is good practice for hospitals and LSSAs to hold a list of solicitors who undertake tribunal work for use by patients. Further guidance on information for patients is given in chapter 22.

26.6 If a patient wants to apply to the MHRT for Wales but is unable to do so, for example if they are unable to write, it is acceptable for someone else to make a written application on their behalf.

26.7 Local protocols should be developed to ensure that staff are available to help patients make an application - this is especially important for patients on SCT who may not have daily contact with such staff.

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<sup>9</sup> The MHRT in England is to be replaced by a new First-tier Tribunal established under the Tribunals, Courts and Enforcement Act 2007. There will be separate Rules governing the procedures of the MHRT for Wales and the First-tier Tribunal.

## Hospital managers' duty to refer cases to the MHRT for Wales

26.8 The hospital managers have various duties to refer cases to the MHRT for Wales, and they may also ask the Welsh Ministers to refer a patient. There are certain circumstances where they should always consider doing so. Further details are given in chapter 11.

### Reports

26.9 Responsible authorities (the hospital managers or the responsible LSSA for a guardianship patient) should be familiar with the MHRT for Wales' rules and procedures. The responsible authority must provide the tribunal with a statement of relevant facts and certain reports.

26.10 The responsible authority must ensure that up-to-date reports prepared specifically for the tribunal are provided in accordance with the tribunal's rules and procedures and in good time for any hearing. Missing, out-of-date or inadequate reports can lead to postponements, adjournments or needlessly long hearings. If responsible clinicians, social workers or others are required to provide reports, they should do so promptly and always within the statutory timescale.

26.11 If the patient is under 18 and the patient's responsible clinician is not a child and adolescent mental health services (CAMHS) specialist, the responsible clinician should ensure that a report from such a specialist is provided.

26.12 In the case of a restricted patient, if the opinion of the responsible clinician or other professional providing a report, changes from that which was recorded in the original tribunal report(s), this must be communicated in writing before the hearing to the MHRT for Wales office and the Mental Health Unit (MHU) of the Ministry of Justice, enabling the MHU to prepare a supplementary statement.

26.13 Sometimes the statutory time limit for submitting reports is well in advance of the hearing. In these cases the report writers should consider whether anything in the patient's circumstances has changed and produce a concise update to the report, either in writing or orally at the hearing.

26.14 If a tribunal feels it needs more information on a report, or additional reports, it may request a new report in advance of the hearing or it may question a witness at the hearing itself.

26.15 If the author of a report prepared for the tribunal knows of information they do not think the patient should see, they should follow the tribunal's procedures for the submission of such information. Ultimately it is for the tribunal to decide what should be disclosed to the patient.

## Withdrawing an application

26.16 A request to withdraw an application may be made by the applicant in accordance with the tribunal rules.

26.17 An application will also be considered to be withdrawn if the patient is discharged from the detention, guardianship or SCT as the case may be. The tribunal must be notified of a patient's discharge as soon as possible. A patient cannot withdraw a referral made to the MHRT for Wales by the hospital managers, Secretary of State for Justice, or the Welsh Ministers.

## Medical examination

26.18 A medical member of the tribunal may want to examine the patient at any time before the hearing. Hospital managers must ensure that the medical member is able to meet the patient in private and examine their case records. It is important that the patient is told of the visit in advance.

## Hearings

### Before the hearing

26.19 The responsible authority must ensure that the tribunal is notified immediately of any events or changes that might have a bearing on tribunal proceedings - for example, where a patient is discharged, the section under which they are detained changes, or one of the parties is unavailable.

### Accommodation for hearings

26.20 The managers of a hospital in which a tribunal hearing is to be held must provide suitable accommodation. 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 left in the room would not interfere with the proceedings or adversely affect the patient.

26.21 The patient should have access to a separate room in which to hold any private discussions that are necessary, for example with their representative. Tribunal members must also be able to discuss their decision in private.

26.22 If a patient is being treated in the community, a venue other than a hospital may be more suitable.

### Interpretation

26.23 The MHRT for Wales has a Welsh language scheme, and hearings can be held in English or Welsh depending on the patient's language of choice.

26.24 Where necessary, the tribunal will provide free-of-charge interpretation services for patients and their representatives. If patients or their representatives are hard of hearing or have speech difficulties (or both) the tribunal will provide any services necessary. Responsible authorities should tell the tribunal well in advance if they think such services might be necessary.

### Attendance at hearings

26.25 Normally patients will be present throughout the hearing. They do not need to attend but professionals should encourage them to do so unless they judge it would be detrimental to their health or well-being. An IMHA may accompany the patient to offer support, but where a patient is legally represented the IMHA will not usually speak on behalf of the patient.

26.26 It is important that the patient's responsible clinician attends the tribunal, 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 continued detention or SCT under the Act. Wherever possible the responsible clinician and other relevant staff should attend the full hearing so they are aware of all the evidence and the tribunal's decision and reasons.

26.27 The responsible clinician can attend the hearing solely as a witness or as the nominated representative of the responsible authority. As a representative, the responsible clinician may call and cross-examine witnesses and make submissions to the tribunal. However this may not always be desirable (for example they may be required to speak on matters outside their responsibility, such as service funding and provision) and responsible authorities 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 they are attending and understand the implications.

### Conducting a hearing

26.28 The tribunal will conduct the hearing in the way it considers most suitable but it should seek to avoid formality and should help the patient to understand and contribute to the proceedings as fully as possible.

26.29 The tribunal may ask the author of a report to talk to their report, so the author should re-familiarise themselves with their report's content before the hearing. If the author is unable to attend, it is important that anyone attending on their behalf also has, where possible, a good knowledge of the patient's case and is familiar with the report. Everyone attending the hearing should provide further up-to-date information about the patient, including (where relevant) information about home and social circumstances and available after-care in the event of a decision to discharge the patient.

26.30 Responsible authorities should ensure that all practitioners who attend tribunal hearings are familiar with its rules and procedures, understand what will happen during the hearing and what their input into the process is likely to be.

## Communication of the decision

26.31 The tribunal 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 tribunal will speak to the patient personally. Otherwise, the decision will be given to the patient's representative (if there is one). If the patient is not represented and it is not feasible to discuss matters with them after the hearing, the responsible authority should ensure that the patient is told the decision as soon as practicable.

## Other matters

26.32 Complaints about the tribunal should be sent to the tribunal office. The MHRT for Wales has procedures in place to deal with complaints promptly.

26.33 The MHRT for Wales publishes further information and guidance about its procedures and operations. The MHRT for Wales can be contacted at:

Mental Health Review Tribunal for Wales  
4th Floor  
Crown Buildings  
Cathays Park  
Cardiff CF10 3NQ



# Chapter 27

## The hospital managers' power of discharge

27.1 This chapter deals with the processes and good practice that should be adopted by hospital managers (or those delegated to act on their behalf) in considering whether they should use their power of discharge.

### Background

27.2 Section 23 gives hospital managers (see chapter 11) the power to discharge an unrestricted patient from detention or supervised community treatment (SCT). Discharge of a restricted patient requires the consent of the Secretary of State for Justice.

27.3 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. It is helpful to patients and staff that any such committee is referred to in a way which clearly indicates that the committee is formed solely to consider whether hospital managers' power of discharge should be exercised.

27.4 In the case of a Trust or Local Health Board, the committee or sub-committee must not include any employee or officer of that Trust or Board, but should include a non-executive director. In the case of an independent hospital, the committee or sub-committee should not include people who are on the staff of the hospital or have a financial interest in it. Appointments to the committee or sub-committee for the exercise of the hospital manager's power of discharge should be for a fixed period and there should be a review before any reappointments.

27.5 The hospital managers retain the final responsibility for the performance of their delegated duties, including considering whether patients should be discharged.

27.6 The Act does not define the criteria or the procedure for reviewing a patient's detention. However the exercise of this power is subject to the general law and public law duties which arise from it. The hospital managers' conduct of reviews must abide by the rules of natural justice:

- they must adopt and apply a procedure which is fair and reasonable
- 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
- they must act in good faith and without bias, giving everyone the opportunity to state their case adequately
- they must not act unlawfully.

## Review panels

- 27.7 The panel must have at least three members and the hospital managers should ensure that all those appointed are properly informed and experienced and receive suitable training.
- 27.8 For patients on section 17 leave to another hospital, the hospital managers of the original hospital should undertake any necessary hearings.

## When to review

- 27.9 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 hearing by the Mental Health Review Tribunal for Wales (MHRT for Wales).
- 27.10 The hospital managers:
- may undertake a review at any time;
  - must review a patient's detention when the responsible clinician submits a report under section 20(3) renewing detention or section 20A(4) extending SCT;
  - must consider holding a review when a patient requests it;
  - must consider holding a review when the responsible clinician makes a report under section 25(1) opposing a nearest relative's application for the patient's discharge.
- 27.11 The hospital managers should consider a report made under section 20(3) or section 20A(4) and whether it is appropriate to exercise their discretion of discharge, before the current period of detention or community treatment ends. However the responsible clinician's report provides authority for a patient's continued detention or community treatment under the Act.
- 27.12 A restricted patient is entitled to ask the hospital managers to consider whether they should conduct a review of his or her detention, although the hospital managers may not discharge the patient following any such review without the consent of the Secretary of State for Justice.
- 27.13 In the cases covered by paragraph 27.10c and d above, the patient, or the nearest relative, will be actively seeking discharge. Where the responsible clinician submits a report renewing detention or extending SCT, the hospital managers must consider the renewal or extension even if the patient does not object to it. The hospital managers may adopt procedures that differentiate 'uncontested' renewals from reviews where the patient contests detention (see below).

## Criteria

- 27.14 The Act does not define specific criteria for the hospital managers to apply when considering the discharge of a patient who is detained, liable to be detained or liable to be recalled. The hospital managers should consider whether the criteria for detention or SCT under the Act are satisfied.



27.15 For a patient who is detained, or liable to be detained, the review panel should consider the following questions in this order:

- 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?
- Is detention in hospital for treatment still necessary in the interests of the patient's health or safety, or for the protection of other people?
- Is appropriate medical treatment available for the patient?

27.16 For a patient who is subject to SCT, the review panel should consider the following questions in this order:

- Is the patient still suffering from mental disorder?
- If so, is the disorder of a nature or degree which makes it appropriate for them to receive medical treatment?
- If so, is it necessary in the interest of patient's health and safety or for the protection of other people?
- Can such treatment be provided without the patient being detained in hospital but subject to being liable to recall?
- Is appropriate medical treatment available for the patient?

27.17 In cases where the responsible clinician has made a report under section 25(1), and the nearest relative has not applied to the MHRT for Wales for a review, the managers should not only consider the questions above but also the following question:

- Would the patient, if discharged, be likely to act in a manner dangerous to other people or to themselves?

This question focuses on the probability of dangerous acts, such as causing serious physical injury, not just the patient's general need for safety and others' general need for protection: it provides a stricter test for continuing detention.

27.18 If three or more members of the review panel are satisfied from the evidence that the answer to any of these questions is 'no', the patient should be discharged.

27.19 Hospital managers may order the immediate discharge of a patient, or make a decision not to order the patient's discharge, in line with their findings. They may also:

- adjourn the hearing to seek further evidence and information
- or recommend SCT or guardianship
- or order the deferred discharge of the patient (which must not be a date after the current authority for compulsion ends).

Recommendations made by the hospital managers about this are not enforceable, but should be considered by the responsible clinician. Hospital managers may not order the discharge of a patient subject to certain conditions being achieved (for example, an after-care package being prepared).

27.20 When exercising their discretion for 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 will be incompatible with Article 5 of the European Convention of Human Rights, 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 (this does not necessarily mean the expertise of a medical practitioner)
- 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.

27.21 If professionals follow the requirements of the Act and the guidance in this Code, there should not be any such breach.

## Conduct of reviews (where continued compulsion is contested)

27.22 The review should be conducted so as to ensure that the case for discharging, or continuing compulsion, of the patient is properly considered against the above grounds and in the light of all relevant evidence. The review panel needs to have sufficient information about the patient's history of care and treatment, and details of any care plans. The panel must be fully informed about any history of violence or self-harm, and the findings of any risk assessments made available to the hospital managers.

27.23 Before the hearing, the review panel should receive written reports from the patient's responsible clinician and others directly involved in the patient's care such as other approved clinicians, the key worker, named nurse, care coordinator, social worker and clinical psychologist. The patient should receive copies of the reports unless the hospital managers judge that the information would adversely affect the health or well-being of the patient or others.

27.24 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 their report.

27.25 The report submitted by the responsible clinician should cover the history of the patient's care and treatment and details of his or her CPA or care and treatment plans, including all risk assessments. Where there is a report prepared by the responsible clinician under section 20, 20A or 21B renewing detention, the panel should also have a copy of this, supplemented by a

copy of the record by the professional who was consulted by the responsible clinician (under section 20(5) and (5A)). Any report made under section 25(1) should also be made available to the hospital managers.

27.26 The hospital managers decide how the hearing is run, but need to balance informality against the rigour demanded by the importance of the task. If a patient is being treated in the community, they should consider the most appropriate venue - the patient's home should never be used, but a location in the community may be more suitable than a hospital.

27.27 Key points are:

- The patient should be given full opportunity, and any necessary help, to explain why they want to be discharged.
- The patient should be allowed to choose a friend or representative to help put their point of view to the panel. This may be an independent mental health advocate.
- The responsible clinician and other professionals should be asked to give their views on whether the patient's continued detention or SCT is justified; and the factors on which those views are based.
- The patient and the other parties should be able to hear each other's statements to the panel and put questions to each other, but the patient should always have the opportunity of speaking to the panel alone.

27.28 While the panel must give full weight to the views of all the professionals concerned in the patient's care, its members will not usually be qualified to form clinical assessments of their own. If there is disagreement about whether the patient meets the criteria for continued detention or SCT, especially in relation to matters such as risk assessment, the panel should consider adjourning to seek further professional advice.

27.29 In applying the criteria set out above in paragraphs 27.15 to 27.17, and deciding 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 before 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 concludes that the patient ought to be discharged but arrangements for aftercare need to be made, they may adjourn the panel briefly for a full after-care planning meeting to take place. The managers should ensure that a full risk assessment has been carried out when considering discharge.

## Uncontested renewals

27.30 If a patient's detention or SCT is renewed or extended under section 20, 20A or 21B, and the patient has indicated that they do not object, the review panel should meet to consider the papers and should interview the patient (if the patient wishes) and their care coordinator. If the panel then agrees the patient should not be discharged, the review can be concluded and the outcome recorded in the patient's records.

## Decision

27.31 The hospital managers should fully record the evidence they considered in reaching their decision, the reasons for their decision, and the decision itself.

27.32 At the time their decision is made, the reasons for it should be communicated in full, 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 member of the panel should 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.

# Chapter 28

## Leave of absence from hospital

28.1 This chapter provides guidance on the use of leave of absence and the matters which should be considered in granting such leave under section 17 of the Act.

### General matters

28.2 A patient who is detained can only leave hospital, or a specified hospital unit, lawfully by being:

- discharged from detention (including conditionally)
- transferred to another hospital or into guardianship (under section 19 of the Act)
- returned to custody (for example, prison), if applicable
- made the subject of supervised community treatment (SCT)
- or granted leave of absence in accordance with section 17 of the Act.

Leave of absence is therefore an important part of a patient's treatment plan.

28.3 Only the patient's responsible clinician, with the approval of the Secretary of State for Justice in the case of restricted patients, can grant a detained patient leave of absence. A responsible clinician may not grant leave of absence to patients detained under sections 35, 36 and 38 of the Act.

28.4 A patient who has been granted leave of absence under section 17 of the Act continues to be 'liable to be detained'.

28.5 Except where the patient is detained in a specified hospital unit, no formal procedures under the Act are required in order to allow a patient to visit different parts of the hospital or hospital grounds, as part of their care programme. It may, however, be appropriate for hospital managers to ensure there is a local policy for granting permission for detained patients to have 'ground leave' or leave to visit other parts of the hospital.

### Informal patients

28.6 Informal patients are not subject to leave requirements under section 17. A patient who is not detained has the right to leave (other than those patients subject to authorisation under the deprivation of liberty safeguards<sup>12</sup> of the Mental Capacity Act 2005). However, patients may be asked by staff to inform them when they want to leave the ward.

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<sup>10</sup>The deprivation of liberty safeguards are expected to come into force from April 2009

## Granting leave of absence

### Matters to be considered

28.7 When considering and planning authorised leave of absence the responsible clinician should:

- consider the benefits and any risks to the patient's health and safety of granting or refusing leave
- consider the benefits of granting leave for aiding the patient's recovery
- balance these benefits and risks against any risks the patient may pose to other people (either generally or specifically)
- consider any conditions which should be attached to the leave, for example requiring the patient not to visit particular places or people
- be aware of any child protection and child welfare issues in granting leave
- take full account of the patient's wishes about leave, and those of carers, friends and family who may be involved in any planned leave of absence
- take account of any necessary support for the patient during their leave of absence
- ensure any community services providing support for the patient during their leave are involved in planning the leave, and know the leave dates and times and any conditions placed on the patient during their leave
- ensure the patient knows about any contingency plans in place for their support, including how they may seek to end the leave early if they want
- consider SCT as an alternative to longer-term leave (more than seven consecutive days) - see paragraph 28.11 below.

### Unrestricted patients

28.8 The responsible clinician cannot delegate the decision to grant leave of absence to any other professional, including another approved clinician. They are responsible for ensuring and undertaking appropriate consultation, and may impose conditions on any leave, either in the interests of the patient, or for the protection of other people.

28.9 While the responsible clinician's power to grant leave of absence cannot be restricted by hospital managers, if the responsible clinician grants leave subject to certain conditions (e.g. residence at a hostel) this does not mean the managers or anyone else has to fund or arrange the particular placement or services. Responsible clinicians should not grant leave on such a basis without first ensuring the necessary services, authorisation and/or accommodation are available.

28.10 Leave of absence can be granted by the responsible clinician for specific occasions, periods of time or for an indefinite period. While such authorised leave may be extended in the patient's absence, granting leave should not be used as an alternative to discharging the patient or to considering the use of SCT.

28.11 In considering whether to grant more than seven consecutive days' leave (either in the first instance or through extension of leave), the responsible clinician must consider whether the patient would be more appropriately discharged onto SCT. In granting leave in the community, rather than to another hospital, the responsible clinician is clearly indicating the possibility that the patient may need to be detained in hospital for treatment again, at some future point. A patient on a community treatment order will be treated while living in the community on an ongoing basis, and will only need to be detained in hospital should it be deemed necessary to use the power of recall.

### **Restricted patients**

28.12 Any proposal to grant leave for restricted patients must be approved by the Secretary of State for Justice who should be given as much notice as possible, together with full details of the proposed leave.

### **Short-term leave**

28.13 The responsible clinician, with the authority of the Secretary of State for Justice if the patient is subject to restrictions, may decide to authorise short-term local leave, managed by other staff. As an example, the patient may be given leave for a shopping trip of two hours every week, with the decision on which particular two hours being left to the discretion of the responsible nursing staff. It is vital that such decisions fall within the terms of the leave granted by the responsible clinician, which should be precisely set out, and that those terms and their implementation are reviewed regularly and the outcome explicitly recorded in the patient's case notes. It is important that the terms of the leave prescribed by the responsible clinician cannot be interpreted differently by the staff managing the leave of absence.

### **Longer periods of leave**

28.14 If the responsible clinician has decided that leave, rather than SCT, is the best option for the patient, the leave must be properly planned and, if possible, well in advance.

28.15 Such 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 in turn, be able to demonstrate that they are likely to cope outside the hospital. Subject to the patient's consent, there should be detailed consultation with any appropriate relatives and friends and others (especially where the patient is to stay with them), including independent advocacy and community services. Leave should not be granted if the patient does not agree to the consultation.

### **Recording and information**

28.16 The granting of leave and the conditions attached to it, should be clearly recorded in the patient's case notes. It is good practice for hospital managers to adopt a local record form for the responsible clinician to authorise leave and specify any conditions. Copies of the authorisation of the leave should be given to the patient, any appropriate relatives or friends and any professionals in the community who may need to be informed.

28.17 The outcome of the leave, such as whether it went well or whether the staff or patient had concerns about it, should be recorded in the patient's records. Patients should be involved in discussions about their care planning, of which leave will form a part.

## Care and treatment while on leave

28.18 The responsible clinician's obligation for the patient's care remains the same while they are on leave, although it is exercised in a different way. The duty to provide after-care under section 117 applies to patients who are on leave of absence, provided they would otherwise qualify (see chapter 31 of this Code).

28.19 Because the patient granted leave under section 17 remains 'liable to be detained' the provisions of Part 4 of the Act continue to apply. If it becomes necessary to administer treatment in the absence of the patient's consent under Part 4, consideration should be given to recalling the patient to hospital. The refusal of treatment may not on its own be sufficient grounds for recall.

## Patients in custody or in other hospitals

28.20 The responsible clinician may 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 take part in escorted trips, or to have compassionate home leave. This power however, can only be exercised within Wales and England. It can be exercised in Scotland only with the agreement of Scottish Ministers.

28.21 While it may often be appropriate to authorise leave subject to the condition that a patient is accompanied by a friend or relative (for example on a pre-arranged day out from the hospital), responsible clinicians should only specify that the patient is to be in the legal 'custody' of a friend or relative if that person understands and accepts the responsibilities of being the patient's legal custodian, and if it is appropriate for such a person to be legally responsible for the patient.

## Leave to another hospital

28.22 Section 17 leave may be necessary to allow a patient to attend a general hospital for treatment, for example to undergo an operation. In these circumstances the responsible clinician should clearly set out the conditions for granting the leave, including any requirements for the patient to remain in the custody of staff. The responsible clinician must ensure that the staff in the second hospital understand the restrictions which the patient is under because of their detention under the Act, as well as the safeguards. It is important that those staff understand the limits and protections given to the patient by Part 4 of the Act. If the patient needs further leave of absence from the second hospital - for example, if their friends or family want to take them out for a few hours - that leave can only be granted by the patient's responsible clinician in accordance with section 17, and not by the consultant or other professional in charge of their treatment in the second hospital.



28.23 Section 17 leave may also be used to grant a patient leave to another hospital for further treatment of their mental disorder, often as progression to a unit with lesser security (commonly referred to as 'trial leave'). This can be a useful stage in the patient's recovery. Therefore the responsible clinician can require that the patient, as a condition of leave, stays at another hospital in Wales or England and that they may be kept in the custody of an officer of that hospital.

28.24 Although, in these circumstances, day-to-day functions relating to the patient's care can be delegated to an approved clinician at the second hospital, the functions of the responsible clinician to consider renewal of detention or granting further leave cannot be delegated.

28.25 The patient's detention can be renewed during such a period of leave. However, consideration should be given to whether it would be better to transfer the patient under the provisions of section 19 of the Act, rather than being given section 17 leave. For guidance on hospital manager's responsibilities for considering the renewal of detention in these circumstances, see chapter 27 of this Code.

28.26 Section 17 leave is not required to allow a patient to be transferred from one hospital to another under section 19 of the Act. If a patient is being transferred between hospitals under section 19, that section of the Act gives the authority for the patient to leave the original hospital and be taken to the second hospital.

## Duration of leave and renewal of authority to detain

28.27 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 while the patient is on leave, the responsible clinician should examine the patient and consider writing a report renewing the detention, while the patient is still on leave, if the responsible clinician thinks further hospital treatment is necessary and the statutory criteria are met. The renewal of detention and leave provides a further opportunity to consider if it would be more appropriate for the patient to be placed onto SCT instead.

## Recall to hospital

28.28 The responsible clinician may revoke the leave of absence of an unrestricted patient at any time, if they consider this necessary in the interests of the patient's health or safety or for the protection of other people. A restricted patient's leave may be revoked either by the responsible clinician or the Secretary of State for Justice. The effect of revoking the leave is that the patient again becomes an inpatient

28.29 The responsible clinician must carefully consider the reasons for recalling a patient and the effect this may have on the patient's care and treatment. As an example, the refusal to take medication may not on its own be a reason for revocation. For an unrestricted patient, the responsible clinician would have to be satisfied that the likely consequences of such a refusal would make it necessary in the patient's interests or for the safety of others for the patient to be recalled.

28.30 If recall is considered necessary, the responsible clinician may, by notice in writing, revoke the patient's leave. Such notice should be served on the patient or on the person temporarily in charge of the patient. The reasons for recall should be fully explained to the patient and a record placed in the patient's case notes.

28.31 It is essential that any carers, friends or relatives of the patient, and practitioners in the community, have access to the patient's responsible clinician if they feel that the patient's early return to hospital should be considered.

# Chapter 29

## Absence without leave

29.1 This chapter gives guidance on the powers under section 18 of the Act to return a patient who is absent without leave.

### General matters

29.2 Section 18 of the Act provides powers for the return of patients to hospital if they are absent without leave and are liable to be detained or have been recalled to hospital from supervised community treatment (SCT) or conditional discharge. Section 18 also applies to patients subject to guardianship, if they are absent without the leave of their guardian from the place they are required to live.

29.3 All instances of absence without leave should be recorded in the patient's case notes, and reported through local incident reporting mechanisms.

29.4 Reasons for a patient absconding may arise as a result of the patient's inability to accept and cooperate in their treatment plan. Therefore, if it is thought that a patient may try to abscond, the responsible clinician should consider whether an alternative approach to treatment can be found. For example, if a patient is detained in hospital and unless the protection of others is an issue the responsible clinician might consider allowing the patient leave of absence or discharge on to SCT, rather than making the patient subject to increased supervision.

### Patients who are liable to be detained

29.5 Such patients are considered to be absent without leave if:

- they have left the hospital without their absence being agreed by their responsible clinician (under section 17 of the Act)
- they have failed to return to the hospital at the time required under the conditions of their leave under section 17
- they are absent (without permission) from a place where they are required to live as a condition of their leave under section 17
- they have failed to return to the hospital if their leave under section 17 has been revoked.

29.6 In these circumstances the patient may be taken into custody and returned to the hospital, or the place where they are required to live, by an approved mental health professional (AMHP), any officer on the staff of the hospital, any police officer, or anyone authorised in writing by the hospital managers. If the patient is required to live in another hospital as a condition of leave of absence, they may also be taken into custody by any officer on the staff of that hospital or by anyone authorised by the managers of that hospital.

29.7 The patient may be initially taken to another hospital, for example because that is the closest hospital to where they are found. The temporary hospital may, if authorised by the managers of the detaining hospital in writing, detain the patient while arrangements are made for their return. This authority can be given electronically or by fax.

## Community patients

29.8 Patients on SCT or conditional discharge are considered to be absent without leave if they fail to return to hospital when 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 police officer, or anyone authorised in writing by the responsible clinician or the hospital managers, and returned to the hospital to which they were recalled.

## Patients subject to guardianship

29.9 Where a patient who is subject to guardianship is absent without permission from the place where they are required to live by their guardian, they are considered to be absent without leave. Such a person may be taken into custody by any member of the staff of the local social services authority (LSSA), or by anyone authorised in writing by the guardian, or the LSSA. The patient may only be returned to the place where they are required to live; there is no power to take them to a new place of residence.

## Local policies

29.10 Hospital managers should ensure there is a clear written policy on the actions to be taken when a detained patient or a community patient goes missing. This policy should be agreed with other agencies, including the police, where necessary. Service users should be given the opportunity to comment and inform the development of the policy.

29.11 The policy should include guidance on:

- The immediate action to be taken by any member of staff who becomes aware that a patient has gone missing, including the requirement that they immediately inform the person in charge of the patient's ward (where applicable) who should in turn ensure that the patient's responsible clinician is immediately informed.
- The circumstances when there should be a search of the hospital and its grounds.
- The circumstances when other local agencies with an interest, including the LSSA, should be notified.
- The circumstances and processes for when the police should be informed. This should be the subject of agreed local arrangements with the police, and in such circumstances the police may be asked to help return a patient to hospital only if absolutely 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. There may be other cases where, although police help 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.

- The circumstances which would prompt an application being made under section 135(2) of the Act. Those people who have a power to return a patient to hospital (see paragraphs 29.6 and 29.8) do not have the power under section 18 of the Act to force entry into premises where the patient is staying. If powers of entry are required, an application under section 135(2) should be made for a warrant authorising a police officer to enter the premises and remove the patient. Chapter 7 gives further guidance.
- How and when other people, including the patient's nearest relative, should be informed. This should include guidance on informing people if there is good reason to think they might be at risk as a result of the patient's absence.

29.12 LSSAs should have equivalent policies for the actions which should be taken in the case of someone received into guardianship and who is absent without leave from the place where he or she is required to live. This should include notification of the specified guardian and the LSSA.



# Chapter 30

## Supervised community treatment

- 30.1 This chapter provides guidance on the purpose of supervised community treatment (SCT) including the process for assessing the suitability of the use of SCT and the management of community treatment orders (CTOs). This chapter also provides guidance on the duties of the practitioners and agencies involved in the management of patients subject to SCT.
- 30.2 Guidance on the treatment of patients under SCT and the operation of Part 4A of the Act is given in chapter 17.
- 30.3 The purpose of SCT is to enable eligible patients to be treated safely in the community rather than under detention in hospital, and to provide a way to help prevent relapse and any possible harm, to the patient or others. SCT is intended to help the patient to maintain stable mental health outside hospital and to promote recovery.
- 30.4 SCT provides a framework for the management of patient care in the community and gives the responsible clinician the power to recall the patient to hospital for treatment if necessary. This is achieved by the responsible clinician placing the patient on a CTO. This allows conditions to be applied to the patient and provides the means to recall them to hospital if necessary.
- 30.5 Given the constraints inherent within SCT, practitioners should pay particular attention to the guiding principles in chapter 1 when considering its use.

### Considering the use of SCT

- 30.6 Careful consideration should be given to the most appropriate means of ensuring the delivery of effective patient care and supervision in the community for those patients not subject to special restrictions. These include:
- granting short-term or extended leave of absence under section 17 of the Act
  - transfer into guardianship (section 7 of the Act)
  - supervised community treatment.
- 30.7 Only patients who are detained under an unrestricted treatment or hospital order are eligible for SCT. Patients detained in hospital for assessment under section 2 of the Act are not eligible.

## Leave of absence (section 17)

- 30.8 Section 17 leave is primarily intended to allow a patient detained under the Act to be temporarily absent from hospital where further inpatient treatment as a detained patient is still thought to be necessary. It will ordinarily be used for short-term leave as part of the delivery of the patient's care plan, for example, to enable visits to family. It is also helpful in preparing for discharge from hospital.
- 30.9 Under section 17 of the Act the patient remains liable to be detained and subject to the treatment or assessment order for the remaining duration of that order. Further guidance is given in chapter 28 of this Code.
- 30.10 For some patients SCT may be a better option than longer-term leave for the ongoing management of their care. Therefore, whenever considering longer-term leave for a patient (that is, for more than seven consecutive days), the responsible clinician must consider whether SCT is the more appropriate way of managing the patient in the community. The responsible clinician can still use longer-term leave if that is the more suitable option, but they will need to be able to show that both options have been duly considered. The decision, and the reasons for it, should be recorded in the patient's notes.

## Guardianship (section 7)

- 30.11 A patient who is liable to be detained in hospital may be transferred into guardianship if they meet the criteria for its use. Guardianship is led by social care and is primarily focused on patients with welfare needs. Its purpose is to enable such patients to receive care in the community where it cannot be provided without the use of compulsory powers.
- 30.12 Guardianship enables the guardian to supervise the patient within the community. The patient is not liable to be detained and is not subject to recall to hospital. Guardianship is most appropriately used to enable health and social care agencies to provide a framework that ensures the welfare of eligible patients. Patients subject to guardianship can have conditions placed upon them, for example to live in a particular place or to attend particular places as set out in their care plan. It would not however, normally be used where ensuring the delivery of medical treatment is the primary objective. Further guidance is given in chapter 6 of this Code.

## Supervised community treatment (section 17A)

- 30.13 As set out above, the purpose of SCT is to enable patients to be treated safely in the community rather than under detention in hospital, and to provide a way to help prevent relapse and harm. It is a more structured system than leave of absence and has more safeguards for patients. A key feature of SCT is that it is suitable where there is no reason to think that the patient will need further treatment as a detained inpatient for the time being, but the responsible clinician needs to be able to recall the patient to hospital if that becomes necessary.



30.14 Patients can only be placed onto SCT if they meet the following criteria:

- 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 the patient's health or safety or for the protection of other people that they should receive such treatment
- subject to the patient being liable to be recalled as mentioned below, such treatment can be provided without the patient continuing to be detained in a hospital
- it is necessary that the responsible clinician should be able to exercise the power under section 17E(1) to recall the patient to hospital
- appropriate medical treatment is available for the patient.

30.15 In considering whether SCT or longer-term leave of absence or guardianship is more appropriate for a patient, some pointers appear below:

### SCT or longer-term leave of absence: relevant factors to consider

Factors suggesting longer-term leave	Factors suggesting SCT
<ul style="list-style-type: none"> <li>• discharge from hospital is for a specific purpose or a fixed period</li> <li>• the patient's discharge from hospital is specifically on a 'trial' basis</li> <li>• patient is likely to need further in-patient treatment without their consent or compliance</li> </ul>	<ul style="list-style-type: none"> <li>• confidence that the patient is ready for discharge from hospital on an indefinite basis</li> <li>• good reasons to expect that the patient will not need to be detained for the treatment they need to be given</li> <li>• patient appears prepared to consent or comply with the treatment they need - but risks (as below) mean recall may be necessary</li> <li>• risk of arrangements in the community breaking down or patient needing to be recalled to hospital for treatment is sufficiently serious to justify SCT, but not to the extent that it is very likely to happen</li> </ul>

## SCT or guardianship: relevant factors to consider

Factors suggesting guardianship	Factors suggesting SCT
<ul style="list-style-type: none"><li>• focus is on patient's general welfare, rather than specifically on medical treatment</li><li>• little risk of the patient needing to be admitted compulsorily and quickly to hospital</li><li>• need for enforceable power to require patient to live at a particular place</li></ul>	<ul style="list-style-type: none"><li>• main focus is on ensuring that patient continues to receive necessary medical treatment for mental disorder, without having to be detained</li><li>• compulsory recall may well be necessary and speed is likely to be important</li></ul>

### Making a community treatment order

30.16 The responsible clinician is responsible for initiating the process of making a CTO.

The decision to make the order is taken jointly with an approved mental health professional (AMHP). The AMHP may be a member of the multi-disciplinary team involved in the care of the patient but this is not a requirement.

30.17 In reaching their decision, the responsible clinician and AMHP should consider this Code's guiding principles and whether the objectives of the discharge onto SCT could safely and effectively be achieved in a less restrictive way.

30.18 In assessing the patient's suitability for SCT the responsible clinician must decide whether the patient can only safely be treated for mental disorder in the community, if the responsible clinician can exercise the power to recall the patient to hospital for treatment if that becomes necessary.

30.19 In reaching that decision, the responsible clinician must assess any risk of the patient's condition deteriorating after discharge, for example as a result of refusing to receive treatment. To assess that risk the responsible clinician should consider the patient's history of mental disorder and any other relevant factors, including whether or not a patient has previously had repeated admissions. For example, a tendency to fail to follow a treatment plan or to discontinue medication in the community, making relapse more likely, may suggest a risk justifying use of SCT. Other relevant factors will vary, but are likely to include the patient's current mental state, the patient's insight and attitude to treatment, and the circumstances into which the patient would be discharged.

30.20 Taken together, all these factors should help the responsible clinician to assess the risk of the patient's condition deteriorating after discharge, and inform the decision as to whether continued detention, SCT or full discharge would be the right option for the patient at that particular time.

30.21 The AMHP should ensure that they consider the patient's wider social circumstances including any cultural issues. For example, they should consider any support networks the patient may have, the potential impact on the patient's family, employment and educational circumstances.

30.22 If the AMHP does not agree that a CTO should be made, or agree the suggested conditions, the SCT cannot proceed. It would not be appropriate for the responsible clinician to approach another AMHP in the absence of any change in circumstances. Where such disagreement occurs, an alternative plan to deliver after-care should be developed by the relevant professionals in consultation with those people listed at 30.27 below.

30.23 In all cases the AMHP must reach an independent professional view and record this.

30.24 If the responsible clinician and AMHP agree that the patient should be discharged onto SCT they should complete the relevant statutory form and send it to the hospital managers. The responsible clinician must specify on the form the date the CTO is to be made. This date is the authority for SCT to begin, and may be a short while after the date on which the form is signed, to allow time for arrangements to be put in place for the patient's discharge.

30.25 When SCT begins the patient becomes a 'community patient' and the treatment order they are subject to (e.g. section 3) does not end or expire but the authority of the hospital managers to detain the patient in hospital is suspended.

## Consultation

30.26 Patients do not formally have to consent to SCT. But in practice patients will need to be involved in decisions about the treatment to be provided in the community and how and where it is to be given, and be prepared to cooperate with the proposed treatment. Patients should not be given the impression that refusal to comply will lead to discharge without conditions.

30.27 Consultation should be undertaken at all the stages of SCT. The people to be consulted include:

- the patient who may be supported by an IMHA during the consultation process
- the nearest relative and any carers (unless the patient objects or it is not reasonably practicable)
- the multidisciplinary team involved in the patient's care
- anyone with authority to act on the patient's behalf
- the patient's general practitioner (GP) - if the patient does not have a GP, they should be encouraged and helped to register with a practice
- other relevant professionals.

30.28 Consultation is clearly vital when a CTO is first considered for a patient but should also take place on any review of the CTO, when a change in the conditions is envisaged and where it appears that the patient needs to be recalled to hospital, unless the need for recall is too urgent to allow prior consultation.

## Conditions

30.29 The CTO will include, in writing, conditions which the patient is required to abide by while the order is in force. There are two conditions which must be included in all cases - for the patient to make themselves available for medical examination:

- where extension of the CTO is being considered
- where necessary to allow a second opinion approved doctor (SOAD) to provide a Part 4A certificate authorising the patient's treatment in the community.

30.30 The responsible clinician may, with the AMHP's agreement, set other conditions which are necessary and appropriate to achieve one or more of the following objectives:

- to ensure that the patient receives medical treatment
- to prevent a risk of harm to the patient's health or safety
- to protect other people.

30.31 Conditions should be as least restrictive of the patient's liberty as possible and represent the minimum necessary to achieve their purpose. They should be in keeping with the Code's guiding principles, and be clearly and precisely expressed, so that the patient can readily understand what is expected.

30.32 The conditions to be set will depend on the patient's individual circumstances. The patient and, where appropriate, their carer and other relevant people such as family members should be involved and consulted when considering the conditions to be set. Where applicable, the responsible clinician should take account of any representation from a victim or their family, where the provisions of the Domestic Violence, Crime and Victims Act 2004 apply. In considering what conditions might be necessary or appropriate, the responsible clinician should always keep in view the patient's specific cultural needs and background.

30.33 Conditions might include stipulating where the patient is to live, the arrangements for receiving treatment in the community and may cover matters such as avoiding the use of illegal drugs, non-prescription drugs and/or alcohol where their use has led to relapse in their mental disorder. There would need to be clear justification for any other conditions relating to behaviour, but it may be appropriate, for example, to require a patient to try to avoid certain situations if directly relevant to their health or safety or the protection of others.

30.34 The reasons for any condition should be explained to the patient and others, as appropriate, and recorded in the patient's notes. It is important, if SCT is to be successful, that the patient agrees to keep to the conditions, or to try to do so, and that patients have access to the help they need to be able to comply.

## Varying and suspending the CTO conditions

- 30.35 The responsible clinician has the power to vary or suspend any of the conditions of the CTO. They do not have to obtain an AMHP's agreement before doing so, but it would not be good practice to vary or suspend conditions which had recently been agreed with an AMHP unless there is a change of circumstances and an urgent need to vary, for example, the delivery of treatment or the place of residence. The responsible clinician should, where practicable, discuss these matters with an AMHP.
- 30.36 Any condition no longer required should be removed.
- 30.37 A variation of the conditions might be appropriate where the patient's treatment needs or living circumstances have changed. For example, if a patient has been attending a clinic weekly to receive medication and it is agreed that the medication needs to be given fortnightly, the responsible clinician can vary the conditions to reflect this change.
- 30.38 Any variation in the conditions must be recorded on the relevant statutory form, which should be sent to the hospital managers.
- 30.39 The responsible clinician may also suspend any of the conditions at any stage, for example, to allow for the patient's temporary absence to go on holiday or due to a change in the treatment regime. The responsible clinician should record any decision to suspend conditions in the patient's notes, with reasons.
- 30.40 Whenever any changes are made to the conditions, it is important to ensure that the patient, and anyone else affected by the changes, knows that they have been varied, understands why, and how to comply with any new conditions.

## Information

- 30.41 Following the decision to discharge a patient onto SCT, the responsible clinician should inform the patient, orally and in writing, of the decision and the reasons for the decision, the conditions to be applied to the CTO, and the services that will be available to them in the community.
- 30.42 The patient's GP should be informed that the patient is to be made subject to a CTO, as well as others who are directly involved in the patient's care and service delivery plans, including members of the voluntary sector.
- 30.43 There is a duty on hospital managers to take steps to ensure patients understand what SCT means for them and their rights to apply for discharge. A copy of this information must also be provided to the nearest relative, where practicable, if the patient does not object. Further guidance is in chapter 22.

## Supporting and monitoring a patient on SCT

- 30.44 The CTO should form a part of the patient's care plan and review. Where a CTO is in force it will form a fundamental part of the care planning and service delivery process.
- 30.45 Once discharged from hospital close contact with the patient and the monitoring of their mental health and well-being is vital. The Act does not specify how this is to be achieved and arrangements are likely to vary depending on the patient's needs and individual circumstances, and the way local services are organised. All those involved will need to agree to the arrangements and respective responsibilities should be clearly set out in the patient's care and service delivery plans.
- 30.46 Appropriate action will need to be taken if the patient becomes unwell, engages in high-risk behaviour as a result of mental disorder, or withdraws consent to treatment (or begins to object to it). The responsible clinician should consider, with the patient (and others where appropriate), the reasons for this and what the next steps should be. If the patient refuses crucial treatment, an urgent review of the situation will be needed. Recalling the patient to hospital will be an option if the risk justifies it. If suitable alternative treatment is available which would allow SCT to continue safely and which the patient would accept, the responsible clinician should consider such treatment if this can be offered. If so, the care and service delivery plans, and if necessary the conditions of the CTO, should be varied accordingly. A patient on SCT must always give consent to the treatment but if they lack capacity to consent then treatment for their mental disorder must be in accordance with Part 4A (see paragraph 17.40).
- 30.47 The patient's compliance with the conditions will be a key indicator of how SCT is working in practice. If the patient is not complying, the reasons for this should be properly investigated. Appropriate action will be needed, which may entail review of the conditions, or indicate a need to consider if the patient should be recalled to hospital. For example the patient's health may have improved so that a particular condition is no longer relevant or necessary and in this case the responsible clinician should vary conditions as appropriate. Changes may also be needed to the patient's care and service delivery plan.

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

- 30.48 Particular attention should be paid to carers and relatives when they raise a concern that the patient is not complying with the conditions and/or their mental health appears to be deteriorating. The team responsible for the patient needs to give due weight to those concerns and any requests by carers or relatives in deciding what action to take. Carers and relatives are typically in much more frequent contact with the patient than professionals, even under well-run care plans. Their concerns may prompt a review of how SCT is working and consideration of whether it might be necessary to recall the patient to hospital. The managers of responsible hospitals should develop local protocols to cover how concerns raised should be addressed by the relevant treatment and care services.

## Extending SCT

- 30.49 In addition to the statutory requirements for review of SCT in the Act, it is good practice to review the patient's progress on SCT as part of all reviews of the care plan. Reviews should cover whether SCT is meeting the patient's treatment needs, and if not, what action is necessary to address this.
- 30.50 A patient who no longer satisfies all the criteria for SCT must be discharged without delay.
- 30.51 Before the period of the CTO can be extended, the responsible clinician must examine the patient in the two months leading up to the day on which the CTO is due to expire. The responsible clinician must consult one or more people who have been professionally concerned with the patient's treatment, and take their views into account.
- 30.52 An AMHP must agree that the criteria continue to be met, and that it is appropriate to extend the CTO, for the extension to take place. The AMHP does not have to be the same AMHP who originally agreed that the patient should become an SCT patient. It may (but need not) be an AMHP who is already involved in the patient's care and treatment. The role of the AMHP is to consider whether the criteria for extending the CTO are met and, if so, whether an extension is appropriate.
- 30.53 If the CTO is to be extended, a report must be completed by the responsible clinician and the AMHP and submitted to the hospital managers, who should consider the report (see chapter 27).

## Recalling a patient subject to SCT

- 30.54 The power of recall is intended to provide a means to respond to evidence of relapse or high-risk behaviour relating to mental disorder before it becomes critical and leads to the patient or other people being harmed. This is achieved by ensuring that the patient receives treatment quickly - increasing the likelihood that the patient's condition can be stabilised and that they can resume life in the community as soon as is practicable. The need for recall might arise as a result of relapse, or by a change in the patient's circumstances giving rise to increased risk.
- 30.55 The responsible clinician may recall a patient on SCT to hospital for treatment if the patient needs to receive treatment for mental disorder in hospital and there would be a risk of harm to the health or safety of the patient or to other people if the patient were not recalled for that purpose. The criteria for recall (see section 17E) must be satisfied before the recall power can be used.
- 30.56 A patient may also be recalled to hospital if they break a condition relating to making themselves available for medical examination to allow consideration of extension of the CTO, or for a Part 4A certificate to be made by a SOAD. The patient must always be given the

opportunity to comply with the condition before recall is considered. Before exercising the recall power for this reason, the responsible clinician should consider if the patient has a valid reason for failing to comply, and take any further action accordingly.

30.57 A failure to comply with a condition (apart from those relating to availability for medical examination, as above) is not in itself enough to justify recall, although any such failure to comply may be taken into account in making the decision. Recall would only be justified if the breach of a condition results in an increased risk of harm to the patient or to anyone else.

30.58 Each case should be considered on its merits but any action should be proportionate to the level of risk posed by the patient's non-compliance. In some cases negotiation with the patient, carer or other interested parties may resolve the problem and avoid the need for recall. It might also be sufficient to monitor a patient who has failed to comply with a condition requiring attendance for treatment, before deciding if the lack of treatment means that recall is necessary.

30.59 For some patients, the risk arising from a failure to comply with treatment could mean that immediate recall will be appropriate, to prevent the risk from escalating. In other cases negotiation with the patient - and (unless the patient objects or it is not reasonably practicable) the nearest relative and any carer - may resolve the problem and so avert the need for recall.

30.60 A need for recall might also arise where a patient has been complying with the conditions, but is still deteriorating, and the risk cannot be managed other than by securing treatment in hospital.

30.61 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 should consider reviewing the patient's treatment and consider whether the use of SCT remains appropriate.

30.62 The patient may be recalled to hospital even if they are in the hospital when the decision to recall is made.

### Procedure for recall to hospital

30.63 The responsible clinician has responsibility for co-ordinating the recall process, unless it has been agreed locally that someone else will do this. It will be important to ensure that the practical impact of recalling the patient on the patient's domestic circumstances is considered and managed.

30.64 The responsible clinician must complete a written notice of recall to hospital (as set out in the *Mental Health (Hospital, Guardianship, Community Treatment and Consent to Treatment) (Wales) Regulations 2008*), which is effective only when served on the patient. It is important that, wherever possible, the notice should be handed to the patient personally. Otherwise, the notice is served by delivery to the patient's usual or last known address.



- 30.65 The hospital to which the patient is being recalled need not be the patient's responsible hospital (that is, the hospital where the patient was detained immediately before going onto SCT) or under the same management as that hospital. A copy of the notice of recall, which provides the authority to detain the patient, should be sent to the relevant hospital managers.
- 30.66 Once the recall notice has been served, the patient can - if necessary - be treated as absent without leave, and taken to hospital (and a patient who leaves the hospital without permission can be returned there). The time at which the notice is deemed to be served will vary according to the method of delivery.
- 30.67 It will not usually be appropriate to post a notice of recall to the patient. This may however be an option if the patient has failed to attend for medical examination as required by the conditions of the CTO, despite having been requested to do so, when the need for the examination is not urgent. Sufficient time must be allowed for the patient to receive the notice before any action is taken to ensure compliance.
- 30.68 Where the need for recall is urgent, as will usually be the case, it will be important that there is certainty as to the timing of delivery of the notice. A notice handed to the patient is effective immediately. However it may not be possible to achieve this if the patient's whereabouts are unknown or if the patient is unavailable or simply refuses to accept the notice. In that event the notice should be delivered to the patient's usual or last known address. The notice is then deemed to be served (even though it may not actually be received by the patient) on the day after it is delivered - that is, the day (which does not have to be a working day) beginning immediately after midnight following delivery.
- 30.69 If the patient's whereabouts are known but access to the patient cannot be obtained, it might be necessary to consider whether a warrant issued under section 135(2) is needed.
- 30.70 The patient should be taken to hospital in the least restrictive way possible, and if the responsible clinician thinks it appropriate, the patient might be accompanied by a family member, carer or friend.
- 30.71 The responsible clinician should ensure that the hospital to which the patient is recalled is ready to receive the patient and to provide treatment. While recall must be to a hospital, the required treatment may then be given, if appropriate, on an outpatient basis.

### Outcomes following recall

- 30.72 When the patient arrives at hospital after recall, the clinical team will need to assess the patient's condition, provide the necessary treatment and determine the next steps. The patient may be well enough to return to the community after treatment, or may need longer for assessment or treatment in hospital.

- 30.73 The patient may be detained in hospital for a maximum of 72 hours after recall<sup>13</sup> to allow the responsible clinician to determine what should happen next. During this period the patient remains an SCT patient, even if they stay in hospital for one or more nights.
- 30.74 The responsible clinician may allow the patient to leave the hospital at any time within the 72 hours, but after 72 hours the patient must be allowed to leave. On leaving hospital the patient will remain on SCT as before, but a review of the conditions may be considered necessary.
- 30.75 If the patient requires inpatient treatment beyond 72 hours, the responsible clinician should consider revoking the CTO, which would mean the patient will again be detained under the powers of the Act. The responsible clinician may only revoke the CTO with the agreement of the AMHP.
- 30.76 If the CTO has not been revoked, or the patient discharged once more, within 72 hours of the patient being detained following recall, the patient must be released and the CTO will remain in force.
- 30.77 The responsible clinician and the clinical team will need to consider the reasons why it was necessary to exercise the recall power and whether SCT remains the right option for that patient. They will also need to consider, with the patient, and (unless the patient objects or it is not reasonably practicable) the nearest relative and any carers, what changes might be needed to help to prevent those circumstances from reoccurring. It may be that a variation in the conditions is required, or a change in the care plan (or both).

## Revoking the CTO

- 30.78 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 criteria for detention as set out in section 3(2) of the Act.
- 30.79 In making the decision as to whether it is appropriate to revoke a CTO, the AMHP should consider the wider social context for the person concerned, in the same way as when making decisions about applications for admissions under the Act.
- 30.80 If the AMHP does not agree that the CTO should be revoked then the patient cannot be detained in hospital after the end of the maximum recall period of 72 hours. The patient will therefore remain on SCT. The AMHP's decision and the full reasons for it should be recorded in the patient's notes. It would not be appropriate for the responsible clinician to approach another AMHP for an alternative view.
- 30.81 If the responsible clinician and the AMHP agree that the CTO should be revoked they must complete the relevant statutory form for the revocation to take legal effect, and send it to the hospital managers. The patient's detention under their original treatment section of the

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<sup>11</sup> The period of 72 hours commences from the time when the patient's detention in hospital (by virtue of the notice of recall under section 17E of the Act) begins (see section 17F(8)(a))

Act will be re-instated from the date of revocation. A new detention period begins for the purposes of subsequent review and applications to the Mental Health Review Tribunal for Wales (MHRT for Wales). See also chapter 17 on medical treatment after revocation of a CTO.

30.82 Even where a patient has not exercised their right to apply to the MHRT for Wales, the hospital managers must refer the case to the MHRT for Wales for review as soon as possible after the CTO is revoked (see chapter 11).

## Discharge from SCT

30.83 The need for the patient to remain on SCT should be kept under review.

30.84 The patient can be discharged from SCT in the following ways:

- by the responsible clinician at any time (the responsible clinician must do this if the patient no longer meets the criteria for SCT)
- by the hospital managers
- by the Mental Health Review Tribunal for Wales
- for Part 2 patients by their nearest relative.

The effect of discharge is to end the CTO and liability to detention.

30.85 If guardianship is considered the better option for a patient on SCT, an application may be made in the usual way.

30.86 The reasons for discharge should be explained to the patient and any concerns on the part of the patient, the nearest relative or any carer should be considered and dealt with as far as possible. On discharge from SCT the patient will remain entitled to after-care services under section 117 of the Act and the team should ensure that the services the patient needs will be available. The patient is likely to need to continue to receive support in the community.

## Professional and agency responsibilities relevant to SCT

### The responsible clinician

30.87 The responsible clinician is responsible for:

- giving appropriate consideration to SCT as an alternative to longer-term section 17 leave, if that is proposed
- determining the eligibility and suitability of a patient for SCT
- examining the patient
- consultation with the patient, nearest relative, carer and other professionals
- making the CTO in accordance with the statutory requirements

- determining the conditions to be applied to a CTO
- suspending or varying the CTO conditions
- oversight of the patient's care and treatment in the community
- revoking, with the involvement of an AMHP, the CTO if that becomes necessary
- exercising the power of recall
- extension of the CTO
- discharging a patient from SCT if the patient no longer meets the criteria.

### The approved mental health professional (AMHP)

30.88 The AMHP is responsible for:

- assessing the eligibility and suitability of a patient for SCT
- considering and agreeing the conditions with the responsible clinician
- assessing the appropriate decisions about extending the CTO
- considering the recall of a patient from the CTO, as requested by the responsible clinician
- assessing the appropriateness or otherwise of revoking the CTO.

30.89 In reaching these decisions, the AMHP should consider the wider social context for the person concerned. Relevant factors may include any support networks the patient may have, the potential impact on the rest of the patient's family, and employment issues. The AMHP should consider how the patient's social and cultural background may influence the family environment in which they will be living and the support structures potentially available. But no assumptions should be made simply on the basis of the patient's ethnicity, social or cultural background.

30.90 The Act does not specify who this AMHP should be. It may (but need not) be an AMHP already involved in the patient's care and treatment as part of the multidisciplinary team. It can be an AMHP acting on behalf of a local social services authority (LSSA), and LSSAs may agree with each other and with hospital managers the arrangements that are likely to be most convenient and best for patients. Responsibility for ensuring an AMHP considers the case should lie with the LSSA which would become responsible under section 117 for the patient's after-care if the patient is discharged.

30.91 If the AMHP does not agree that the patient should go onto SCT, then SCT cannot go ahead. The AMHP's decision and the full reasons for it should be recorded in the patient's notes. It would not be appropriate for the responsible clinician to approach another AMHP for an alternative view.

## The hospital managers (of the responsible hospital)

30.92 The hospital managers are responsible for:

- ensuring the correct procedures are followed in placing patients on SCT
- liaising with the Local Health Board and LSSA to ensure correct after-care services are in place in accordance with section 117 of the Act
- exercising their powers to transfer responsibility from their hospital for patients on SCT as necessary
- exercising their power to detain a recalled patient
- ensuring that detention after recall does not last for more than 72 hours unless the CTO is revoked
- referring to the Mental Health Review Tribunal for Wales a patient whose CTO has been revoked
- considering the discharge of SCT patients
- advising relevant victims of unrestricted Part 3 patients.

30.93 Following recall and revocation of the CTO, the hospital managers are responsible for ensuring that no patient is detained following recall for longer than 72 hours unless the CTO is revoked. The relevant statutory form must be completed on the patient's arrival at hospital. Arrangements should be put in place to ensure that the patient's length of stay following the time of detention after recall, as recorded on the form, is carefully monitored.

30.94 The hospital managers should also ensure that arrangements are in place to cover any necessary transfers of responsibility between responsible clinicians in the community and in hospital.

30.95 The hospital managers have a duty to ensure that a patient whose CTO is revoked is referred to the MHRT for Wales without delay.

## Local Health Boards and local social services authorities

30.96 The Local Health Board and LSSA are jointly responsible for ensuring the provision of statutory after-care services in line with the requirements of section 117 of the Act.



# Chapter 31

## After-care

31.1 This chapter outlines the responsibilities of Local Health Boards (LHBs) and local social services authorities (LSSAs) in providing after-care for certain patients under section 117 of the Act.

### After-care services

31.2 After-care services are provided to meet an assessed need arising from the patient's mental disorder and are aimed at reducing the likelihood of the patient being readmitted to hospital for treatment for that disorder. Services will therefore normally include treatment for mental disorder; social work support to help the patient with problems of employment, accommodation or family relationships, the provision of domiciliary services and the use of day centre and residential facilities. Administration of medication for mental disorder, and its subsequent monitoring, will often be a key part of an after-care plan.

31.3 Services under section 117 can include those directly provided by primary and secondary health and social care services as well as those provided under arrangements with private and voluntary service providers.

### Entitlement to statutory after-care

31.4 Section 117 of the Act requires LHBs and LSSAs, in collaboration with non-statutory agencies, to provide after-care for certain categories of detained patients. This section applies to patients who are detained under sections 3, 37, 45A, 47, or 48, and then cease to be detained and leave hospital.

31.5 The requirement also includes patients granted leave of absence under section 17 (if they would otherwise qualify when leaving hospital permanently) and patients going on to supervised community treatment (SCT). Section 117 states that after-care must be provided for such patients throughout the time they are subject to SCT.

31.6 LHBs, LSSAs and NHS Trusts should establish jointly agreed policies on providing services under this section. The policy should include an appropriate form for recording the after-care arrangements for patients.

- 31.7 After-care is a vital component in patients' care plans, which aims to enable patients to develop and enhance their skills in order to adjust to life outside hospital and to live their lives successfully at home in their communities. The planning of after-care therefore needs to start when the patient is admitted to hospital and for those patients to whom Care Programme Approach (CPA) applies should continue as part of the CPA planning and review process.
- 31.8 While the after-care of detained patients should be included in the general arrangements for delivering the CPA, because of the specific statutory obligation it is important that all patients who are entitled to section 117 are identified and records kept.

## After-care planning

- 31.9 Before any decision is made to grant leave, discharge absolutely or onto SCT, the responsible clinician must ensure (in full consultation with other professionals involved), that all of the patient's needs have been fully identified and assessed and that the after-care plan addresses them fully. If a patient is being granted leave for only a short period, a less comprehensive review may be sufficient, but the arrangements for the patient's care should still be properly recorded (see also chapters 14 and 28).
- 31.10 The after-care plan should be regularly reviewed. The care coordinator is responsible for arranging reviews of the plan until it is jointly agreed that the patient no longer needs after-care services. The senior officer in the key worker's agency responsible for after-care arrangements should ensure that all aspects of the procedure are followed.

## Tribunal and hospital managers' hearings

- 31.11 LHBs and LSSAs have the power to make preparatory after-care plans before a patient leaves hospital. In view of this, some discussion of after-care should take place between the LSSA and other professionals before the patient appears in front of the Mental Health Review Tribunal for Wales (MHRT for Wales) or hospital managers, so that suitable after-care arrangements can be implemented if the patient is discharged. This will also allow the MHRT for Wales or the hospital managers to be informed of what after-care arrangements might be made.
- 31.12 Where the MHRT for Wales has provisionally decided to conditionally discharge a restricted patient, the LHB and LSSA must do their best to put after-care in place which would allow that discharge to take place.



## Ending the duty to provide after-care services

31.13 The duty to provide after-care services exists until the LHB and LSSA have jointly decided that the patient no longer needs them. The decision should take into account the views of the patient, their family and carers. A patient should not be discharged from care under section 117 solely because:

- the patient has been discharged from the care of specialist mental health services
- an arbitrary period has elapsed since the care was first provided
- the patient is no longer on SCT or leave under section 17
- the patient is deprived of their liberty under the Mental Capacity Act 2005
- or the patient is now settled in the community or a care home, unless the agencies agree there is no longer a need for continued after-care services.

31.14 A patient may refuse after-care services, but unwillingness to accept services does not mean the patient does not need them. It also does not relieve the statutory agencies of their responsibility to offer after-care services.



# Chapter 32

## Assessment, admission and discharge under Part 3 of the Act

32.1 This chapter offers guidance on the use of the Act to arrange treatment for mentally disordered people who come before the criminal justice system. It provides guidance on admission and discharge.

### General matters

32.2 People subject to criminal proceedings have the same right to psychiatric assessment and treatment as anyone else in Wales. A person in police or prison custody, or before the courts charged with a criminal offence, and who needs medical treatment for mental disorder should be considered for admission to hospital. If possible, people who appear to the court to be mentally disordered should be considered by the court mental health assessment scheme at the earliest opportunity. They may be at greatest risk of self-harm while in custody and prompt access to specialist treatment may prevent significant deterioration in their condition. If criminal proceedings are ended it may be appropriate for the relevant local social services authority (LSSA) to arrange for an approved mental health professional (AMHP) to consider making an application for admission under Part 2 of the Act.

32.3 All professionals involved in the operation of Part 3 of the Act should remember:

- 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.
- A prison health care centre is not a hospital within the meaning of the Act. The provisions of Part 4 of the Act do not apply and treatment cannot be given in a prison without the patient's consent other than in circumstances defined within the Mental Capacity Act 2005 (see chapter 13).

### Assessment

#### Assessment by a doctor

32.4 A doctor who is asked to give evidence to the court about a possible admission under Part 3 of the Act should bear in mind that the request is not for a general report on the defendant's condition but for advice on whether they should be diverted from prison by way of the Act or a community order with a mental health treatment requirement under criminal justice legislation.

32.5 In preparing the report, the doctor should:

- identify themselves to the person being assessed, explain who has requested the report and the limits of confidentiality relating to the report, including that the content could be relevant not only to medical disposal by the court but also to the imposition of a sentence, or to its length
- request relevant pre-sentence reports, case notes from the prison (if any) previous psychiatric reports, as well as relevant documents about the alleged offence (if any, of this information is not available, the doctor's report should clearly state this)
- use other independent sources of information, where possible, about the person's history including general practitioner (GP) records, and information about psychiatric treatment and patterns of behaviour.

32.6 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. In the case of a defendant under the age of 18, the doctor should ideally have specialist knowledge of child and adolescent mental health services and the specialist needs of young people.

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

32.8 In cases where the doctor cannot state with confidence at the time of preparing the report whether detention in hospital for treatment is appropriate, they should consider recommending an interim hospital order under section 38 of the Act, so the court can decide the most appropriate and effective outcome.

32.9 If the doctor has concluded it is appropriate for the person to receive treatment while detained in hospital but is not able to identify a suitable facility where the person could be admitted immediately, they should consider seeking advice from the mental health 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 Local Health Board (LHB), with supporting information.

### Independent reports

32.10 A patient remanded to hospital for a report (section 35) or for treatment (section 36) is entitled to obtain an independent report on their mental condition from a registered medical practitioner or other approved clinician. This is at the patient's own expense, or where applicable, through Legal Aid, and is for applying to the court to end the remand.

## Assessment by an approved mental health professional (AMHP)

32.11 If an 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, they must be given as much notice as possible. Suitable facilities should be provided for the assessment. The AMHP should be given access to the pre-sentence report and any other relevant records and reports, including the clinical record held by the prison or court.

## Reports to the court

32.12 Clinical opinion is particularly important in helping courts determine the sentence. In particular it 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 more suitable. A medical report should set out clearly:

- the data on which the report is based
- how this relates to the opinion given
- where relevant, how the opinion may be related to any medical condition defence or other trial issue
- factors relating to the presence of mental disorder that may affect the risk that the patient poses to themselves, or to others, including risk of re-offending
- and, if admission to hospital is recommended, what, if any, special treatment or security is needed and how this would be addressed.

32.13 The report should not comment on guilt or innocence.

32.14 The court is bound by section 157 of the Criminal Justice Act 2003 to consider any information before it which relates to the person's mental condition, if considering a custodial sentence. Except where the offence is one for which 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.

32.15 It may, therefore, be appropriate to include recommendations, including any need for a further report in the event of conviction. The doctor should consider the longer term as well as immediate consequences. Factors to be taken into account should include:

- whether the court may wish to make a hospital order subject to special restrictions
- whether, for restricted patients, the order should designate admission to a named unit within the hospital
- whether, in the event of the court concluding that a prison sentence is appropriate, the offender should initially be admitted to hospital through a hospital direction under section 45A
- whether a community order may be appropriate.

32.16 Where an offender is made subject to special restrictions, the court, or the Secretary of State for Justice in some circumstances, may specify a named unit within a hospital where the person may be detained. This is to ensure an appropriate level of security. A named hospital unit can be any part of a hospital which is treated as a separate unit. The court (or Secretary of State) will define what is meant in each case where it makes use of the power. Admission to a named unit will mean the consent of the Secretary of State will be required for any leave or transfer from the unit to another part of the hospital or to another hospital.

32.17 The need to consider the longer term implications of a recommended disposal is particularly important where an extended or indeterminate sentence for public protection is indicated under the Criminal Justice Act 2003. Either a hospital order under section 37 or a prison sentence with a hospital direction under section 45A is available to the court. The decision rests with the court.

### Provision of information to courts

32.18 Section 39 requires LHBs, the Welsh Ministers and Primary Care Trusts (PCTs) on request, to provide information to courts regarding the availability of hospital places where admission of defendants usually resident in their area is being considered.

32.19 Courts should ensure procedures are in place to request information from the above named bodies.

32.20 LHBs and the Welsh Ministers should:

- 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 facilities available for a potential patient from their area, including secure facilities
- provide prompt medical assessment of defendants to help the speedy completion of the trial process and the most suitable outcome for the offender
- designate a named planning lead to respond to requests for information
- work together as necessary to provide information about low, medium and high secure facilities.

Where information is requested from a PCT, the Mental Health Act Code of Practice for England will apply.

32.21 Section 39A requires an LSSA to inform the court if requested, whether it or anyone else is willing to receive the offender into guardianship and how the guardian's powers would be exercised.

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

## Patients admitted from custody

### Transfer of prisoners to hospital

32.23 The need for inpatient treatment for a prisoner should be identified and acted upon quickly, and contact made immediately with the responsible LHB/PCT by the head of healthcare in the prison (or delegated member of the prison health care team). Delays in identifying the responsible commissioner should never delay the transfer of the prisoner to an appropriate facility.

32.24 Responsible NHS commissioners should aim to ensure transfers of mentally disordered prisoners are carried out in a timeframe at least equivalent to levels of care experienced by patients admitted to mental health care services from the community. Any unacceptable delays in transfer after identifying a need should be actively monitored and investigated.

32.25 Prisoners with severe and enduring mental disorder who have given informed consent to treatment should also be considered for transfer to hospital for treatment if being in prison is considered to be contributing to their mental disorder. An assessment of need and regular review should consider whether the prison healthcare centre is able to provide for the prisoner's care if they are too unwell or vulnerable to return to residential wings.

### Transfer and admission

32.26 At the time of transfer, the following documents should be made available to the hospital managers:

- an up-to-date medical report from the prison health service including details of any medication
- a report from the prison health care service covering the patient's day-to-day care and management including risk factors
- any relevant pre-sentence probation service reports which should be provided by the court, prison or immigration detention centre as appropriate.

32.27 All information should be made available to the patient's responsible clinician and other professionals concerned at the earliest opportunity.

### Information

32.28 When a person is transferred from prison to hospital under sections 47 or 48 as a restricted patient, the hospital managers and the responsible clinician must ensure the patient has received, and as far as possible, understood the letter from the Ministry of Justice explaining the roles of hospital managers and responsible clinicians in relation to restricted patients. Further guidance on providing information to patients is in chapter 22 of this Code.

## Conveyance of patients on remand/subject to an interim hospital order

32.29 For patients on remand or subject to a hospital or interim hospital order (under sections 35, 36, 37 and 38) the court will determine responsibility for organising transport from the court to the receiving hospital, having due regard to the health and safety of the patient and escorting staff.

## Treatment without consent (patients remanded for assessment)

32.30 Since the consent to treatment provisions of the Act do not apply to patients remanded under section 35, treatment can only be administered with consent or, in the case of a patient aged 16 or over who is not capable of consenting, in accordance with the Mental Capacity Act 2005.

32.31 If a patient remanded under section 35 is thought to need medical treatment for mental disorder under Part 4 of the Act, the patient should be referred back to court by the clinician in charge of their care as soon as possible with an appropriate recommendation, and with an assessment of whether they are 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 Part 2 of the Act to enable compulsory treatment. This will be concurrent with, and not a replacement for, the remand made by the court.

## Patients returned to custody

### Return to court

32.32 When a patient has been admitted on remand or subject to an interim hospital order, the hospital is responsible for returning the patient to court as required. The court should give adequate notice of hearings, and the hospital should liaise with the court in plenty of time to confirm arrangements for escorting the patient to and from court. The hospital will be responsible for providing an escort for the patient when travelling from the hospital to the court and should plan for the provision of staff to do this. If possible, and bearing in mind the patient's needs, medical or nursing staff should stay with the patient on court premises, even through legal accountability while detained for hearings remains with the court. Police help may be requested if the risk assessment indicates it is necessary.

### Return to prison

32.33 Particular care should be taken when remitting to prison patients who have been in hospital under sections 45A, 47 or 48. To ensure continuity of care, they should not be returned to prison without a section 117 after-care planning meeting, to which appropriate staff from the receiving prison should be invited, as well as any relevant community staff.



# Chapter 33

## Children and young people under the age of 18

- 33.1 This chapter provides guidance regarding children and young people who suffer from mental disorder.
- 33.2 A child is a person under the age of 18 years but the terms 'young person' or 'adolescent' may be more appropriate for older children. This chapter uses the terms 'child' and 'children' throughout, which should be read as including all children and young people under the age of 18 unless otherwise stated. Where the term 'young person' is used it refers to a child aged 16 or 17.
- 33.3 This chapter is concerned with:
- the guiding principles which, taken together with the first chapter of this Code, should inform decision-making for all children whether or not they are subject to compulsion or detention
  - assessing, caring for and treating children subject to compulsion, including their detention, using powers given by the Mental Health Act 1983
  - choosing between the Mental Health Act 1983 and the Children Act 1989 as amended.
- 33.4 Guidance on consent to treatment of children and young people, including issues of competence and capacity, is given in chapter 16 of this Code.

### Guiding principles and overarching matters

#### Guiding principles

- 33.5 Chapter 1 of this Code establishes the guiding principles that inform decisions made under the Act and which apply to children and adults. There are also particular principles relating to children:
- In law, the welfare and protection of children is of paramount importance.
  - The views of children who use services should be actively sought by planners, commissioners and practitioners and incorporated, whenever possible, into planning and delivering services for particular children.
  - Services for children must be holistic, flexible and centred on the needs, opinions, cultures and life-styles of children.

- Professional practitioners, regardless of discipline, should view each child as a developing person in his or her context, view problems in the ways in which children experience them, empower good parenting, include a focus on prevention and health promotion, develop relationships that aid children in tackling their problems, and be realistic.
- Services should respect and protect children.
- Services should operate within the spirit and intentions as well as the fact of the law.

33.6 These principles mean the guidance in chapter 1 applies equally to children although in their cases there will be special considerations. In particular:

- The best interests of each child must always be the primary consideration.
- Each child's views, wishes and feelings should always be ascertained and taken into account, bearing in mind their age and understanding.
- Children should always be kept as fully informed as possible, and should receive clear and detailed information about their care and treatment.
- Children have the right to share in decisions about their care and treatment by expressing their views, if any.
- Any intervention in the life of each child that is considered necessary because of their mental disorder should be the least restrictive and least stigmatising option consistent with effective care and treatment.
- Any intervention in the life of a child, considered necessary because of their mental disorder, should result in the least possible separation from family, carers, friends, community and education as is consistent with their well-being.
- All children should receive appropriate educational provision.
- The dignity of all children should be respected.
- The privacy and confidentiality of all children should be respected, unless it is necessary to protect them or others from significant harm.
- Additionally, the functions of all NHS bodies and the services for which they contract are subject to section 11 of the Children Act 2004 and this means they must be carried out having regard to the need to safeguard and promote the welfare of children.

33.7 When assessing, caring for and treating children under 16, including where the use of compulsion under the Act is indicated, the following questions (among others) should be asked:

- a) Who has parental responsibility for the child? It is essential that those responsible for the care and treatment of each child are clear about who has parental responsibility, and staff should always request copies of any court orders for reference in hospital. These 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 a 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 ability of the child to make their own decisions in terms of emotional maturity, intellectual capacity, mental state, and, if the child is under 16, their competence? (See chapter 16)
- d) If a parent or other person with parental responsibility refuses consent to treatment, what are the reasons and on what grounds is the refusal made? Should an application to the court to authorise treatment be considered, for example if the person with parental responsibility has a mental disorder?
- e) Could the child's needs be met if social services or education resources or placement were made available and to what extent have these authorities carefully considered all possible alternative suitable interventions including placements away from home?

## Education

33.8 All patients aged 16 or 17 who want to continue their education should not be denied access to learning because they are receiving medical care and treatment. The duties on local authorities are set out in the Education Act 1996 and include powers to make provision for 16 to 19-year-olds who cannot attend school for medical reasons.

## Admission to appropriate services

33.9 Children admitted to hospital for treatment of mental disorder should, subject to their needs, be accommodated suitably for their age. This means they should have appropriate physical facilities, staff with the right training to understand and address their specific needs as children, and a hospital routine that will allow their personal, social and educational development to continue as normally as possible.

33.10 If, exceptionally, this is not practicable, discrete accommodation in an adult ward, with facilities, security and staffing appropriate to the child's needs might provide the most satisfactory solution.

33.11 If possible, all staff involved in the care and treatment of children should be child specialists. They must always have been vetted satisfactorily with the Criminal Records Bureau. If it is not possible to have such a specialist in charge of the child's treatment, arrangements should be made for the clinical staff caring for the child to have access to a practitioner who is a specialist in child and adolescent mental healthcare (CAMHS) - that is an experienced specialist practitioner who has been trained and practices in delivering the functions of tiers 2, 3 and/or 4 in the CAMHS Strategic Framework for Wales.

33.12 In a few cases, the child's need to be accommodated in a safe environment could, in the short term, take precedence over the suitability for their age. It is also important to recognise the clear difference between a suitable environment for a young person in an emergency and a suitable longer-term environment for a young person. In an emergency, such as when a patient is in crisis, the important thing is that the patient is in a safe environment. Once the initial emergency has subsided, the hospital managers must consider what a suitable environment is, taking into account matters such as whether the child can mix with other children, receive visitors of all ages, and have access to education. They should consider whether a patient should be transferred and, if so, for this to be arranged as soon as possible.

33.13 If a young patient's presence on a ward with other children might have a detrimental effect on the other patients, the hospital managers must ensure the interests of other patients are protected. However, other patients' needs should not override the need to provide accommodation in an environment suitable for their age (subject to their needs) for a patient under 18.

### Welfare of children admitted to hospital

33.14 NHS Trusts and Local Health Boards (LHBs), and the services for which they contract, are subject to section 11 of the Children Act 2004, which means they must carry out their functions bearing in mind the need to safeguard and promote the welfare of children.

33.15 Local authorities should arrange for visits to be made to:

- children looked after by them, whether or not they are the subjects of care orders, who are in hospital
- and those children who are accommodated or intended to be accommodated for three months or more by LHBs, NHS Trusts, local education authorities or in residential care (this is in addition to their duty for children in their care in hospitals in Wales as outlined by section 116 of the Children Act 1989).

33.16 Local authorities should take any other steps in relation to a child in hospital, as would be expected to be reasonably undertaken by their parent and in the child's best interests. Local authorities have a duty to:

- promote contact between children in need and their families, if they live away from home and to help them get back together, if considered safe and appropriate
- arrange for independent visitors to visit and befriend children who are looked after by the authority wherever they are, if they have not been visited regularly by their parents.

33.17 Local authorities should be alerted when the whereabouts of a person with parental responsibility are not known, or where a person has not visited the child or young person for a significant time. The local authority should then consider whether visits should be arranged as outlined above.

### **Children and the Mental Health Act 1983**

33.18 The Mental Health Act 1983 applies to children as well as adults, although only a person aged 16 or above can be received into guardianship.

33.19 When a child is being assessed with a view to an application for detention under the Act, at least one of the people involved in the child's formal assessment (i.e. one of the two registered medical practitioners or the approved mental health professional) should be an experienced specialist CAMHS practitioner. When this is not possible, such a specialist should be consulted as soon as possible afterwards. Chapter 2 gives fuller information on the assessment process.

33.20 Guidance on the administration of medication and electroconvulsive therapy (ECT) to children, including informal patients, is given in chapter 17 of this Code.

## Choosing between the Mental Health Act 1983 and the Children Act 1989 (as amended)

33.21 When 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 making an application under the Mental Health Act or the Children Act is not always easy. Careful consideration must be given to the environment that is most appropriate for each child.

33.22 In considering the appropriate legislative framework to meet a child's needs, it is particularly important to identify the primary purpose of the proposed intervention. If it is not to provide medical treatment for mental disorder, but the intervention requires the detention of the child, consideration should be given to using section 25 of the Children Act.

33.23 A child who has, for example, a serious mental disorder may require treatment under compulsion using the Mental Health Act and benefit from the protections that it provides, whereas the needs of another child who has very serious behaviour problems may be more appropriately met within secure accommodation using powers available by using the Children Act 1989. Under section 25 of the latter Act, the court may make an order for a child to be detained in secure accommodation, but this does not authorise medical treatment to be given.

33.24 Professional and managerial staff who address these questions should:

- understand the relevant statutory provisions and have easy access to competent legal advice
- keep in mind the importance of ensuring the child's care and treatment is managed with clarity, consistency and within a recognisable framework
- select the option that reflects the predominant needs of each child at that time - whether to provide mental healthcare and treatment or to achieve safety and protection (either way, they should seek the least restrictive option, consistent with the care and treatment objectives for the child).

## Seeking the court's assistance

33.25 In some circumstances, it may be appropriate to seek the court's assistance in determining whether the proposed care or treatment is in the child's best interests.

33.26 Cases may arise:

- when care and treatment decisions need to be made if a child is neither 16 nor competent and the person with parental responsibility cannot be identified, or is incapacitated

- if a person with parental responsibility is thought not to be acting in the best interests of the child, or if the matter is considered to be outside their responsibility as parent
- in some instances when a child is competent, but is refusing treatment.

33.27 In cases involving emergency protection orders, child assessment orders, interim care orders and full supervision orders, the Children Act 1989 specifically provides that a child may refuse assessment, examination or treatment. In such cases, it may be considered appropriate to seek the inherent jurisdiction of the High Court to override a child's refusal, where it considers it is in the child's best interests.

# Chapter 34

## People with learning disabilities and autistic spectrum disorder

34.1 This chapter provides guidance to professionals working with people with learning disabilities or autistic spectrum disorder (ASD), who may need extra consideration beyond the guidance elsewhere in the Code.

### People with learning disabilities

34.2 A learning disability is an impairment of intellectual function, which significantly affects development and leads to problems in understanding and using information, learning new skills and managing to live independently.

### Assessment under the Mental Health Act

34.3 The assessment of a person with a learning disability requires special consideration to enable and ensure clear two-way communication. Anyone involved in the assessment should understand that high-quality and skilled communication is essential and should take all necessary steps to ease any difficulties.

34.4 Professionals trained in the mental health care of people with learning disabilities should be involved wherever practicable. In addition, the approved mental health professional (AMHP) involved in any formal assessment under the Act should have training and experience in working with people with learning disabilities.

34.5 Where the examiners or assessors have only limited expertise with this patient group it is good practice, wherever possible, to seek advice from the local specialist service who should provide details of alternatives to compulsory treatment and advise on good communication. This, however, should not be allowed to delay action which is considered immediately necessary.

34.6 During examination or assessment, people with learning disabilities should have someone with them who they know well and with whom they have good communication, which could include an advocate, provided this does not compromise confidentiality. Consideration should also be given to:

- the location for the assessment as an unfamiliar place or one which has negative connotations for the person may adversely affect them
- and to the time of the assessment, for example early morning may not be the best time of the day for some individuals

34.7 The potential of co-morbidity of personality disorder with other types of mental disorder should also be considered, in order that the skills of clinicians and others with appropriate expertise can be brought into play throughout assessment, treatment and care.

### The legal framework

34.8 Learning disability is defined in the Act as a 'state of arrested or incomplete development of the mind which includes significant impairment of intelligence and social functioning' (section 1(4)). For most purposes, except for admission for assessment under section 2 of the Act, a learning disability by itself is not considered a mental disorder unless it is associated with abnormally aggressive or seriously irresponsible conduct by the patient.

34.9 Identifying a learning disability should be informed by a careful assessment of intellectual and social functioning, preferably by a specialist, and should include a psychological assessment. Those who assess the patient must be satisfied that the patient displays characteristics which are difficult to define in practice. However the following can be considered a general guidance to key factors in the definition of learning disability for the purposes of the Act:

- Arrested or incomplete development of mind - this means the features which determine the learning disability were present before adulthood and permanently prevented the usual maturation of intellectual and social development. It excludes people whose learning disability originates from accident, injury or illness after the point generally accepted as complete development - such conditions do however fall within the definition of mental disorder in the Act (see paragraph 2.13).
- Significant impairment of intelligence - a specialist in the assessment of cognitive and social development, such as a clinical psychologist, must make a judgement about the presence of these characteristics on the basis of reliable and careful assessment.
- 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 several sources, such as social workers, nurses and psychologists. Evidence should include the results of one or more social functioning assessment tests.

34.10 If considering detention in hospital (other than admission for assessment) or reception into guardianship under the Act where the mental disorder is based on a learning disability alone, at least one of following features must also be associated with the learning disability:

- Abnormally aggressive behaviour - any assessment of this 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 damage and/or distress occurring recently or persistently or with excessive severity.
- Seriously irresponsible conduct - the assessment of this should be based on an observation of behaviour which shows a lack of responsibility, or a disregard of the consequences of action taken, and where the results cause damage or distress, either recently or persistently or with excessive severity.



34.11 Except where urgent action is needed, no patient with a learning disability should be diagnosed as meeting either of these additional conditions without having been assessed by a consultant psychiatrist with special experience in learning disabilities and having received a formal psychological assessment. This assessment should form part of a comprehensive appraisal by medical, nursing, social work and psychology professionals, with special experience in learning difficulties. Such an assessment should (where practical and appropriate) be carried out in consultation with a relative, friend or supporter (for example, an advocate) of the patient.

## Treatment and care

34.12 All those involved in the examination, assessment, treatment or decision-making in relation to people with learning disabilities should bear in mind such patients may encounter specific problems such as:

- an assumption by staff that they lack the capacity to make decisions for themselves and a tendency to be over-protective towards them
- over reliance by professionals on family members for support and decision-making (this may put families in the difficult position of having to make decisions for the patient where it may not be appropriate to do so)
- a lack of appreciation of the potential abilities of people with learning disabilities, including their potential to speak up for themselves
- the potential to be denied full and inclusive access to the decision-making process, for example, not being included in meetings about them, not having information made accessible to them, and having decisions made in their absence
- limited life experiences to draw on when making choices
- difficulties in understanding what is being explained to them and explaining their views (when people are experiencing anxiety it may make it more difficult for them to understand what is being said).

34.13 Those working under the Act with people with learning disabilities should also consider the following general points:

- Many people with learning disabilities are able to make their own decisions about medical treatment and other areas of their lives, and they should be given the information and support 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, so care professionals should have specific skills and awareness of the issues which people with learning disabilities may face.
- The needs and wishes of the person with learning disabilities in relation to the role of their family should be given the same importance as any other patient.
- People with learning disabilities may have limited spoken language, so behaviour may replace language as a form of communication and it is therefore important to recognise behaviour which represents communication rather than a symptom of mental disorder (for example hitting out because they do not want to go to hospital).

- People with learning disabilities may have problems coping with places they find new or frightening such as a hospital, so every effort should be made to adapt to their needs to maximise communication.
- Information should be appropriate in format and content, for each patient with a learning disability, making 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 should be identified as soon as possible - it is helpful to identify a specific person to undertake this task.
- Some people with learning disabilities may prefer to have communication through written material in simple language with images or symbols to help. This can be reinforced verbally, by personal contact, or other means such as audio tape, CD or video. It can also be helpful to repeat information and keep a record of what information has been passed on and how.
- It is important to set aside enough time to prepare suitable information and for preparation before meeting. This should include anyone supporting the person with a learning disability as they will need time to understand the options and to present them in ways which will help communication.
- People with learning disabilities will need information about their rights under the Mental Health Act 1983 in a form which they can understand.

## People with autism

34.14 The World Health Organisation defines autism as follows:

*'the group of pervasive developmental disorders characterised by qualitative abnormalities in reciprocal social interactions and in patterns of communication and by a restricted, stereotyped, repetitive repertoire of interests and activities'*

34.15 The Act's definition of mental disorder covers the full range of ASDs including those existing alongside a learning disability or other mental health problem. It is possible, but rare, for someone on the autistic spectrum to meet the conditions for treatment under the Act without having any other form of mental disorder.

34.16 The autistic spectrum covers disorders, which occur from early stages in development with the person showing marked difficulties with social communication, social interaction and social imagination.

34.17 These disorders are developmental difficulties and not mental illnesses in themselves. However, people with an ASD may have additional or related problems which frequently include anxiety. These may be related to communication problems or patterns of thought and behaviour that are literal in nature. There may be times when these circumstances lead to seriously irresponsible or aggressive behaviour if not properly managed. It should be borne in mind that people with ASD may also have co-morbid mental disorders including mood disorders and personality disorders.

## General care and treatment

- 34.18 Generally, the care and treatment of those with ASDs should follow those guidelines outlined above for learning disability patients. This includes ensuring that if the assessors have only limited expertise with this patient group, they seek advice from the local specialist service who should provide details of alternatives to compulsory treatment and advice on good communication. This however should not be allowed to delay action which is considered immediately necessary.
- 34.19 A person with an ASD may have additional sensory and motor difficulties, which make them behave unusually and which could be interpreted as a mental illness but is in fact a coping mechanism. They may have sensitivity to light, sound, touch or balance, possibly resulting in a range of regulatory behaviours, including rocking, self-injury and avoidance (such as running away). Eccentricity is not itself a reason for compulsion.
- 34.20 There can also be a repetitive element to behaviour where someone appears to be choosing to act in a particular way, but their behaviour may distress themselves and may be driven or made worse by anxiety and could lead to harm of self or others. Repetitive behaviour in itself does not constitute a mental disorder.
- 34.21 A person with an ASD may show a marked difference between their intellectual and their emotional development, sometimes associated with aggressive or seriously irresponsible behaviour. They may be able to discuss an action intellectually and express a desire not to do it, but not have the instinctive social empathy to keep to their intentions.
- 34.22 The therapeutic team should in such circumstances try to help the person to understand their behaviour and work with them to minimise it. When the person is unable to prevent themselves from causing severe harm to themselves or others, compulsion under the Act may become necessary.
- 34.23 People with social and communication disorders can become mentally ill and this mental illness may need compulsory treatment. When someone is brought to hospital under compulsion, they should be placed in a setting which can accommodate their social and communication needs as well as treat the mental disorder.
- 34.24 It is important that consideration is given as soon as possible to whether the person with social and communication disorders is eligible as a 'qualifying patient' to support from an independent mental health advocate - see chapter 25.

## Further information

34.25 The 2008 *Autistic Spectrum Disorder (ASD) Strategic Action Plan for Wales* sets out how the Welsh Assembly Government expects people with ASD to be supported, and to ensure that support services provided by a range of organisations are delivered appropriately and in a coordinated way.

# Key words and phrases

Term	Meaning
<b>Absent without leave (AWOL)</b>	When a patient leaves hospital without getting permission first or does not return to hospital when required to do so  The term applies to informal patients as well as those detained in hospital under the Act and also to guardianship patients who leave the place their guardian say they should live; in the context of patients on supervised community treatment and those who are conditionally discharged it applies if they do not return to hospital when recalled, or leave the hospital without permission after they have been recalled
<b>Absolute discharge</b>	Discharge from detention, liability to detention, guardianship or supervised community treatment under the Act
<b>The Act</b>	Unless otherwise stated, the Mental Health Act 1983
<b>Advance decision to refuse treatment</b>	A decision, under the Mental Capacity Act 2005, to refuse specified treatment made in advance by a person who has capacity to do so. This decision will then apply at a future time when that person lacks capacity to consent to, or refuse the specified treatment
<b>Advocacy</b>	Independent help and support with understanding issues and assistance in putting forward one's own views, feelings and ideas. See also <i>independent mental health advocate</i>
<b>After-care</b>	Services provided following discharge from hospital; especially the duty of health and social services to provide after-care under section 117 of the Act following the discharge of a patient from detention for treatment under the Act. The duty applies to SCT patients and conditionally discharged patients, as well as those who have been absolutely discharged
<b>Application for detention</b>	An application made by an approved mental health professional or a nearest relative under Part 2 of the Act for a patient to be detained in hospital for assessment or for medical treatment
<b>Appropriate medical treatment</b>	Medical treatment for mental disorder which is appropriate taking into account the nature and degree of the person's mental disorder and all the other circumstances of their case
<b>Appropriate medical treatment test</b>	The requirement in some of the criteria for detention, and in the criteria for supervised community treatment, that appropriate medical treatment must be available for the patient

<b>Term</b>	<b>Meaning</b>
<b>Approved clinician</b>	<p>A mental health professional approved by the Welsh Ministers (or the Secretary of State) to act as an approved clinician for the purposes of the Act. In practice, Local Health Boards take these decisions on behalf of the Welsh Ministers</p> <p>Some decisions under the Act can only be undertaken by people who are approved clinicians. A responsible clinician must be an approved clinician</p>
<b>Approved mental health professional</b>	A professional with training in the use of the Act, approved by a local social services authority to carry out a number of functions under the Act
<b>Assessment</b>	<p>Examining a patient to establish whether the patient has a mental disorder and, if they do, what treatment and care they need.</p> <p>It is also used to mean examining or interviewing a patient to decide whether an application for detention or guardianship should be made</p>
<b>Assessor</b>	An approved mental health professional or a doctor who undertakes an assessment or examination under the Act to decide whether an application for detention or guardianship should be made
<b>Attorney</b>	Someone appointed under the Mental Capacity Act who has the legal right to make decisions within the scope of their authority on behalf of the person (the donor) who made the power of attorney. Also known as a 'donee of lasting power of attorney'
<b>Capacity</b>	The ability to take a decision about a particular matter at the time the decision needs to be made. Some people may lack mental capacity to take a particular decision because they cannot understand, retain or weigh the information relevant to the decision. A legal definition of lack of capacity for people aged 16 or over is set out in section 2 of the Mental Capacity Act 2005. See also <i>competence to consent</i>
<b>Care Programme Approach (CPA)</b>	The CPA is a co-ordinated system of care management, based on a person centred approach determined by the needs of the individual. There are four key elements within CPA: a systematic assessment that includes identifying needs and assessing risks, the development of a care plan addressing the assessed needs, the appointment of a care co-ordinator who is a qualified health or social care professional to design and oversee the care plan, and regular reviews as appropriate to evaluate the progress of the care plan
<b>Carer</b>	Someone who provides voluntary care by looking after and assisting a family member, friend or neighbour who requires support because of their mental health needs
<b>Child (also children)</b>	A person under the age of 16
<b>Child and adolescent mental health services (CAMHS)</b>	Specialist mental health services for children and adolescents. CAMHS covers all types of provision and intervention - from mental health promotion and primary prevention and specialist community-based services through to very specialist care, such as that provided by in-patient units for children and young people with mental disorder.

<b>Term</b>	<b>Meaning</b>
<b>Children Act 1989</b>	A law relating to children and young people and those with parental responsibility for them which also describes the roles, duties and responsibilities of statutory agencies, such as local authority social services
<b>Community treatment order (CTO)</b>	Written authorisation on a prescribed form for the discharge of a patient from detention in a hospital onto supervised community treatment
<b>Competence to consent</b>	Similar to capacity to consent, but specifically used in relation to children. As well as covering a child's inability to make particular decisions because of their mental condition, it also covers children who do not have maturity to take the particular decision in question
<b>Compulsory measures</b>	Things that can be done to people under the Act without their agreement. This includes detention in hospital, supervised community treatment and guardianship
<b>Compulsory treatment</b>	Medical treatment for mental disorder given under the Act
<b>Conditional discharge</b>	The discharge from hospital by the Secretary of State for Justice or the Mental Health Review Tribunal for Wales of a restricted patient subject to conditions. The patient remains subject to recall to hospital by the Secretary of State
<b>Conditionally discharged restricted patient</b>	A restricted patient who has been given a conditional discharge
<b>Consent</b>	Agreeing to allow someone else to do something to or for you; particularly consent to treatment.
<b>Convey (and conveyance)</b>	Transporting a patient under the Act to hospital (or anywhere else), compulsorily if necessary
<b>Court of Protection</b>	The specialist court set up under the Mental Capacity Act to deal with all issues relating to people who lack capacity to take decisions for themselves
<b>Criteria for detention</b>	A set of criteria that must be met before a person can be detained, or remain detained, under the Act. The criteria are different in different sections of the Act
<b>Criteria for supervised community treatment (SCT)</b>	A set of criteria that must be met before a person can go onto supervised community treatment (SCT) or remain on SCT
<b>Criminal Records Bureau</b>	An Executive Agency of the Home Office, which provides access to criminal record information through its disclosure service
<b>Deprivation of liberty</b>	A term used in Article 5 of the European Convention on Human Rights to mean the circumstances in which a person's freedom is taken away. Its meaning in practice has been developed through case law
<b>Deprivation of liberty safeguards</b>	The framework of safeguards under the Mental Capacity Act for people who need to be deprived of their liberty in their best interests for care or treatment to which they lack the capacity to consent themselves

<b>Term</b>	<b>Meaning</b>
<b>Deputy (or Court-appointed deputy)</b>	<p>A person appointed by the Court of Protection under section 16 of the Mental Capacity Act to take specified decisions on behalf of someone who lacks capacity themselves</p> <p>This is not the same thing as the nominated deputy sometimes appointed by the doctor or approved clinician in charge of a patient's treatment</p>
<b>Detained patient</b>	<p>Unless otherwise stated, a patient who is detained in hospital under the Act, or who is liable to be detained in hospital but who is (for any reason) currently out of hospital</p> <p>In chapters 17 and 18 detained patients has a more specific meaning</p>
<b>Detention/detained</b>	<p>Unless otherwise stated, being held compulsorily in hospital under the Act for a period of assessment or medical treatment for mental disorder. Sometimes referred to as "sectioning" or "sectioned"</p>
<b>Discharge</b>	<p>Unless otherwise stated, a decision that a patient should no longer be subject to detention, supervised community treatment, guardianship or conditional discharge</p> <p>Discharge from detention is not the same thing as being discharged from hospital. The patient may already have left hospital or might agree to remain in hospital as an informal patient</p>
<b>Displacement (of nearest relative)</b>	<p>The provision under section 29 of the Act under which the county court can order that the functions of the nearest relative be carried out by another person or by a local social services authority</p>
<b>Doctor</b>	<p>A registered medical practitioner</p>
<b>Doctor approved under section 12 (also 'section 12 doctor')</b>	<p>A doctor who has been approved by the Welsh Ministers (or the Secretary of State) under the Act as having special experience in the diagnosis or treatment of mental disorder. In practice, Local Health Boards take these decisions on behalf of the Welsh Ministers</p> <p>Some medical recommendations and medical evidence to courts under the Act can only be made by a doctor who is approved under section 12. Doctors who are approved clinicians are automatically treated as though they have been approved under section 12</p>
<b>Electro-convulsive therapy (ECT)</b>	<p>A form of medical treatment for mental disorder in which seizures are induced by passing electricity through the brain of an anaesthetised patient; generally used as a treatment for severe depression</p>
<b>Emergency application</b>	<p>An application for detention for assessment of mental disorder made with only one supporting medical recommendation in cases of urgent necessity. Also known as a section 4 application</p>
<b>European Convention on Human Rights (ECHR)</b>	<p>The European Convention for the Protection of Human Rights and Fundamental Freedoms. The substantive rights its guarantees are largely incorporated into UK law by the Human Rights Act 1998</p>
<b>GP</b>	<p>A patient's general practitioner (or 'family doctor')</p>
<b>Guardian</b>	<p>See guardianship</p>



<b>Term</b>	<b>Meaning</b>
<b>Guardianship</b>	The appointment of a guardian to help and supervise patients in the community for their own welfare or to protect other people. The guardian may be either a local social services authority (LSSA) or someone else approved by the LSSA (a private guardian)
<b>Guardianship application</b>	An application to a local social services authority by an approved mental health professional or a nearest relative for a patient to become subject to guardianship
<b>Guardianship order</b>	An order by the court, under Part 3 of the Act, that a mentally disordered offender should become subject to guardianship
<b>Guiding principles</b>	The principles set out in Chapter 1 of the Code of Practice for Wales that have to be considered when decisions are made under the Act
<b>Habilitation</b>	Equipping someone with skills and abilities that they have never had; as opposed to rehabilitation who means helping them to recover skills and abilities they have lost
<b>Holding powers</b>	The powers in section 5 of the Act which allow hospital inpatients to be detained temporarily so that a decision can be made about whether an application for detention should be made
<b>Hospital direction</b>	An order by the court under Part 3 of the Act for the detention for medical treatment in hospital of a mentally disordered offender. It is given alongside a prison sentence.
<b>Hospital managers</b>	The organisation (or individual) responsible for the operation of the Act in a particular hospital (e.g. an NHS trust)  Hospital managers have various functions under the Act, which include the power to discharge a patient. In practice most of the hospital managers' decision are taken on their behalf by individuals (or groups of individuals) authorised by the hospital managers to do so. This can include clinical staff
<b>Hospital order</b>	An order by a court under Part 3 of the Act for the detention for medical treatment in hospital of a mentally disordered offender; given instead of a prison sentence or other form of punishment. Hospital orders are normally made under section 37 of the Act
<b>Human Rights Act 1998</b>	A law largely incorporating into UK law the substantive rights set out in the European Convention on Human Rights
<b>Independent mental capacity advocate (IMCA)</b>	Someone who provides support and representation for a person who lacks capacity to make specific decisions, where the person has no-one else to support them. The IMCA service is established under the Mental Capacity Act. It is not the same as an ordinary advocacy service or an independent mental health advocacy (IMHA) service
<b>Independent hospital</b>	A hospital which is not managed by the NHS
<b>Independent mental health advocate (IMHA)</b>	An advocate independent of the team involved in patient care available to offer support to patients under arrangements which are specifically required to be made under the Act. The Act calls patients who are eligible for support by the advocate, 'qualifying patients'. The IMHA is not the same as an ordinary advocate or an independent mental capacity advocate (IMCA)

<b>Term</b>	<b>Meaning</b>
<b>Independent mental health advocacy services</b>	The services which make independent mental health advocates available to patients
<b>Informal patient</b>	Someone who is being treated for mental disorder in hospital and who is not detained under the Act; also sometimes known as a voluntary patient
<b>Interim hospital order</b>	An order by a court under Part 3 of the Act for the detention for medical treatment in hospital of a mentally disordered offender on an interim basis, to enable the court to decide whether to make a hospital order or deal with the offender's case in some other way. Interim hospital orders are made under section 38 of the Act
<b>Learning disability</b>	In the Act, a learning disability means a state of arrested or incomplete development of the mind which includes a significant impairment of intelligence and social functioning. It is a form of mental disorder for the purposes of the Act
<b>Leave of absence</b>	Formal permission for a patient who is detained in hospital to be absent from the hospital for a period of time; patients remain under the powers of the Act when they are on leave and can be recalled to hospital if necessary in the interests of their health or safety or for the protection of others. Sometimes referred to as 'section 17 leave'
<b>Local social services authority (LSSA)</b>	The local authority (or council) responsible for social services in a particular area of the country
<b>Managers</b>	See hospital managers
<b>Medical recommendation</b>	Normally means a recommendation provided by a doctor in support of an application for detention or a guardianship application
<b>Medical treatment</b>	In the Act this covers a wide range of services. As well as the kind of care and treatment given by doctors, it also includes nursing, psychological therapies, and specialist mental health habilitation, intervention rehabilitation, and care
<b>Medical treatment for mental disorder</b>	Medical treatment which is for the purpose of alleviating, or preventing a worsening of, the mental disorder or one or more its symptoms or manifestations
<b>Mental Capacity Act 2005</b>	An Act of Parliament that governs decision-making on behalf of people who lack capacity, both where they lose capacity at some point in their lives and where the incapacitating condition has been present since birth
<b>Mental disorder</b>	Any disorder or disability of the mind. As well as mental illness, it includes conditions like personality disorders, autistic spectrum disorders and learning disabilities
<b>Mental Health Act Commission (MHAC)</b>	The independent body which is responsible for monitoring the operation of the Act  The Health and Social Care Act 2008 will abolish the MHAC and transfer its functions, in relation to Wales, to the Welsh Ministers. This is expected to take place in April 2009. References to MHAC in the Code of Practice for Wales are therefore to be read as references to its legal successors at the appropriate time

<b>Term</b>	<b>Meaning</b>
<b>Mental Health Review Tribunal for Wales (MHRT for Wales)</b>	A judicial body that has the power to discharge patients from detention, supervised community treatment, guardianship and conditional discharge.
<b>Mental illness</b>	An illness of the mind. It includes common conditions like depression and anxiety and less common conditions like schizophrenia, bipolar disorder, anorexia nervosa and dementia
<b>Mentally disordered offender</b>	A person who has a mental disorder and who has committed a criminal offence
<b>Nearest relative</b>	A person defined by section 26 of the Act who has certain rights and powers under the Act in respect of a patient for whom they are the nearest relative
<b>NHS</b>	The National Health Service
<b>NHS trust</b>	Type of NHS body responsible for providing NHS services in a local area
<b>Nominated deputy</b>	A doctor or approved clinician who may make a report detaining a patient under the holding powers in section 5, in the absence of the doctor or approved clinician who is in charge of the patient's treatment
<b>Part 2</b>	<p>The Part of the Act which deals with detention, guardianship and supervised community treatment for civil (i.e. non-offender) patients</p> <p>Some aspects of Part 2 also apply to some patients who have been detained or made subject to guardianship by the courts or who have been transferred from prison to detention in hospital by the Secretary of State for Justice under Part 3 of the Act</p>
<b>Part 2 patient</b>	A civil patient - i.e. a patient who became subject to compulsory measures under the Act as a result of application for detention or guardianship application by a nearest relative or an approved mental health professional under Part 2 of the Act
<b>Part 3</b>	The Part of the Act which deals with mentally disordered offenders and defendants in criminal proceedings. Among other things, it allows courts to detain people in hospital for treatment instead of punishing them, where particular criteria are met. It also allows the Secretary of State for Justice to transfer people from prison to detention in hospital for treatment
<b>Part 3 patient</b>	A patient made subject to compulsory measures under the Act by the courts or by being transferred to detention in hospital from prison under Part 3 of the Act. Part 3 patients can be either 'restricted' (i.e. subject to special restrictions on when they can be discharged, given leave of absence, and various other matters) or 'unrestricted' (i.e. treated for the most part like a Part 2 patient)
<b>Part 4</b>	The Part of the Act which deals mainly with the medical treatment for mental disorder of detained patients (including conditionally discharged and supervised community treatment patients who have been recalled to hospital). In particular, it sets out when they can and cannot be treated for the mental disorder without their consent

<b>Term</b>	<b>Meaning</b>
<b>Part 4A</b>	The Part of the Act which deals with the medical treatment for mental disorder of supervised community treatment patients when they have not been recalled to hospital
<b>Part 4A certificate</b>	A second opinion appointed doctor's certificate approving particular forms of medical treatment for mental disorder for supervised community treatment patients
<b>Part 4A patient</b>	In chapters 17 and 18 means a supervised community treatment patient who has not been recalled to hospital
<b>Patient</b>	A person who is, or appears to be, suffering from mental disorder. The use of the term is not a recommendation that the term 'patient' should be used in practice in preference to other terms such as 'service user', 'client' or similar. It is simply a reflection of the terminology used in the Act itself
<b>Place of safety</b>	A place in which people may be temporarily detained under the Act. In particular a place to which the police may remove a person for the purpose of assessment under section 135 or 136 of the Act. (A place of safety may be a hospital, a residential care home, a police station, or any other suitable place)
<b>Private guardian</b>	An individual person (rather than a local social services authority) who is the patient's guardian under the Act
<b>Qualifying patients</b>	Patients who are eligible for support from independent mental health advocacy services
<b>Recall (and recalled)</b>	A requirement that a patient who is subject to the Act return to hospital. It can apply to patients who are on leave of absence, who are on supervised community treatment, or who have been given a conditional discharge from hospital
<b>Regulations</b>	Secondary legislation made under the Act. In most cases, it means the <i>Mental Health (Hospital, Guardianship, Community Treatment and Consent to Treatment) (Wales) Regulations 2008</i>
<b>Rehabilitation</b>	See habilitation
<b>Remand(ed) to hospital</b>	An order by a court under Part 3 of the Act for the detention in hospital of a defendant in criminal proceedings. Remand under section 35 is for a report on the person's mental condition. Remand under section 36 is for medical treatment for mental disorder
<b>Responsible clinician</b>	The approved clinician with overall responsibility for the patient's case.
<b>Responsible hospital</b>	The hospital whose managers are responsible for a supervised community treatment (SCT) patient. To begin with, at least, this is the hospital in which the patient was detained before being discharged onto SCT
<b>Responsible local social services authority</b>	The local social services authority (LSSA) responsible for a patient who is subject to guardianship under the Act. The responsible LSSA is normally the LSSA for the area where the patient lives. If the patient has a private guardian, it is the LSSA for the area where the guardian lives

<b>Term</b>	<b>Meaning</b>
<b>Restricted patient</b>	<p>A Part 3 patient who, following criminal proceedings, is made subject to a restriction order under section 41 of the Act, to a limitation direction under section 45A or to a restriction direction under section 49</p> <p>The order or direction will be imposed on an offender where it appears necessary to protect the public from serious harm. One of the effects of the restrictions imposed by these sections is that such patients cannot be given leave of absence or be transferred to another hospital without the consent of the Secretary of State for Justice, and only the Mental Health Review Tribunal for Wales can discharge them without the Secretary of State's agreement. See also unrestricted Part 3 patient</p>
<b>Review panel</b>	A panel of three or more people appointed to take decisions on behalf of hospital managers about the discharge of patients from detention or supervised community treatment
<b>Revocation (and revoke)</b>	Term used in the Act to describe the rescinding of a community treatment order (CTO) when a supervised community treatment patient needs further treatment in hospital under the Act. If a patient's CTO is revoked, the patient is detained under the powers of the Act in the same way as before the CTO was made
<b>SCT patient</b>	A patient who is on supervised community treatment
<b>Second opinion appointed doctor (SOAD)</b>	An independent doctor appointed by the Mental Health Act Commission who gives a second opinion on whether certain types of medical treatment for mental disorder should be given without the patient's consent
<b>Secretary of State</b>	Cabinet ministers in the UK Government
<b>Secretary of State for Justice</b>	The Secretary of State who is responsible, among other things, for courts, prisons, probation, criminal law and sentencing. The Secretary of State for Justice is supported by the Ministry of Justice
<b>Section 4 application</b>	See emergency application
<b>Section 12 doctor</b>	See doctor approved under section 12
<b>Section 57 treatment</b>	A form of medical treatment for mental disorder to which the special rules in section 57 of the Act apply, especially neurosurgery for mental disorder (sometimes called psychosurgery)
<b>Section 58 treatment</b>	A form of medical treatment for mental disorder to which the special rules in section 58 of the Act apply, which means medication for mental disorder for detained patients after an initial three-month period
<b>Section 58A treatment</b>	A form of medical treatment for mental disorder to which the special rules in section 58A of the Act apply, especially electro-convulsive therapy
<b>Section 117</b>	See after-care
<b>SOAD certificate</b>	A certificate issued by a second opinion appointed doctor (SOAD) approving particular forms of medical treatment for a patient

<b>Term</b>	<b>Meaning</b>
<b>Supervised community treatment (SCT)</b>	Arrangements under which patients can be discharged from detention in hospital under the Act but remain subject to the Act in the community rather than in hospital. Patients on SCT are expected to comply with conditions set out in the community treatment order (CTO) and can be recalled to hospital if treatment in hospital is necessary again
<b>Three month period</b>	The period of three months from when treatments to which section 58 of the Act would apply are first administered
<b>Unified assessment process</b>	The approach to assessment and planning care for adults, which focuses on outcomes for service users and their carers. Care programme approach is a specialist assessment within the unified assessment process
<b>Unrestricted Part 3 patient</b>	A patient subject to a hospital order or guardianship order under Part 3 of the Act, or who has been transferred from prison to detention in hospital under that part, who is also not subject to a restriction order or direction. For the most part, unrestricted patients are treated in the same way as Part 2 patients, although they cannot be discharged by their nearest relative. See also restricted patient
<b>Voluntary patient</b>	See informal patient
<b>Welsh Ministers</b>	Ministers in the Welsh Assembly Government
<b>Young person</b>	A person aged 16 or 17

# List of policies and procedures

This annex contains a summary of the policies, procedures and guidance which the Code of Practice for Wales says should be put in place locally by hospital managers, local social services authorities (LSSAs) and others.

Paragraph of the Code	Policy, procedure or guidance
2.71	<p><b>Assessment of patients temporarily outside the LSSA area</b></p> <p>LSSAs may make arrangements with neighbouring LSSAs to undertake assessments on patients who are temporarily outside their area; arrangements should be agreed to enable approved mental health professionals to act on behalf of other LSSAs in this way</p>
2.74	<p><b>Training of approved mental health professionals (AMHPs)</b></p> <p>LSSAs should have agreements with partner NHS Trusts regarding training eligible staff as AMHPs, who are not employees of LSSAs</p>
2.76	<p><b>Nearest relative requests</b></p> <p>LSSAs should have policies in place to respond to repeated requests by nearest relatives for assessment under the Mental Health Act 1983</p>
3.2	<p><b>Undue pressure to make an application</b></p> <p>Local arrangements should be established to enable approved mental health professionals to raise concerns regarding undue pressure being placed upon them to make an application under the Act</p>
6.1	<p><b>Guardianship</b></p> <p>Each LSSA should have a policy setting out the arrangements for the way in which it will discharge its responsibilities in relation to guardianship</p>
7.3	<p><b>Guidance on use of section 135</b></p> <p>LSSAs should develop guidance for approved mental health professionals outlining how, and when, they should make applications for a warrant under section 135 of the Mental Health Act 1983</p>
7.11 (and elsewhere in Chapter 7)	<p><b>Places of safety</b></p> <p>Local Health Boards, NHS Trusts, LSSAs, police forces and the ambulance service should have jointly agreed policies governing all aspects of the use of sections 135 and 136, as well as agreed places of safety in their areas</p>
9.4	<p><b>Conveyance of patients under the Act</b></p> <p>Authorities, including the ambulance service and the police, who are involved in conveying patients should agree joint policies, procedures and protocols which set out the arrangements and responsibilities for conveyance</p>

Paragraph of the Code	Policy, procedure or guidance
10.5	<p><b>Receipt of guardianship applications</b></p> <p>Each LSSA should prepare a checklist for the guidance of those delegated to receive guardianship applications on their behalf</p>
10.8	<p><b>Receipt of applications for detention</b></p> <p>Hospital managers should prepare a checklist for the guidance of those delegated to receive applications for admission on their behalf</p>
11.8	<p><b>Hospital managers' scheme of delegation</b></p> <p>Hospital managers should have a scheme of delegation for the exercise of their behalf of functions under the Mental Health Act 1983</p>
11.15	<p><b>Approved clinicians</b></p> <p>Hospital managers should keep a register of approved clinicians employed by or contracted to them</p>
11.32	<p><b>Correspondence of patients (section 134)</b></p> <p>Hospital managers should establish a policy regarding the exercise of relevant powers under section 134 of the Mental Health Act 1983</p>
12.3	<p><b>Appointment of responsible clinicians</b></p> <p>Hospital managers should have local protocols in place for allocating responsible clinicians to patients</p>
12.19	<p><b>Renewal of detention</b></p> <p>Hospital managers should establish a policy relating to the second professional for the purposes of consultation for renewal of detention</p>
17.11	<p><b>Arrangements for Part 4 and 4A</b></p> <p>Hospital managers should ensure that proper arrangements are made to enable responsible clinicians and clinicians in charge of treatment to discharge their responsibilities correctly under Parts 4 and 4A of the Mental Health Act 1983</p>
17.20	<p><b>Section 57 treatments</b></p> <p>Hospitals proposing to offer treatments to which section 57 of the Mental Health Act 1983 applies are strongly encouraged to agree with the Mental Health Act Commission (and any legal successor) the procedures which will be followed to implement the requirements of the Mental Health Act 1983</p>



Paragraph of the Code	Policy, procedure or guidance
17.72	<p><b>Cancellation of certificates of treatment under Parts 4 or 4A</b></p> <p>Hospital managers should make sure that arrangements are in place so that certificates which no longer authorise treatment are clearly marked as such</p>
19.27	<p><b>Restraint</b></p> <p>Service providers should have in place a system of post-incident support and review, which allows the organisation, staff and patients to learn from the experience of using restraint</p>
19.28	<p><b>Assaults in hospital</b></p> <p>Hospitals are recommended to ensure arrangements are in place to provide support to patients (and others) who have suffered serious assaults in hospital, including where appropriate the involvement of the police 19.28</p>
19.30	<p><b>Rapid tranquilisation</b></p> <p>Hospital al managers should ensure that there is a local protocol covering all aspects of rapid tranquilisation</p>
19.36 and 19.46	<p><b>Seclusion</b></p> <p>Service providers should have in place clear written guidelines on the use of seclusion</p> <p>Service providers are also required to have a local policy regarding the implementation and review of longer-term seclusion, where such intervention is used</p>
19.50	<p><b>Locking clinical areas (and locked doors)</b></p> <p>Local policies on the locking of clinical areas need to be in place, and must be clearly displayed in relevant environments of care and explained to each patient on admission</p>
19.57	<p><b>Effective management of patients exhibiting behaviours that challenge</b></p> <p>Service planners and providers should ensure that relevant policies, procedures, education and training programmes are in place to equip staff to effectively manage patients who exhibit behaviours that challenge</p>
20.7 and 20.12	<p><b>Visits by and to children and young people</b></p> <p>Hospitals should have written policies on the arrangements for patients to be visited by children and young people, which should be drawn up in consultation with LSSAs</p>
20.15	<p><b>Visits to patients in hospital</b></p> <p>Hospitals should have an agreed policy on the clinical or security grounds which may justify restricting visits to patients in hospital</p>

Paragraph of the Code	Policy, procedure or guidance
21.8	<p><b>Searching</b></p> <p>Hospital managers should ensure that there is an operational policy on searching detained patients, their belongings, and the environment in which they are being treated, and on searching visitors</p>
22.44	<p><b>Information policy</b></p> <p>Hospital managers should have in place policies to ensure that all detained and community patients and their nearest relatives are given information about their legal situation and rights in accordance with the legislation</p>
23.16 and 23.26	<p><b>Applications to the county court seeking displacement of the nearest relative</b></p> <p>LSSAs should ensure they provide clear practical guidance to help the AMHP decide whether to make an application to the county court, and how to proceed. The LSSA should consult the county court in developing this guidance</p> <p>LSSAs should provide clear practical guidance to help the AMHP decide whom to nominate as the nearest relative in these circumstances</p>
25.30	<p><b>Independent mental health advocates (IMHAs)</b></p> <p>Hospital managers and LSSAs should establish a policy regarding information, access, record keeping and involvement in a patient's case in relation to IMHAs</p>
26.7	<p><b>Applications to the Mental Health Review Tribunal for Wales</b></p> <p>Local protocols should be developed to ensure that staff are available to help patients make an application to the Mental Health Review Tribunal for Wales</p>
28.5	<p><b>Leave of absence within the hospital or its grounds</b></p> <p>It may be appropriate for hospitals to have local policies on granting permission for detained patients to have 'ground leave' or leave to visit other parts of the hospital</p>
29.10	<p><b>Detained and community patients absent without leave</b></p> <p>Hospital managers should ensure there is a clear written policy (agreed with other agencies, including the police, where necessary) on the actions to be taken when a detained patient or a community patient goes missing</p>
29.12	<p><b>Guardianship patients absent without leave</b></p> <p>LSSAs should have policies setting out the actions which should be taken in the case of guardianship patients absent without leave from the place where they are required to live</p>
30.48	<p><b>Supervised community treatment - concerns of carers and relatives</b></p> <p>The managers of responsible hospitals should develop local protocols to cover how concerns raised by carers and relatives of community patients are addressed</p>

Paragraph of the Code	Policy, procedure or guidance
30.94	<p data-bbox="395 286 1126 320"><b>Transfer of responsible clinicians relating to SCT</b></p> <p data-bbox="395 349 1366 461">Hospital managers should ensure that arrangements are in place to cover any necessary transfers of responsibility between responsible clinicians in the community and in hospital</p>
31.6	<p data-bbox="395 470 756 504"><b>After-care (section 117)</b></p> <p data-bbox="395 533 1342 602">LHBs, LSSAs and NHS Trusts should establish jointly agreed policies for the provision of services under section 117 of the Mental Health Act 1983</p>



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