

**MENTAL HEALTH
ACT 1983
CODE OF
PRACTICE FOR
WALES**

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Foreword by the Minister for Health and Social Services

To be added post consultation

Introduction

- i. The Mental Health Act 1983 Code of Practice for Wales (the Code) has been prepared and is issued under section 118 of the Mental Health Act 1983 by the Welsh Ministers after consulting with such bodies as appear to the Welsh Ministers to be concerned, and being laid before the National Assembly for Wales. The Code will come into force in November 2015.

Presentation

- ii. Throughout the Code, the Mental Health Act 1983 is referred to as the Act.
- iii. The Mental Health Act 1983 (the Act) sets out the legal framework, and the Code provides the principles and guidance on how the Act should be applied in practice. Connections between the Mental Health Act 1983 and other legislation are detailed where relevant.
- iv. The Code assumes that readers are familiar with the main provisions of other legislation as they relate to the care and treatment of people with mental disorder.
- v. The Code generally uses the word 'patient', in line with the term used throughout the Act, though it is recognised some people prefer the terms 'service user', 'survivor', 'client', 'consumer' and 'recipient'. The Code uses the terms 'child' and 'children' for people aged under 18 years and 'young person' when matters apply only to those aged 16-18 years. A list of key words and phrases used in the Code is provided.
- vi. The Code is available in both English and Welsh.

Purpose and status of the Code of Practice

- vii. The Code provides guidance to particular individuals including registered medical practitioners ('doctors'), approved clinicians, managers and staff of hospitals, independent hospitals and care homes, independent mental health advocates 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.
- viii. These people are required to have regard to the Code in carrying out their relevant functions under the Act.
- ix. The Code is designed to support and promote good practice amongst all those who are providing mental health services under the Act.
- x. The Code applies to the care and treatment of all patients in Wales who are subject to the Act. This includes patients who are liable to be detained, subject to community treatment orders (CTOs) or those received into guardianship.
- xi. The Act applies to England and Wales. England has its own Code of Practice that applies in England.

Statutory Guidance

Who this applies to	Context
<ul style="list-style-type: none"> Registered medical practitioners ('doctors') Approved clinicians, managers and staff of providers Approved mental health professionals (AMHPs) 	Given under section 118 of the Act in relation to the performance of their functions, including in relation to admission, guardianship and community patients
<ul style="list-style-type: none"> Registered Medical Practitioners (doctors) and other professionals 	Given under section 118 of the Act in relation to the medical treatment of patients with a mental disorder
<ul style="list-style-type: none"> Local authorities and their staff 	Given under section 7 of the Local Authority Social Services Act 1970 (duty to exercise social services functions under guidance of the Welsh Ministers) ¹

- xii. Departures from the Code may give rise to legal challenge and should therefore be recorded with reasons. A court will scrutinise the reasons for the departure to ensure there is a sufficiently convincing justification. It is expected that any such reasons are appropriately evidenced.

Beneficial but not statutory guidance

Who this applies to	Context
<ul style="list-style-type: none"> The police Ambulance services Others in health and social services (including the independent and voluntary sectors) involved in the commissioning or providing services to people who are, or may become, subject to compulsory measures under the Act 	The Code is not statutory guidance, but it is beneficial to these persons in carrying out their duties

- xiii. The Code should be accessible to patients, families, carers, advocates and others who support them.
- xiv. The table below describes the terminology used in the Code and how it should be understood.

¹The term local social services authority (LSSA) will be replaced by the term local authority as of April 2016 and therefore local authority is the term used in the Code

Terminology	How it is to be understood	Exceptions
Must	Reflects legal obligations which it is essential to follow	No exceptions
Should	<ul style="list-style-type: none"> For those to whom this is statutory guidance, see the Statutory Guidance table on page 4 For those to whom it is not statutory guidance, see the Beneficial but not Statutory Guidance table on page 4 	<ul style="list-style-type: none"> Any exceptions should be documented and recorded including the reason for the departure from the code Patients, their families and carers, regulators, commissioners and other professionals may ask to see this
May/Could/Can	Reflects guidance to be followed wherever possible	Good practice but exceptions permissible

Inspectorates Role

- xv. Healthcare Inspectorate Wales (HIW) is the independent inspectorate and regulator of all health care in Wales. HIW's primary focus is on:
- making a contribution to improving the safety and quality of healthcare services in Wales
 - improving citizens' experience of healthcare in Wales whether as a patient, service user, carer, relative or employee
 - strengthening the voice of patients and the public in the way health services are reviewed, and
 - ensuring that timely, useful, accessible and relevant information about the safety and quality of healthcare in Wales is made available to all.
- xvi. The role of the Review Service for Mental Health, within HIW, is to review the use of the Act and check that it is being used properly on behalf of Welsh Ministers. The Review Service is independent of all staff and managers of hospitals and mental health teams. Mental Health reviewers include doctors, nurses, social workers, lawyers, psychologists, service users and other people with knowledge of the Act and mental health services. When requested by a patient's responsible clinician, the Review Service arranges for an independent doctor, called a Second Opinion Appointed Doctor (SOAD) to provide a second opinion to ensure the treatment is appropriate if a patient is not able or willing to consent to their treatment. The Review Service may investigate certain types of complaints and publishes a report of its activities and findings every year.
- xvii. HIW is a member of the UK's National Preventative Mechanism (NPM). The United Kingdom (UK) ratified the United Nations Optional Protocol to the Convention against Torture (OPCAT) in 2003. The protocol requires participating states to carry out regular reviews of places where people are deprived of their liberty to ensure that they are not being abused. The UK established its NPMs, in 2009. HIW visits places of detention in Wales as part of the UK's NPM.

- xviii. Reviewers meet with patients in places where they are detained under the Act. They may also meet with patients subject to guardianship or CTO to check that:
- patients are lawfully detained and well cared for
 - patients are informed about their rights under the Act
 - patients are given respect for their qualities, abilities and diverse backgrounds as individuals, and that account is taken of their needs in relation to age, gender, sexual orientation, social, ethnic, cultural and religious backgrounds
 - patients are enabled to lead as fulfilling life as possible
 - the Mental Health Act 1983 Code of Practice for Wales is being followed, and
 - the right plans are made for patients before they are discharged from hospital.
- xix. During visits, reviewers talk to detained patients in private and meet with managers and other staff to talk about things that affect patients' care and treatment and to raise issues on behalf of patients.
- xx. The Review Service cannot:
- discharge patients from their section under the Act
 - discharge patients from hospital
 - arrange for patients to have leave
 - transfer patients to another hospital
 - offer individual medical advice
 - offer individual legal advice
 - help informal patients.
- xxi. The Review Service for Mental Health Team can be contacted at:
Review Service for Mental Health
Healthcare Inspectorate Wales
Welsh Government
Rhydycar Business Park
Merthyr Tydfil
CF48 1UZ.
- xxii. The Care and Social Service Inspectorate for Wales (CSSIW) carries out their functions on behalf of Welsh Ministers under the following legislation:
- The Health and Social Care (Community Health and Standards) Act 2003 which gives powers to review the way in which local authorities discharge their social services functions; including those under the Act
 - The Care Standards Act 2000, The Children Act 1989 (as amended), Adoption and Children Act 2002 and the Children and Families (Wales) Measure 2010 which give power to register and inspect providers of social care services in Wales including care homes.

Raising Concerns

- xxiii. Each NHS organisation, NHS-funded provider and local authority should have its own locally agreed 'raising concerns/whistleblowing' policy and procedures, which follow best practice, and which should be publicised.

- xxiv. For NHS organisations, an all Wales procedure for staff to raise concerns within NHS Wales was issued in February 2015², for local agreement and adoption. To ensure better protection for patients, staff should be encouraged and supported to raise concerns about poor care in accordance with these policies and procedures, and these concerns should be listened to and, where appropriate, acted upon.

Safeguarding

- xxv. The Social Services and Well-being (Wales) Act 2014 requires local authorities to establish a Safeguarding Board (the Board).
- xxvi. For adults, every local authority must establish a Safeguarding Adults Board comprising the local authority, the local health board, the NHS trust, the police and probations services, together with others who exercise functions or are engaged in activities relating to adults.
- xxvii. The Boards' functions and objectives are to protect adults in its area who have needs for care and support (whether or not the local authority is meeting any of those needs) and are experiencing, or at risk of abuse or neglect and to prevent adults in its area from becoming at risk. Anyone with concerns about an adult's safety should contact the Safeguarding Board for the area where that adult is living.
- xxviii. For children and young people under 18, the statutory guidance, Working Together to Safeguard Children 2004, sets out the legislative requirements and expectations on individual services to safeguard and promote the welfare of children. This includes the role of Safeguarding Children Boards, whose functions and objectives mirror those of Safeguarding Adults Boards to protect children and prevent them from experiencing abuse through the co-ordination of partners' safeguarding arrangements; undertaking child practice reviews and the publication of annual plans and reports.
- xxix. Anyone who has a concern about a child's welfare is under a duty to report their suspicions to the local authority where the child normally lives (whether or not they are in hospital or on a community treatment order).

²[http://www2.nphs.wales.nhs.uk:8080/PHWPapersDocs.nsf/\(\\$All\)/22491CF0DD9F797380257E2A0057FD45/\\$File/38%2010%20All%20Wales%20Procedure%20of%20NHS%20Staff%20to%20Raise%20Concerns.pdf?OpenElement](http://www2.nphs.wales.nhs.uk:8080/PHWPapersDocs.nsf/($All)/22491CF0DD9F797380257E2A0057FD45/$File/38%2010%20All%20Wales%20Procedure%20of%20NHS%20Staff%20to%20Raise%20Concerns.pdf?OpenElement)

Chapter 1

Guiding principles

- 1.1 This chapter sets out the guiding principles which should always be considered when making decisions about a course of action under the Mental Health Act 1983 (the Act). The guiding principles are:
- Dignity and respect
 - Fairness and equality
 - Empowerment and involvement
 - Least restrictive option and maximising independence
 - Keeping people safe
 - Efficiency and effectiveness.
- 1.2 These principles apply equally to all patients who are receiving services under the Act.

Dignity and Respect

- 1.3 Practitioners performing functions under the Act should respect the rights and dignity of patients and their families and carers, while also ensuring their safety and that of others.
- 1.4 Patients, families and carers should be listened to and their views positively valued and taken into account when decisions are made.
- 1.5 Patients should be offered treatment and care in supportive environments that are safe for them, staff and the public. The environment should support practitioners to deliver therapies which focus on patient recovery, other positive clinical and personal outcomes and promote the maintenance of patients' dignity to the fullest possible extent.
- 1.6 Issues of faith, spirituality, religion and belief may be central to a patient's cultural needs in general and these must be considered when decisions about their care and treatment are being made.

Fairness, Equality and Equity

- 1.7 People taking decisions under the Act must recognise and respect the diverse needs, values and circumstances of each patient, including their age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex and sexual orientation and culture. There must be no unlawful discrimination and reasonable adjustments must be made.
- 1.8 Ensuring effective communication between practitioners, patients and others who are concerned with the care of the patient is central to fair and equitable practice. Everything possible should be done to overcome any barriers to communication that may exist.

- 1.9 Welsh speakers must be given the option of assessment, treatment and provision of information in line with the Welsh Language Standards (No. 1) Regulations 2015. The commissioners and providers of services must act in accordance with Welsh Language Measure (Wales) 2011.
- 1.10 If a patient's language is other than English or Welsh, assessments should be conducted using an appropriate interpreter, who will address issues of both language and cultural interpretation. This includes the use of British Sign Language.

Empowerment and involvement

- 1.11 Where assessment under the Act is required, patients should be empowered to be as fully involved in the assessment process as possible. Mental health professionals undertaking assessments should give due regard to patients' present and past wishes, including any advance decisions.
- 1.12 All patients should be enabled and given the opportunity to participate in planning, developing and reviewing their own care and treatment. Care and treatment planning should draw on and build upon patients' strengths, and should seek to enable patients to progress towards recovery and to re-establish or maximise independence as soon as is safely practicable. Patients should also be supported to manage, in accordance with their wishes, as many other aspects of their lives as possible.
- 1.13 Patients must, and their families and carers should normally, be informed of the support that an independent mental health advocate (IMHA) or an independent mental capacity advocate (IMCA), where relevant, can provide.
- 1.14 The patient's choices and views should be recorded. Where a decision in the care and treatment plan is contrary to the wishes of the patient or others, the reasons for this should be explained to them and fully documented. As far as is practicable, patients should be encouraged and supported to develop advance statements of wishes and feelings.

Keeping People Safe

- 1.15 Patient well-being and safety should be at the heart of all decision-making under the Act. When necessary, this should be consistent with ensuring the well-being and safety of others when needed.
- 1.16 Patients, their families and/or carers and other relevant individuals should be actively involved in assessing the risks posed to the health and safety of the patient and others. Patients should, wherever practicable, be involved, if needed, in creating and implementing a risk management plan.
- 1.17 Decision-making should be open and transparent, subject to the need to manage information which, if disclosed, could harm the patient and/or the well-being and safety of others.
- 1.18 When discharged from hospital, the patient's discharge must be effectively planned to maximise recovery and independence.

Least restrictive option and maximising independence

- 1.19 Services should be provided in line with the presumption of capacity, the least restrictive option, a person's best interests and maximising independence.
- 1.20 Retaining independence and promoting the patient's recovery should be central to all interventions under the Act. The least restrictive options should always be considered and alternatives to avoid the use of compulsory powers should be explored before making an application for admission. Where it is possible to treat a patient safely and lawfully without detaining them under the Act, the patient should not be detained.
- 1.21 Where an application for detention under the Act is made the patient should be informed of the reasons and a clear explanation of the purpose for doing so. This is in addition to providing the patient with information on their statutory rights to information.
- 1.22 In making decisions under the Act, adherence to other legislation and guidance may also be relevant, including that on safeguarding. Mental health professionals should not view mental health and learning disability guidance in isolation, and should ensure their practice takes account of wider legislation and guidance.
- 1.23 If the Act is used, detention should be used for the shortest time necessary in the least restrictive hospital setting available, and be delivered as close as reasonably possible to a location that the patient identifies they would like to be close to (e.g. their home or close to a family member or carer).
- 1.24 Restrictions that apply to all patients in a particular setting (blanket or global restrictions) should be avoided and should never be for the convenience of the provider. Any restrictions should be the minimum necessary to safely provide the care and treatment required having regard to whether the purpose for the restriction can be achieved in a way that is less restrictive of the person's rights and freedom to act.
- 1.25 It is important that care and treatment planning should begin when the patient is admitted to hospital in order to focus on seeking early discharge and providing after-care, if necessary, at the earliest opportunity.

Efficiency and effectiveness

- 1.26 Anyone made subject to compulsion under the Act should be provided with appropriate treatment and care, the purpose of which should be to alleviate, to minimise the harm caused by, or prevent a worsening of, their mental disorder, or any of its symptoms or manifestations.
- 1.27 Health, social care and other relevant agencies should work together to ensure patients are provided a range of mental health services that are effective accessible, responsive and of high quality.
- 1.28 Staff should have sufficient skills, information and knowledge about the Act to support all their patients. There should be clear mechanisms for accessing specialist support for those with additional needs.

- 1.29 All relevant organisations should work together to ensure, as far as practicable, the duration of detention is minimised, safe discharge from hospital is facilitated, with appropriate support upon discharge.

Using the principles

- 1.30 All guiding principles are of equal importance, and should inform any decision made under the Act. The weight given to each principle in reaching a particular decision will need to be balanced in different ways according to the circumstances and nature of each particular decision.
- 1.31 All decisions must be lawful and informed by good professional practice. Lawfulness necessarily includes compliance with the Human Rights Act 1998 (HRA) and Equality Act 2010.

Supporting Information

- 1.32 Services provided under the Act should be provided in line with current strategies and be compliant with all relevant legislation.
- 1.33 The following list (which is not an exhaustive list) of legislation and strategies are relevant:
- Mental Health (Wales) Measure 2010
 - Mental Capacity Act 2005
 - Equality Act 2010
 - Human Rights Act 1998 (HRA)
 - Welsh Government Mental Health Strategy, 'Together for Mental Health'
 - European Convention of Human Rights
 - United Nations Convention on the Rights of the Child (UNCRC)
 - United Nations Convention on The Rights of Persons with Disabilities (UNCRPD)
 - Fundamentals of Care³
 - Declaration of Rights for Older People in Wales
 - Children Act 1989 and 2004
 - The Wales Language Measure (Wales) 2011
 - The Children and Families (Wales) Measure 2010

³ <http://www.wales.nhs.uk/documents/booklet-e.pdf>

Chapter 2

Definition of mental disorder

- 2.1 Mental disorder is defined by section 1(2) of the Mental Health Act 1983 (the Act) as 'any disorder or disability of the mind'. Relevant professionals should determine whether a patient has a disorder or disability of the mind in accordance with good clinical practice and accepted standards of what constitutes such a disorder or disability. The fact that someone has a mental disorder is not sufficient grounds for compulsory measures to be taken under the Act.
- 2.2 Care must be taken not to diagnose, or fail to diagnose, mental disorder on the basis of stereotypes or assumptions about people and/or a failure to appreciate cultural and social differences. What may be indicative of mental disorder in one person, given their background and individual circumstances, may be not be indicative of mental disorder in another person. Difference should not be confused with disorder.
- 2.3 No-one should be considered to be mentally disordered solely because of their political, religious or cultural beliefs, values or opinions alone.
- 2.4 The same is true of a person's involvement, or likely involvement, in illegal, anti-social behaviour, or behaviour that may be considered by some to be immoral. Beliefs, behaviours or actions which do not result from a disorder or disability of the mind are not a basis for compulsory measures under the Act, even if they appear unusual or cause other people alarm, distress or danger.

Dependence on alcohol or drugs

- 2.5 Section 1(3) of the Act states that dependence on alcohol or drugs is not considered to be a disorder or disability of the mind for the purposes of the definition of mental disorder in the Act.
- 2.6 There are no grounds under the Act for detaining a person in hospital on the basis of alcohol or drug dependence alone. However alcohol or drug dependence may be accompanied by, or associated with, a mental disorder which does fall within the Act's definition. If the criteria for detention are met, it is appropriate to detain people who are diagnosed with a mental disorder, even though they are also dependent on alcohol or drugs and/or if the mental disorder in question results from the person's alcohol or drug dependence.
- 2.7 Disorders or disabilities of the mind which are related to the use of alcohol or drugs e.g. withdrawal state with delirium or associated psychotic disorder, acute intoxication, or organic mental disorders associated with prolonged abuse of drugs or alcohol – remain mental disorders for the purposes of the Act.
- 2.8 Medical treatment for mental disorder under the Act can include measures to address alcohol or drug dependence if that is an appropriate part of treating the mental disorder which is the primary focus of the treatment.

Learning disabilities

- 2.9 Learning disabilities are forms of mental disorder as defined in the Act. However someone with a learning disability and no other form of mental disorder may not be detained for treatment or made subject to guardianship or a community treatment order (CTO) under the Act unless their learning disability is associated with abnormally aggressive or seriously irresponsible conduct on the part of the person concerned.
- 2.10 They can however be detained for assessment under section 2 of the Act.
- 2.11 Professionals should record their reasons for concluding that an individual's conduct is abnormally aggressive or seriously irresponsible, why the conduct relates to the person's learning disability and that it is not attributable to other factors such as an unmet physical health, social or emotional needs.
- 2.12 For further guidance on particular issues relating to people with learning disabilities see Chapter 20.

Autistic spectrum disorders

- 2.13 Whilst experience suggests that the use of compulsory measures under the Act in respect of a person with an autistic spectrum disorder is rarely necessary, the possibility should not be discounted. It is possible for someone with an autistic spectrum disorder to meet the criteria for compulsory measures under the Act without having any other form of mental disorder, even where their autistic spectrum disorder is not associated with abnormally aggressive or seriously irresponsible behaviour.
- 2.14 For further guidance on particular issues relating to people with autistic spectrum disorders see Chapter 20.

Personality disorders

- 2.15 Apart from the learning disability qualification described above, the Act does not distinguish between different forms of mental disorder. The Act therefore applies to the diagnosis of all types of personality disorders in exactly the same way as it applies to other mental disorders, see Chapter 21.

Chapter 3

Human rights and reducing inequalities

- 3.1 Those delivering mental health services and, in particular, those delivered under the provisions of the Mental Health Act 1983 (the Act) need to consider and make decisions which are in accordance with the relevant legislation and international conventions.

Human rights

- 3.2 Human rights legislation provides a framework for professionals to help them achieve the best possible outcomes for everyone who uses mental health services. There may be occasions when competing human rights will need to be considered and in these circumstances decisions will need to be made on the basis of finely balanced judgements. Such decisions and the reasons for them must be clearly documented. Any decision which restricts a person's rights will need to be necessary and proportionate in the circumstances. Any restriction imposed should be kept to the minimum needed to meet the purpose of the restriction.

Equality Act 2010

- 3.3 The Equality Act makes it unlawful to discriminate, either directly or indirectly, against a person on the basis of a protected characteristic or combination of protected characteristics. Protected characteristics under the Equality Act are; age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex and sexual orientation. Those providing mental health services should be aware that, under the Equality Act, the protected characteristic of disability includes 'a mental impairment that has a substantial and long-term adverse effect on the person's ability to carry out normal day-to-day activities'.
- 3.4 Under the Public Sector Equality Duty, set out at section 149 of the Equality Act, public authorities must have due regard to the need to:
- eliminate unlawful discrimination, harassment and victimisation
 - advance equality of opportunity between people who share a protected characteristic and those who do not
 - foster good relations between people who share a protected characteristic and those who do not.
- 3.5 Complying with the Public Sector Equality Duty may involve treating people with mental health problems more favourably than others in order to achieve equality of access to services and outcomes⁴.

Reasonable Adjustments

- 3.6 The Equality Act also places a duty on public bodies to make reasonable adjustments for people with an impairment (including mental impairment) that constitutes a disability under the Equality Act.

⁴http://www.equalityhumanrights.com/sites/default/files/publication_pdf/Essential%20guide%20to%20the%20public%20sector%20equality%20duty%20Wales.pdf

- 3.7 The reasonable adjustments that a person may need should be considered as part of the care and treatment planning process throughout a person's contact with mental health services. The duty applies where:
- a provision, criterion or practice puts disabled people at a substantial disadvantage compared with those who are not disabled
 - a physical feature puts disabled people at a substantial disadvantage compared with people who are not disabled, and
 - not providing an auxiliary aid puts disabled people at a substantial disadvantage compared with people who are not disabled.
- 3.8 Some examples of reasonable adjustments include:
- assessment for detention is undertaken by professionals with the appropriate specialist skills to assess the person based on their individual needs, e.g. adjustments if the person has a learning disability, an autism spectrum disorder or is deaf
 - ensuring the care environment is as accessible as possible, e.g. through appropriate signage and lighting
 - ensuring information for patients is in a format accessible to the person, e.g. using pictures and big print, or providing translations into the person's first language
 - ensuring there are adequate numbers of staff with the right skills and experience to communicate effectively with patients, e.g. staff who can use sign language or communicate in the person's first language
 - providing specific or additional training for staff who work with people with learning disabilities or autism spectrum disorders, and
 - ensuring meetings are accessible to people, e.g. providing materials in an appropriate format and holding the meeting in an accessible venue.
- 3.9 Public bodies must, in the exercise of their functions, have due regard to the need to reduce health inequalities between patients with respect to:
- the patients' ability to access health services, and
 - the outcomes achieved for patients by the provision of health services.
- 3.10 These legal duties apply to the exercise of any functions, including decisions made and policies developed.

Monitoring and compliance

- 3.11 All service providers and service commissioners should have in place a human rights and equality policy for service provision which should be reviewed at Board (or equivalent) level at least annually.

Chapter 4

Information for patients, nearest relatives, families, carers and others

- 4.1 This chapter gives guidance on the information which must be given to and explained to patients, and their nearest relatives. It also gives guidance on communication with patients, their families and carers, and other people. Those responsible for caring for patients should identify any communication difficulties and seek to address them.

Generally

- 4.2 Sections 132 and 132A of the Act require hospital managers to take such steps as are practicable to ensure that patients who are detained in hospital under the Act, or who are subject to a community treatment order (CTO) understand important information about how the Act applies to them. This must be done as soon as practicable after the start of the patient's detention or the CTO. Patients who are subject to a CTO and who are recalled to hospital should be given this information at the time they are recalled.
- 4.3 Information should be given to the patient both verbally and in writing, in accessible formats, appropriate to the patient's needs (e.g. Braille, Moon, easy read), and in a language the patient understands. It would not be sufficient to repeat what is already written on an information leaflet as a way of providing information verbally.
- 4.4 Patients should be given all relevant information, which includes how to make a complaint, how to access advocacy services and legal advice and the role of the Inspectorates. Relevant information includes access to the Code. Information should be readily available to patients throughout their detention or the period of their CTO.

Communication with patients

- 4.5 Those with responsibility for the care and treatment of patients should be aware of the most effective way to communicate with each individual and their family, carers and relevant others. It is important the language used is clear and that people check that the information they have communicated has been understood.
- 4.6 Everything possible should be done to overcome barriers to effective communication. Hospitals and other organisations should ensure people with specialist expertise (e.g. in sign language or Makaton) are available as required. Staff should be aware of who to contact to ensure individuals' communication needs can be met.
- 4.7 Being able to communicate in the patient's usual language is essential to ensuring that those providing services can undertake an accurate assessment and deliver ongoing care and treatment. Where interpretation is needed, every effort should be made to identify an interpreter who is suitable to the needs and circumstances of the patient.

- 4.8 Ideally, interpreters will be skilled and experienced in medical or health-related interpreting. Interpreters (both professional and non-professional) must respect the confidentiality of any personal information they learn about the patient through their involvement with the patient.
- 4.9 Using the patient's relatives and friends as intermediaries or interpreters is not usually considered good practice, and should only be used exceptionally and at the express wish of the patient. This applies equally when the patient is a child or a young person. In such a situation, safeguarding issues should be considered if relevant.
- 4.10 Independent mental health advocates (IMHAs) can be valuable in helping patients to understand the questions and information that is being presented to them and in helping patients to communicate their views to staff (see Chapter 6).

Information about detention and CTOs

- 4.11 Patients must be informed:
- of the provisions of the Act under which they are detained or subject to a CTO, and the effect of those provisions
 - what rights of applying to a tribunal are available
 - the rights (if any) of their nearest relative to discharge them and what can happen if their responsible clinician does not agree with that decision
 - for community patients, the effect of the CTO, including the conditions to which they are required to adhere and the circumstances in which their responsible clinician may recall them to hospital
 - that help is available to them from an IMHA, and how to obtain that help.
- 4.12 Patients should be told:
- the reasons for their detention or CTO
 - the maximum length of the current period of detention or CTO
 - that their detention or CTO 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 CTO ends
 - that their detention or CTO will not automatically be renewed or extended when the current period of detention or CTO ends
 - the reasons for being recalled to hospital from a CTO
 - the reasons for the revocation of a CTO.
- 4.13 For the patient to be able to adequately and effectively challenge the grounds for their detention or their CTO, they should be given the full facts about why the detention or CTO has been applied to them individually, rather than the broad reasons why a section may be applied to a person. They should be told they can seek legal advice, and assisted to do so if required.
- 4.14 In addition, a copy of the detention or CTO documentation should be made available to the patient as soon as practicable and as a priority, unless the hospital managers are of the opinion (based on the advice of the authors of the documents) that the information disclosed would adversely affect the health or wellbeing of the patient or others. It may be necessary to remove any personal information about third parties from the CTO documentation prior to making this available to the patient.

- 4.15 Where the section of the Act under which the patient is being detained changes, the patient must be provided with the information to reflect the new situation. The same applies where a detained patient becomes subject to a CTO.
- 4.16 Where a patient is to be recalled to hospital whilst on a CTO, the responsible clinician should give the patient (or arrange for the patient to be given) verbal reasons for the decision to recall before the recall occurs. The patient can nominate another person who they wish to be notified of the decision.
- 4.17 Where a restriction order is in place in respect of a patient who has been conditionally discharged, the Secretary of State may, by warrant, recall the patient. A verbal explanation of the Secretary of State's reasons for recall must be provided to the patient at the time of recall, unless there are exceptional reasons why this is not possible, e.g. the patient is considered to be too violent or too distressed to be receptive to this information. The Secretary of State's warrant will detail the reasons for the recall. The patient should also receive, within 72 hours of admission, a written explanation of the reasons for his or her recall.

Keeping patients informed of their rights

- 4.18 Patients must be made aware of an IMHA's ability to help to obtain and understand the information referred to in this chapter.
- 4.19 Those with responsibility for patient care should ensure patients are reminded regularly of their rights and the effects of the Act. It may be necessary to give the same information on different occasions or in different formats and to check the patient has fully understood it. Information given to a patient who is unwell may need to be repeated when their condition has improved. A fresh explanation of the patient's rights should be considered when there is a change in the patient's circumstances.
- 4.20 When a patient is discharged, or the authority for their detention or the CTO expires, this fact should be made clear to them. The patient should be given an explanation of what will happen next, including any section 117 after-care or other services which are to be provided.

Information for informal hospital inpatients

- 4.21 Although the Act does not impose any duties to give information to informal patients, they should be given an explanation of their legal position and rights. Informal patients should be provided with all relevant information pertinent to their care (e.g. the purpose of specific treatment and consent requirements for treatment).
- 4.22 Both informal patients and, where appropriate, their carers and advocates should be made aware of the patient's right to leave hospital if they wish. Local policies and arrangements about movement around the hospital and its grounds must be clearly explained to them. Failure to do so could lead to a patient mistakenly believing they are not allowed to leave hospital, which could result in an unlawful deprivation of their liberty and a breach of their human rights.

Information about consent to treatment

- 4.23 Patients must be told what the Act says about treatment or their mental disorder. In particular they must be told:
- the circumstances in which they can be treated without their consent and the circumstances in which they have the right to refuse treatment
 - the circumstances (if any) in which they can be treated without their consent
 - the role of second opinion appointed doctors (SOADs) and the circumstances in which they may be involved, and
 - (where relevant) the rules on electro-convulsive therapy (ECT) and medication administered as part of ECT or other invasive treatment.

Information about seeking discharge from detention or CTOs

- 4.24 Patients must be informed of their rights to be considered for discharge and:
- that their responsible clinician and the hospital managers can discharge them (and that for restricted patients that it is subject to the agreement of the Secretary of State for Justice)
 - that they have a right to ask the hospital managers to discharge them
 - that the hospital managers must consider discharging them when their detention is renewed or their CTO is extended
 - of their rights to apply to the Mental Health Review Tribunal for Wales (MHRT for Wales) and of the rights (if any) of their nearest relative to apply to the MHRT for Wales on their behalf, and
 - how to apply to, and the role of, the MHRT for Wales.
- 4.25 Hospital managers should ensure patients are offered assistance to request a hospital managers' hearing or to make an application to the MHRT for Wales, and that the applications are transmitted to the MHRT for Wales without delay. Patients should also be told:
- how to contact a suitably qualified legal representative (and patients should be given assistance to do so if required)
 - that free legal aid may be available, and how this may be accessed, and
 - how to contact any other organisation which may be able to help them to make an application to the MHRT for Wales.
- 4.26 Patients on a CTO who may not have regular contact with people who could help them make an application to the MHRT for Wales should be well informed and supported in this process.
- 4.27 Patients whose CTOs are revoked, and conditionally discharged patients recalled to hospital, should be told that their cases will be referred automatically to the MHRT for Wales.

Information about Healthcare Inspectorate Wales (HIW)

- 4.28 Patients must be informed about the role of HIW, their right to meet visitors appointed by HIW in private and that they may make a complaint to HIW.

Information about withholding of correspondence

- 4.29 Patients should routinely have access to any correspondence they receive and send. Their privacy must be respected. Detained patients must be told their letters for posting may be withheld if the person to whom it is addressed asks the hospital managers to do so (section 134(1) (a) of the Act).
- 4.30 Patients in high security psychiatric hospitals must be told about the other circumstances in which their correspondence may be withheld, the procedures that will be followed in relation to this and of their right to ask Care Quality Commission to review the decisions taken⁵.

Additional information

- 4.31 Patients should also be made aware of the Code, with particular attention drawn to the guiding principles.
- 4.32 Patients should be informed of the provisions for making an application to the county court to displace their nearest relative under section 29 of the Act, and given help with the application if they want it. There is further guidance on this in Chapter 5 of the Code.
- 4.33 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.
- 4.34 Under the Data Protection Act 1998 and the Freedom of Information Act 2000, patients may have a right of access to information held about them. Hospital managers should ensure that patients are aware of these rights.
- 4.35 Nothing in the Act prevents professionals from giving information to patients on other matters, such as understanding care and treatment planning, admission guidance, and welfare benefits.

Information for nearest relatives

- 4.36 The Act requires hospital managers to take such steps as are practicable to give the patient's nearest relative a copy of any written information that is given to the patient, unless the patient requests otherwise. The information should be given to the nearest relative when the information is given to the patient, or within a reasonable time afterwards.
- 4.37 Section 26 of the Act defines 'relative' and therefore who can be the 'nearest relative' for the purposes of the Act. The identity of the nearest relative may change with the passage of time, e.g. if the patient enters into a marriage or civil partnership. The Act includes additional provisions to identify the nearest relative of a child or young person. Guidance is given in Chapter 5.

⁵ All high secure hospitals are based in England and are inspected by the Care Quality Commission (CQC)

- 4.38 When a patient who is detained under the Act or subject to a CTO is given information, they should be told that the written information may also be supplied to their nearest relative.
- 4.39 The nearest relative must be told of the patient's discharge from detention or CTO, if practicable within seven days in advance of the proposed date of discharge, unless either the patient or the nearest relative has requested otherwise. In addition, the Mental Health (Hospital, Guardianship, Community Treatment and Consent to Treatment) (Wales) Regulations 2008 require nearest relatives to be informed of various other events, including the renewal of a patient's detention, extension of a CTO and transfer from one hospital to another.
- 4.40 These duties to inform nearest relatives are not absolute. In almost all cases, information is not to be shared if the patient objects. However, consideration should also be given to any advance decision, wishes or statements made by the patient to inform their nearest relative if detained. It may also be necessary to share information in order to ensure the nearest relative is aware of any risk to themselves, or others. Before disclosing information to nearest relatives without a patient's consent, the person who is considering the disclosure must consider whether the disclosure would be likely to:
- be in breach of the patient's right to privacy under article 8 of the European Convention on Human Rights
 - put the patient at risk of physical harm or financial or other exploitation
 - cause the patient emotional distress or lead to a deterioration in their mental health, or
 - have any other detrimental effect on their health or wellbeing and, if so, whether the advantages to the patient and the public interest of the disclosure outweigh the disadvantages to the patient, in the light of all the circumstances of the case.

Communication with other people nominated by the patient and the involvement of carers

- 4.41 Professionals should agree to a patient's request to involve carers, relatives, friends or other informal supporters or advocates in their care and treatment unless the professional considers that it is not appropriate to do so, for example if:
- contacting and involving the person would result in a delay in making the decision in question that would not be in the patient's interests
 - the involvement of the person is contrary to the interests of the patient
 - the person has requested that they should not be involved.
- 4.42 Where a patient's request to involve others is refused, the reasons for the refusal should be recorded in the patient's notes.
- 4.43 Professionals should take steps to find out whether patients who lack capacity to take particular decisions for themselves have an attorney or deputy with authority to take decisions on their behalf. Where there is such a person, they act as the agent of the patient, and should be informed in the same way as the patient them self about matters within the scope of their authority, as set out in the terms of the attorney or deputy agreement (see Chapter 7).

- 4.44 In order to ensure carers can, where appropriate, participate fully in decision making, it is important they have access to:
- practical and emotional help and support to assist them in participating, and
 - timely access to comprehensive, up-to-date and accurate information.
- 4.45 Even if carers cannot be given detailed information about the patient's case, where appropriate they should be offered general information in a form appropriate to the individual and the circumstances, which may help them understand the nature of mental disorder, the way it is treated, and the operation of the Act.
- 4.46 A carer should be asked to consent to the information they provide being disclosed to the patient in order to promote appropriate care and treatment and in order to respect the patient's right to know what information has been provided. However, if carers request the information they provide is kept confidential, this request should be respected and recorded in the patient's notes.
- 4.47 The information which children or young people (especially young carers) should receive about a parent's condition or treatment will need to balance the interests of the child against the patient's right to privacy and their wishes and feelings. Any such information should be appropriate to the age and understanding of the child or young person.
- 4.48 It will also be appropriate to consider with a young person aged between 16 and 24 the involvement of the local authority that may have various duties towards them if they have been a 'looked after child'.

Hospital managers' information policy

- 4.49 Whilst it is the hospital managers who have responsibilities under the Act for the provision of information to patients, carers and others, in practice it would usually be more appropriate for professionals working with the patient to provide them with the information. However in order to fulfil their statutory duties, hospital managers should have policies in place to ensure that regular checks are made that the required information has been properly given to each patient and understood by them.

Information for those subject to guardianship

- 4.50 Responsible local authorities are required to take steps to ensure that patients who are subject to guardianship understand their rights to apply to the MHRT for Wales and the rights of their nearest relatives to do so. The same information should also be given to nearest relatives, unless there are reasons not to do so. More generally, local authorities (and private guardians) should do what they can to ensure that patients understand why they are subject to guardianship and the support available from an IMHA.

Information about complaints or if the Act is not being applied appropriately

- 4.51 Patients and relevant others must be provided with information about how to make a complaint if they think that the safeguards of the Act are not being appropriately applied or they have concerns about the care and treatment being provided to them.

Chapter 5

The nearest relative

- 5.1 The role of the nearest relative is an important safeguard for patients. The 'nearest relative' for the purposes of the Mental Health Act 1983 (the Act) may not be the same person as the patient's 'next of kin'.
- 5.2 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 by the patient having an attorney or a deputy.

Identification of the nearest relative

- 5.3 Section 26 of the Act defines 'relative' and therefore who can be the 'nearest relative' for the purposes of the Act. The identity of the nearest relative may change with the passage of time, e.g. if the patient enters into a marriage or civil partnership. The Act includes additional provisions to identify the nearest relative of a child or young person.
- 5.4 The nearest relative of patients who are remanded to hospital under sections 35, 36 and 38, or who are subject to special restrictions under part 3 of the Act, can exercise fewer functions than the nearest relatives of those detained under the other parts of the Act. See Chapter 22 for guidance on restricted patients.

The role of the nearest relative

- 5.5 A nearest relative may make an application for detention under the Act for admission for assessment (section 2), for treatment (section 3), or an emergency application for admission (section 4) and for reception into guardianship (section 7).
- 5.6 The nearest relative may also request the local authority where the patient resides to consider making an application for a patient's admission to hospital. If an application for detention under the Act is then not made, the nearest relative must be given the reasons for this decision in writing.
- 5.7 The nearest relative may order the discharge of a patient detained under section 2 or 3, or on a community treatment order (CTO). The nearest relative must give 72 hours notice to the hospital managers or a person authorised by them to receive such a notification, of their intention to discharge the patient.
- 5.8 During this 72-hour period the patient's responsible clinician can provide a 'barring certificate' which can prevent discharge provided there are sufficient grounds.
- 5.9 The nearest relative may order the discharge of a person subject to section 7 guardianship orders. This will have immediate effect and cannot be 'barred' by the responsible clinician.
- 5.10 The nearest relative can, in specific circumstances, also make an application to the Mental Health Review Tribunal for Wales (MHRT for Wales) for the patient to be discharged.

- 5.11 No application for admission for treatment under section 3, or reception into guardianship under section 7, may be made by an Approved Mental Health Professional (AMHP) unless the nearest relative has been consulted. Where, consultation is not reasonably practicable or would cause unreasonable delay the AMHP may make an application. If the nearest relative objects to the application it cannot proceed. Chapter 14 of the Code gives guidance to AMHPs and others on consulting and informing the nearest relative during the assessment process.
- 5.12 The nearest relative will receive information from the hospital managers or local authority in writing about their rights of discharge and of application to the MHRT for Wales. Chapter 4 of the Code gives guidance to hospital managers and others on the legal duty to provide nearest relatives with information required by statute.
- 5.13 The duty to give information to nearest relatives will not apply to patients (whether restricted or unrestricted) who are liable to be detained on the basis of an order or direction under Part 3 of the Act (e.g. a hospital order or transfer direction), including those who have been conditionally discharged. The nearest relative of a ward of court needs the court's permission to exercise their functions under the Act (section 33(2)).

Delegation of nearest relative functions

- 5.14 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.
- 5.15 Notice of any such delegation of powers must be given to the hospital managers or the responsible local authority. The procedure for delegation is set out in the Mental Health (Hospital, Guardianship, Community Treatment and Consent to Treatment) (Wales) Regulations 2008.

Where there is no nearest relative

- 5.16 Following an application where an AMHP becomes aware the patient appears to have no nearest relative, the AMHP should advise the patient of their right to apply to the county court for the appointment of a person to act as their acting nearest relative. If the patient lacks capacity to decide to apply personally, the AMHP should apply to the county court on the patient's behalf.

Appointment of acting nearest relatives by the county court

Grounds for appointment

- 5.17 An 'acting' nearest relative can be appointed by the county court if the patient has no nearest relative within the meaning of the Act or it is not reasonably practicable to ascertain whether the patient has a nearest relative, or who that nearest relative is.

- 5.18 An 'acting' nearest relative can also be appointed by the county court if the person who the Act defines as being the nearest relative:
- is incapable of acting as such because of illness or mental disorder
 - has objected unreasonably to an application for admission for treatment or a guardianship application
 - has exercised the power to discharge a patient without due regard to the welfare of the patient or the interests of the public
 - is otherwise not a suitable person to act as such.
- 5.19 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. However, as an alternative to an order by the court, it may sometimes be enough for the actual nearest relative to delegate their role to someone else.

Who can make an application to the court?

- 5.20 An application to displace the nearest relative may be made by any of the following people:
- the patient (or if the patient lacks capacity to make the application, the patient's litigation friend⁶, who could be an advocate or carer)
 - any relative of the patient
 - anyone with whom the patient is residing (or was residing prior to admission)
 - an AMHP.

Applications for displacement to the court by AMHPs

- 5.21 Factors which an AMHP will wish to consider when deciding whether to make an application to displace a nearest relative on the above grounds include:
- if they have good reasons to think a patient considers their nearest relative unsuitable and would like them to be replaced
 - if it would not be reasonable in the circumstances to expect a patient, or anyone else, to make an application: some patients may wish to apply to displace their nearest relative but may be deterred from doing so by the need to apply to the county court
 - if it is suspected that the patient has suffered, or is at risk of suffering abuse at the hands of the nearest relative or someone with whom the nearest relative is in a relationship
 - if the patient is afraid of the nearest relative or seriously distressed by the possibility of the nearest relative being involved in their life or their care
 - if the patient and nearest relative are unknown to each other, there is only a distant relationship, or their relationship has broken down irretrievably.
- 5.22 This is not an exhaustive list. As with advance statements, a patient's wishes and feelings, as far as they are ascertainable, should be taken into consideration when making any decision with respect to the nearest relative role. It is for the court to decide what constitutes 'suitability' of a person to be a nearest relative.

⁶ In this context, a 'litigation friend' is a legal term defining someone who is appointed by the court to make decisions about a court case for an adult who lacks the mental capacity to manage their own case (or for a child). It may be a parent, a family member, friend, a solicitor, or someone who has a lasting power of attorney.

Making an application for appointment and or displacement

- 5.23 In all cases, the decision to make an application lies with the AMHP personally. However the local authority should provide clear practical guidance to help the AMHP decide whether to make an application and how to proceed. Before producing such guidance, local authorities should consult with the county court and should ensure they have access to the necessary legal advice and support.
- 5.24 When applying to displace a nearest relative, AMHPs should nominate someone to become the acting nearest relative in the event the application is successful. Wherever practicable, they should first consult the patient about the patient's own preferences and any concerns they have about the person the AMHP proposes to nominate. Although not a legal requirement, AMHPs should seek the agreement of the proposed nominee prior to an application being made. The court may not appoint the nominee if the nominee is not willing to act as the patient's nearest relative.
- 5.25 If the patient has any concerns that any information given to the court about their views on the suitability of the nearest relative may have implications for their own safety, an application can be made to the court seeking its permission not to make the current nearest relative a party to the proceedings. The reasons for the patient's concerns should be set out clearly in the application.
- 5.26 Hospital managers should provide support to detained patients to enable them to attend the court, if they wish, subject to the patient being granted leave under section 17 for this purpose.
- 5.27 If, exceptionally, the court decides to interview the patient (as the applicant), the court has the discretion to decide where and how this interview takes place and whether it should take place in the presence of, or separate from, other parties. The patient should be fully supported in this, including through the provision of advocacy to support them.

Effect of an application

- 5.28 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.
- 5.29 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.
- 5.30 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

- 5.31 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.
- 5.32 Where the court has made an order to displace the nearest relative, under section 29 of the Act, on the grounds that:
- they have unreasonably objected to an application being made
 - they have used (or were likely to use) their powers of discharge without due regard to the welfare of the patient or the interests of the public.
- 5.33 The displaced nearest relative has a right to make an application for the discharge of their relative to the MHRT for Wales within 12 months, beginning with the date of the order, and in any subsequent period of 12 months during which the order continues in force.

Chapter 6

Independent mental health advocacy

- 6.1 This chapter explains the role of Independent Mental Health Advocates (IMHAs) and other people's responsibilities in making a patient aware of the help an IMHA provides.
- 6.2 The scope of the independent mental health advocacy scheme was expanded in Wales, by Part 4 of the Mental Health (Wales) Measure 2010 (the Measure), to patients detained under certain short term sections of the Mental Health Act 1983 (the Act) and to informal (i.e. non-detained) patients receiving assessment or treatment for mental disorder in hospitals in Wales.
- 6.3 Part 4 of the Measure makes provision for the expanded IMHA scheme in Wales by inserting new sections into the Act. The definition of 'mental disorder', relied on for the purposes of these new sections, is the definition of 'mental disorder' provided at section 1(2) of the Act i.e. "any disorder or disability of the mind".

The role of the independent mental health advocate (IMHA)

- 6.4 The IMHA provides support to qualifying patients to ensure they understand the Act and their own rights and safeguards. This must include support in obtaining information about and understanding 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, and
 - the requirements of the Act which apply to treatment.
- 6.5 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 the patient in accessing information, understanding better what is happening and what is planned, and understanding better the options available to them
 - support the patient in exploring options, making better-informed decisions and in engaging with the development of their care and treatment plan
 - support the patient to ensure they are valued for who they are, and
 - support the patient to counteract any actual or potential discrimination.
- 6.6 IMHAs may support patients 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 community treatment order 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.

6.7 The involvement of an IMHA will not affect a patient's legal rights to seek independent advice from a lawyer nor does it affect any entitlement to legal aid.

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

Providing support to qualifying patients who cannot instruct the advocate

- 6.9 Wherever possible, IMHAs will take instruction directly from the patient whom they are supporting. Where this is not possible because the patient lacks the capacity to instruct an advocate, for whatever reason, the role of the IMHA is to:
- support the patient to participate as fully as possible in any relevant decision
 - ascertain what alternative courses of action are available in relation to the patient, and
 - ensure the patient's rights are respected.
- 6.10 An IMHA should use his or her own judgement in deciding whether a qualifying patient has the capacity to give them instructions about a particular issue.

Patients who are eligible for IMHA services (qualifying patients)

Eligible patients

- 6.11 Individuals are eligible for independent mental health advocacy services if they fall within the meaning of a Welsh qualifying compulsory patient (set out in section 130I of the Measure) or the meaning of a Welsh qualifying informal patient (set out in section 130J of the Measure).

Welsh qualifying compulsory patients

- 6.12 A Welsh qualifying compulsory patient is a person who is:
- detained or liable to be detained under the Act, which includes patients on leave of absence from hospital in a hospital or registered establishment situated in Wales
 - conditionally discharged
 - subject to guardianship and the responsible local authority is situated in Wales; or
 - subject to a community treatment order (CTO) and the responsible hospital for them is situated in Wales.
- 6.13 This includes patients who are:
- detained for assessment on the basis of an emergency application (section 4); or
 - detained under the “holding powers” in section 5 of the Act.
- 6.14 It does not include a person detained in a place of safety under section 135 or 136 of the 1983 Act.
- 6.15 Other patients are eligible as Welsh qualifying compulsory patients if they are:
- being considered for a treatment to which section 57 applies whether they are detained under the Act or not; or
 - under 18 and being considered for electro-convulsive therapy (ECT) or any other treatment to which section 58A applies, again whether they are detained under the Act or not.
- 6.16 Patients who qualify because they are being considered for one of these treatments remain eligible until the treatment is finished (or stopped), or it is decided that they will not be given the treatment for the time being.

Welsh qualifying informal patients

- 6.17 A Welsh qualifying informal patient is a person who is:
- an in-patient in a hospital or registered establishment situated in Wales
 - is receiving treatment for, or assessment in relation to, mental disorder at that hospital or registered establishment; and
 - not subject to powers under the Act which would render them liable to be detained.

In-patients with a learning disability

- 6.18 Individuals with a learning disability who are receiving assessment, care or treatment for their mental disorder, whilst an in-patient, qualify for support from an IMHA.

Patients’ rights to an IMHA

- 6.19 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 care and 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 5)
- 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 revised
- when a meeting is held to discuss after-care.

6.20 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. However, any professional discussing the possibility of such treatment with a patient should check whether the patient is aware that they are eligible to receive IMHA support and if not should, where appropriate, inform them.

Visits and Interviews

- 6.21 IMHAs must comply with any reasonable request to visit and interview a Welsh qualifying compulsory patient, if the request is made by:
- the patient
 - someone the IMHA believes to be the patient's nearest relative
 - the patient's responsible clinician
 - an approved mental health professional (AMHP)
 - a registered social worker who is professionally concerned with the patient's care, treatment or assessment
 - the managers of the hospital or registered establishment (or a person duly authorised by them) where the patient is liable to be detained, or
 - the patient's attorney or deputy
- 6.22 In respect of a Welsh qualifying informal patient, the duty on IMHAs to visit and interview the patient is the same, but is only engaged if the request is made by:
- the patient
 - the managers of the hospital or establishment where the patient is an in-patient (or a person duly authorised by them)
 - someone the IMHA believes to be the patient's carer
 - the patient's attorney or deputy, or
 - a registered social worker who is professionally concerned with the patient's care, treatment or assessment.

- 6.23 In this context, a carer is an individual who provides (or intends to provide) a substantial amount of care on a regular basis for the patient. This meaning does not include any individual who provides, or intends to provide, this care because of a contract of employment, other type of contract, or as a volunteer for a body (whether or not incorporated).
- 6.24 In relation to donees and deputies:
- the attorney has a lasting power of attorney (under section 9 of the Mental Capacity Act 2005) created by the patient and is acting within the scope of his/her authority and in accordance with that Act when making the request
 - the deputy is appointed for the patient by the Court of Protection (under section 16 of the Mental Capacity Act 2005) and is acting within the scope of his/her authority and in accordance with that Act.
- 6.25 In all cases, although the IMHA is required to comply with any reasonable request to visit and interview the patient, the patient does not have to accept help from an IMHA if they do not want it.

Providing information about the service

The ‘responsible person’

- 6.26 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:

Type of patient	Steps are to be taken by	As soon as practicable after
Detained patients	the managers of the hospital in which the patient is liable to be detained	the patient becomes liable to be detained
Guardianship patients	the responsible local authority	the patient becomes subject to guardianship
CTO patients	the managers of the responsible hospital	the patient becomes a CTO patient
Conditionally discharged patients	the patient’s responsible clinician	the patient is conditionally discharged
Informal patients receiving particular treatments (under section 57 or 58A)	the doctor or approved clinician who first discusses with the patient the possibility of them being given the section 57 or 58A treatment in question	this discussion (or during it)
Informal patients	the managers of the hospital to which the patient has been admitted	the patient becomes an in-patient

The role of the 'responsible person'

- 6.27 The responsible person must ensure that they tell the patient, both verbally and in writing, that support is available to them from an IMHA; and how they can obtain that support.
- 6.28 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.
- 6.29 Further guidance on giving information to patients and their nearest relative is given in Chapter 4 of the Code.
- 6.30 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.
- 6.31 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.
- 6.32 Where a patient lacks capacity, or cannot, for any reason clearly say whether or not they would like an IMHA, the responsible person and other staff working with the patient should consider how an IMHA might be involved and whether or not the patient might benefit from the involvement of an IMHA. In doing so, staff should pay particular attention to the views of people supporting the patient and any views the patient has previously expressed.
- 6.33 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.
- 6.34 If a patient has been fully informed about IMHA support, and chooses not to involve an advocate in their case, the responsible person should:
- 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.

Information for nearest relatives, donees (attorney) or deputies (sections 130K and 130L)

- 6.35 The responsible person for a Welsh qualifying compulsory patient, must also take whatever steps are practicable to give a copy of the written information to:
- the person they think is the patient's nearest relative
 - a donee of a lasting power of attorney (under section 9 of the Mental Capacity Act 2005) created by the patient
 - a deputy appointed for the patient by the Court of Protection (under section 16 of the Mental Capacity Act).

- 6.36 The responsible person for a Welsh qualifying informal patient, must also take whatever steps are practicable to give a copy of the written information to:
- the person they think is the patient's carer
 - a donee of a lasting power of attorney (under section 9 of the Mental Capacity Act 2005) created by the patient
 - a deputy appointed for the patient by the Court of Protection (under section 16 of the Mental Capacity Act 2005).
- 6.37 In all cases this information should be given unless the patient requests otherwise. In the case of an attorney or deputy, the information should only be given where the scope of the attorney or deputy's authority includes matters relating to the care and treatment of the patient.
- 6.38 The information can be given to the nearest relative or carer (as the case may be), attorney and/or deputy either when it is given to the patient or within a reasonable time afterwards.
- 6.39 The duty to give information to nearest relatives will not apply to patients (whether restricted or unrestricted) who are liable to be detained on the basis of an order or direction under Part 3 of the Act (e.g. a hospital order or transfer direction), including those who have been conditionally discharged. It does apply to patients subject to guardianship orders under Part 3, patients who are considering treatment under sections 57 or 58A of the Act, and to CTO patients who were formerly detained under Part 3.

IMHAs and patient confidentiality

- 6.40 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.
- 6.41 In most circumstances the IMHA will tell the patient all the information they have 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 - the rights of IMHAs to interview professionals and other persons and look at records

- 6.42 Patients should have access to a telephone to speak to an IMHA in private.
- 6.43 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.

- 6.44 It is good practice⁷ 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.
- 6.45 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
 - continue the meeting on, for example, an open area of the ward, with the patient's consent.
- 6.46 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 and treatment 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.
- 6.47 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.
- 6.48 Information on independent advocacy should be displayed in public areas, on wards and community facilities, as well as in formats which make information accessible to patients, their carers and others, such as leaflets.
- 6.49 All relevant staff must
- be 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
 - know when they need to give information about an IMHA
 - know how to access an IMHA
 - record an IMHA's involvement in a case and any information they provide to support decision-making
 - ensure that 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
 - give access to the IMHA of any relevant health or social care records when asked under section 130B(3) of the Act
 - ensure the IMHA gets information about changes that may affect the support and representation they provide, and
 - ensure all relevant people are informed when an IMHA is working to support a qualifying patient

⁷ <http://gov.wales/docs/dhss/publications/111222advocacyen.pdf>

Access to records

6.50 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) a local authority about the patient,

as long as:

- 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 an attorney 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.

6.51 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.

6.52 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.

Interface with independent mental capacity advocacy

6.53 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.

6.54 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 the Act, for example as a condition of leave of absence, CTO or conditional discharge from hospital or a requirement imposed by a guardian.

6.55 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 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 local health boards and local authorities must provide under section 117 of the Act for people who have been detained under certain sections of the Act.

Chapter 7

Attorneys and deputies

7.1 This chapter gives guidance on the effect of the Mental Health Act 1983 (the Act) on the powers of donees of lasting power of attorney (attorneys) and court appointed deputies under the Mental Capacity Act 2005 (MCA).

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

7.2 The Act does not prevent detained patients creating a new Lasting Power Attorney (LPA) under the MCA provided they have the capacity to do so. The fact that a person is subject to the Act does not affect the validity of any LPA, nor the scope of the authority of an attorney or deputy (or the Court of Protection), to make decisions on the person's behalf. The Court of Protection may appoint a deputy to take decisions for such patients, when they lack the capacity to make the decisions themselves.

7.3 Attorneys and deputies are therefore able to take any decisions about the welfare, property or affairs of a person subject to the Act that they are 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 Act (including neurosurgery for mental disorder and other treatments under section 57), and
- they will not be able to make decisions about where a person subject to guardianship is to live, nor make other decisions which a guardian has a legal right to make (see Chapter 30).

7.4 In certain cases, conditions can be imposed on patients subject to the Act in relation to leave of absence from hospital; community treatment orders (CTOs) or conditional discharge. If an attorney or deputy takes a decision on the patient's behalf which goes against one of these conditions, the patient will be considered to have breached the condition. In CTO and conditional discharge cases, this might result in the patient's recall to hospital being considered.

7.5 Attorneys and deputies may exercise certain patients' rights under the Act on their behalf, if they have the relevant authority to do so and the patients lack the capacity to do so themselves. In particular, attorneys and deputies may be able to exercise patients' various rights to apply to the MHRT for Wales or the hospital managers for discharge from detention, guardianship or a CTO.

7.6 Attorneys and deputies may not exercise the rights of nearest relatives, unless they are themselves the nearest relative.

7.7 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 the role of the nearest relative is given in Chapter 5.

- 7.8 Clinicians and others involved in the assessment and/or treatment of patients under the Act should take reasonable steps to try to find out if the person has an attorney or deputy.
- 7.9 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 CTO patients, attorneys and deputies should make themselves known to the responsible hospital.
- 7.10 Attorneys and deputies may find it helpful to use the Act administrators' office as a useful first point of contact in relation to patients detained or subject to a CTO.

Chapter 8

Privacy, dignity and safety

- 8.1 An environment which ensures privacy, dignity and safety for patients is essential to provide a therapeutic environment which maximises independence and enables recovery. The use of therapeutic interventions, positive engagement and the use of a therapeutic alliance is critical in all aspects of care, treatment and support. Services should adopt a zero tolerance approach to any form of physical or verbal abuse towards patients and carers, and all staff must be pro-active in ensuring it does not occur.

Balancing privacy, dignity and safety

- 8.2 Providing a safe environment does not mean a person's privacy and dignity cannot or should not be maintained.
- 8.3 Article 8 of the European Convention on Human Rights (ECHR) requires public authorities to respect a person's right to a private life. Article 8 has particular importance for people detained under the Act.
- 8.4 Article 2 of the ECHR provides that everybody's right to life is protected by law. The Equality and Human Rights Commission⁸ report interpreted this as "requiring the provision of a safe and respectful environment to minimise risk for vulnerable individuals in detention".
- 8.5 Article 14 of the ECHR prohibits discrimination and has the effect of ensuring that the other articles are applied regardless of "sex, race, colour, language, religion, political or other opinion, national or social origin, association with a national minority, property, birth or other status".
- 8.6 Compliance with Articles 2, 8 and 14 requires that hospital staff carefully balance issues of privacy and dignity whilst ensuring safety.⁹
- 8.7 Where concerns for the safety of an individual or others require an individual's rights or privacy to be curtailed this should be proportionate to the degree of risk assessed, for as short a period as is possible and should be undertaken in such a way that the patient's dignity is maintained.
- 8.8 It may also be necessary to have in place arrangements for protecting patients and others from people whose mere presence on a ward may pose a risk to their health or safety. Anti-bullying and safeguarding policies should be in place on all wards and reviewed regularly.

⁸ Equality and Human Rights Commission report "Preventing deaths in detention of Adults with Mental Health Conditions"

⁹ The Equality and Human Rights Commission has developed a human rights framework for agencies that may lawfully detain citizens. This Framework can be used to audit policies and procedures designed to safeguard patient's safety privacy and dignity. The Framework is available at <http://www.equalityhumanrights.com/publication/human-rights-framework-adults-detention> .

Blanket restrictions

- 8.9 In this chapter, the term ‘blanket restrictions’ refers to rules or policies that have the effect of restricting patients’ liberty and other rights and which are routinely applied to all patients, or to classes of patients, or within a service without individual risk assessments to justify their application.
- 8.10 Blanket restrictions include restricting a patient’s contact with people and information sources outside the hospital. This may be through restrictions being placed upon access to the internet, mobile telephones incoming or outgoing mail, visiting hours, access to money or the ability to make personal purchases, or taking part in preferred activities.
- 8.11 Blanket restrictions should be avoided unless they can be justified as a necessary and proportionate response to risks identified for particular individuals. Restrictions should never be introduced or applied in order to punish or humiliate, and should only be applied for as long as necessary.
- 8.12 The impact of a blanket restriction on each patient should be considered and documented in the patient’s record. They should only be implemented where expressly authorised by the hospital managers on the basis of the organisation’s policy and subject to local accountability and governance arrangements.
- 8.13 Within secure service settings some restrictions may be part of broader security measures associated with an individual’s identified need for enhanced security in order to manage the risk they pose to themselves, other patients, staff and members of the public.
- 8.14 The application of security measures should be based on the needs of, and identified risks for, individual patients, and impose the least restriction possible. Where individual patients in secure services are assessed as not requiring certain security measures, they should not apply to the individual patient concerned where this will not compromise the overall security of the service. If this is not possible, consideration should be given to whether the patient should receive their care and treatment in a service that operates under conditions of lesser security.

The use of locked doors

- 8.15 A blanket locked door policy which affects all patients in a hospital or on a ward could, depending on its implementation, amount to a restriction or a deprivation of liberty.
- 8.16 A patient’s Article 8 rights should be protected by ensuring a locked door policy imposes only proportionate restrictions on their contact with family, friends, employers or other social or religious affiliations which can be justified as being in the interests of the health and safety of the patient or others. The hospital managers should have a locked door policy which conforms to the guiding principles of the Code.
- 8.17 It is unlikely that there will be a deprivation of liberty if an informal patient, who has capacity to consent to being admitted is informed of the locked door policy and consents to being informally admitted and remaining on the ward under these conditions.

- 8.18 However the safety of informal patients, who may be at risk of harm if they were to leave a clinical environment without supervision should be ensured by adequate staffing levels, positive therapeutic engagement and good observation, not simply by locking the doors of the unit or ward.
- 8.19 The patient should be told who they can speak to if they wish to leave and must be able to leave at any time, unless they are being detained using the holding powers under section 5 of the Act or an application for detention is being made.
- 8.20 Local policies for locking clinical areas should be explained to each patient, and if appropriate their family and carers, on admission and throughout their stay as a patient.
- 8.21 Services should consider how to reduce the potential negative psychological and behavioural effects of having locked doors, whether or not patients are formally detained.

The use of personal mobile telephones computers and tablets for telephone, e-mail and internet access

- 8.22 Communication with family and friends, employers or other social or religious affiliations can be integral to a patient's care and recovery.
- 8.23 When patients are admitted, staff should assess the risk of patients having access to mobile phones and other electronic devices and this should be detailed in the patient's care and treatment plan. Patients should be able to use such devices unless it is deemed inappropriate or unsafe for them to do so, access should only be limited or restricted in certain risk-assessed situations. Particular consideration should be given to people who are deaf and who have specific communication needs.
- 8.24 Generally, hospitals should make every effort to support the patient in making and maintaining contact by telephone, mobile, e-mail or social media. Providers should also ensure access to a coin or card operated telephone.
- 8.25 Hospital managers should have a policy for the possession and use of mobile telephones and other mobile devices (such as laptops and tablets). When drawing up their policy, hospital managers should bear in mind the following points.
- Most people have mobile telephones and/or other mobile computing devices and it is unlikely to be appropriate to impose a blanket restriction banning their use except in units specifically designed to provide enhanced levels of security in order to protect the public.
 - Different considerations may apply to different locations within a hospital. There may be valid reasons for banning or limiting the use of mobile devices in some parts of the premises because, for example, of the potential risk of interference with medical and other electronic equipment which could adversely affect the health of patients or because of the risk of intrusion into the privacy of others.
 - The difficulty in identifying when camera functions and other recording functions are being used may be an additional reason for restricting the areas in which mobile phones and computing devices may be used.

- Each patient should expect a peaceful environment, and constant interruptions from ringing telephones can have a potentially anti-therapeutic effect. It may be reasonable to require mobile devices to be switched off except where their use is permitted and to restrict their use to designated areas to which patients have access and for example silent and vibrate mode to be used at night, in therapy sessions or other meetings.
 - The hospital's policy on the use of mobile devices should be enforceable, e.g. it may be appropriate in certain circumstances to confiscate devices from patients who consistently refuse to comply with the rules.
 - There is also potential for device chargers to pose a ligature risk and all efforts should be made to ensure patients have access to short charger cables. If this is not possible there may be occasions where charging of devices may need to be undertaken in a secure area. Any decision to prevent the use of cameras or to confiscate a device or its charger should be fully documented and be subject to regular review.
 - There should be rules on when staff and visitors may bring mobile devices into a secure setting.
- 8.26 Staff should be fully informed of the hospital's policy, and steps should be taken to communicate it to all patients, carers, families and visitors by providing it in a format and language the patient can understand.
- 8.27 Managers should also develop policies on access by patients to e-mail and internet facilities by means of the hospital's IT infrastructure. This guidance should cover the availability of such facilities and rules prohibiting access to illegal or what would otherwise be considered inappropriate or counter therapeutic material, e.g. pornography, gambling or websites promoting violence, abuse or hate.
- 8.28 The guidance should also cover the appropriate use of social media including reminding patients of the implications of breaching patient and staff confidentiality. Where wards contain coin-operated and card-operated telephones, hospital managers should ensure patients are able to use them without being overheard. Some patients may need help to make a phone call, but should still be given privacy during the call.
- 8.29 The principle that should underpin hospital or ward policies on the use of devices is that freedom to communicate with people outside the hospital should be maintained as far as possible and where it is necessary to place restrictions on their use this should be to the minimum extent necessary.

Private property

- 8.30 Hospitals should provide adequate storage in lockable facilities (with staff override) for the personal possessions which patients may keep with them on the ward and for the secure central storage of anything of value or items which may pose a risk to the patient or to others, e.g. jewellery and razors. Information about arrangements for storage should be easily accessible to patients on the ward.

Hospitals should compile an inventory of what has been allowed to be kept on the ward and what has been stored and give a copy to the patient. The inventory should be updated when necessary. Patients should always be able to access their private property on request if it is safe to do so.

Separate facilities for men and women

- 8.31 All sleeping and bathroom areas should be segregated, and patients should not have to walk through an area occupied by another sex to reach toilets or bathrooms. Separate male and female only toilets and bathrooms should be provided, as should separate day rooms.

Provision of separate facilities for reasons other than gender segregation

- 8.32 Arrangements for the provision of sleeping, toilet and bathing facilities should consider the patient's history and personal circumstances, including:
- any history of sexual or physical abuse and the risks of trauma
 - the particular needs of transgender patients
 - cultural or religious preferences
 - mothers and babies during and after pregnancy
 - other health conditions
 - physical disabilities
 - learning disabilities
 - sensory impairment.
- 8.33 If, in an emergency, it is necessary to treat a patient in an environment that does not fully meet their needs, then senior management should be informed, steps should be taken to rectify the situation as soon as possible, and staff should protect the patient's privacy and dignity against intrusions – particularly in sleeping accommodation, toilets and bathrooms.

Personal and other searches

- 8.34 Hospital managers should ensure there is an operational policy concerning the searching of detained patients, their belongings and surroundings. Policies should address the potential to search informal patients and visitors. The policy should be communicated to patients and visitors in a format and language they understand.
- 8.35 The policy should be based on the following principles:
- to create and maintain a therapeutic environment in which treatment may take place, ensure the security of the premises and the safety of patients, staff and the public
 - that hospital staff are aware of the legal authority to carry out any search
 - searching should be proportionate to the identified risk and should involve the minimum possible intrusion into the individual's privacy, and
 - all searches will be undertaken with due regard to and respect for the person's dignity and privacy.

8.36 The policy may extend to the routine and random searching of detained patients, if necessary without their consent, but only in exceptional circumstances. For example, such searches may be necessary if the patients detained in a particular unit tend to have dangerous or violent propensities which mean they create the need for additional security.

Conducting personal and other searches

8.37 The consent of the person should always be sought before a personal search or a search of their possessions. If consent is given, the search should be carried out with regard to ensuring the maximum dignity and privacy of the person.

8.38 Consent obtained by means of a threat, intimidation or inducement is likely to render the search illegal. Any person who is to be searched or whose possessions are to be searched should be informed they do not have to consent.

8.39 Where personal safety or the safety of others requires, the search may have to be undertaken without consent. Searches should not be delayed if there is reason to think the person is in possession of anything that may pose an immediate risk to their own safety or the safety of others

8.40 If a detained patient refuses consent or lacks capacity to consent to the search, their responsible clinician or, failing that, another senior clinician with knowledge of the patient's case, should be contacted without delay, so that any clinical objection to searching by force may be raised. If a search is considered necessary, despite the patient's objections, and there is no clinical objection to one being conducted, the search should be carried out. The search policy should set out the steps to be taken to resolve any disagreement or dispute where there is a clinical objection to a search.

8.41 Where a patient physically resists being searched, physical intervention should normally only proceed on the basis of a multi-disciplinary assessment, unless it is urgently required. If force has to be used, it should be the minimum necessary that is proportionate to the likelihood and seriousness of harm that could be suffered if the search were not performed. A post-incident review should follow every search undertaken where consent has been withheld.

8.42 A person being searched or whose possessions are the subject of a search should be kept informed of what is happening and why. When needed, the services of an interpreter should be sought, if practicable. The specific needs of people with impaired hearing or a learning disability and those of children and young people should be considered.

8.43 A personal search should be carried out by a member of the same sex, unless necessity dictates otherwise. Another member of the hospital staff should be present during a search and must be present if it is not possible to conduct a same-sex search. The search should be carried out in a way that minimises any breach of a person's right to privacy and seeks to maintain the patient's dignity and respects issues of gender, culture and faith.

8.44 Where a patient's belongings are removed during a search, the patient should be told why they have been removed, given a receipt for them, told where the items will be stored, and when they will be returned.

- 8.45 A comprehensive record of every search, including the reasons for it should be made. There should be support for patients and for staff who are affected by the process of searching. This may be particularly necessary where a personal search has had to proceed without consent or has involved physical intervention.
- 8.46 Staff involved in undertaking searches should receive appropriate instruction and refresher training. The exercise of powers of search should be audited regularly and the outcomes reported to the hospital managers.

Hospital accommodation offering conditions of enhanced security

- 8.47 Some detained patients may present a particular risk to themselves or to others and therefore need to be accommodated in wards or units specifically designed to offer enhanced levels of environmental security. For patients detained under Part 3 of the Act, this may be a requirement of a court or of the Secretary of State for Justice, but in many cases the decision will lie primarily with the patient's responsible clinician.
- 8.48 When considering whether patients should be placed in, moved to or remain in such a ward or unit, responsible clinicians should, in consultation with the multidisciplinary team, ensure:
- they have carefully weighed the patient's individual circumstances and the degree and nature of any risks identified, and
 - they have assessed the relative clinical considerations of placing the patient in an environment with enhanced environmental security, in addition to or as opposed to providing care by way of procedural or relational security by means of intensive staffing.
- 8.49 Treatment in conditions of enhanced security should last for the minimum period. In the case of restricted patients, it will be necessary to seek the consent of the Secretary of State for Justice for a transfer a patient to another hospital or, where the patient's detention is restricted to a particular unit, for a move within the same hospital.
- 8.50 Managers of hospitals offering accommodation with enhanced levels of security should ensure:
- accommodation specifically designated for this purpose has adequate staffing, and
 - written guidelines are drawn up, setting out the categories of patient for whom it is appropriate to use environmentally secure conditions and those for whom it is not appropriate.

Environmental security in other hospital accommodation

- 8.51 Hospital managers will need to consider any arrangements necessary to protect the safety of patients who are not subject to enhanced security. Patients admitted to acute wards, whether detained or informal, will have complex and specific needs. Where restrictions are placed on patients they must be necessary, proportionate and lawful. The reasons for the imposition of restrictions must be explained to the patient.

- 8.52 The use of therapeutic interventions, positive engagement, the use of a therapeutic alliance and regular access to outside space are important factors in encouraging patients to remain on the ward and in minimising a culture of containment emerging in clinical environments.
- 8.53 The use of technology to manage entry and exit from clinical areas and to ensure the safety of patients and of others should be considered. Where managing entry and exit by means of locked external doors (or other physical barriers) is considered to be an appropriate way to maintain safety, this should be reviewed regularly to ensure there are clear benefits for patients and that it is not being used for the convenience of staff. Clinical staff and managers should regularly review and evaluate the mix of patients, staffing levels and the skills mix and training needs of staff.
- 8.54 A written policy that sets out precisely what the ward arrangements are and how patients can exit the ward, if they are not liable to detention, should be drawn up and given to all patients on the ward. The policy should be explained to patients on admission, throughout their stay and to their visitors. In addition to producing the policy in Welsh and English, providers may need to consider drawing it up in other languages if they are in common use in the local area.

Chapter 9

Views expressed in advance

- 9.1 This chapter gives guidance on views expressed by patients about their preferences for what they would, or would not, like to happen if particular situations arise. Views expressed in advance strengthen patients' participation in their care and treatment.
- 9.2 This guidance distinguishes between advance decisions made under the Mental Capacity Act 2005 to refuse treatment, and other statements of views, wishes and feelings that patients make in advance.

Advance decisions under the Mental Capacity Act 2005

- 9.3 The Mental Capacity Act 2005 (MCA) states people who have the capacity to do so, and who are at least 18 years old, may make an advance decision to refuse specified treatment and such a decision will have effect at a time when they no longer have capacity to consent to that treatment.
- 9.4 If a valid and applicable advance decision exists, it has the same effect as if the patient has capacity and makes a contemporaneous decision to refuse treatment. The MCA Code of Practice gives detailed information on what constitutes a valid advance decision.
- 9.5 Clinicians must always start from the assumption that a person had the mental capacity to make the advance decision at the time when the advance decision was made. However, if a clinician is not satisfied the person had capacity at the time they made the advance decision, or if there are genuine doubts about its validity or applicability, they may treat, or continue to treat, the patient without incurring any liability, so long as they comply with the other requirements of the MCA, including the duty to act in the patient's best interest.
- 9.6 In certain circumstances, particularly in relation to the risk the patient may present to themselves or others, the Act allows patients to be given medical treatment for their mental disorder without their consent. This applies equally when someone has the capacity to refuse treatment and in circumstances where, having lost that capacity, they have a valid and applicable advance decision to refuse the treatment (see Chapters 24 and 25).
- 9.7 If a patient who lacks capacity is on a community treatment order (CTO) and 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, except in emergency circumstances where specific criteria are met.
- 9.8 Even where clinicians may lawfully treat a patient compulsorily under the Act, they should, where practicable, and as they would when someone does have capacity, try to comply with the patient's wishes as expressed in an advance decision. They should, for example, consider whether it is possible to use a different form of treatment not refused by the advance decision. If it is not possible to do this, they should explain why to the patient so far as it is practicable.

- 9.9 In all other circumstances (i.e. where a patient cannot be given treatment without consent), clinicians must follow the advance decisions made by their patients.
- 9.10 The MCA Code of Practice also gives more information on what specific additional requirements for the way advance decisions to refuse life-sustaining treatment must be documented, the effect they have and when they are valid and applicable.

Advance statements of wishes and feelings

- 9.11 There may be times when patients who are subject to compulsory powers under the Act are unable or unwilling to express their views, or to participate as fully as they otherwise would in decisions about their care or treatment. In such cases, patients' past wishes and feelings – so far as they are known – may take on a greater significance.
- 9.12 All patients should be enabled to make advance statements if it is likely they may need treatment in the future. Advance statements should be regularly reviewed with the patient. An IMHA and others may be helpful in supporting a patient to do this. Enabling patients to set out their wishes in advance is a way for patients' expertise and lived experience in the management of their mental disorder to be central to recovery and the maintenance of independence.
- 9.13 Even though an advance statement does not meet the criteria to be treated as a valid and applicable advance decision under the MCA, this does not mean the statement can be ignored. It should 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.
- 9.14 The advance statement may include wishes about a variety of issues, including medical treatment, how families and carers should be involved, the steps that should be taken in emergencies and what should be done if particular situations occur, e.g. wishing to be given a particular type of treatment, or to not be restrained in a particular way. In most cases, the views of the nearest relative and other family members and relevant others will be an integral part of the care and treatment being provided to the patient.
- 9.15 Whenever expressing a wish about their future treatment, the patient should be encouraged to identify the circumstances and reasons 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.
- 9.16 Patients' expressions of their wishes about how they should be treated should always be included in their case notes so that they are accessible by all professionals involved in their care and treatment. Similarly, good communication between primary and secondary care services should ensure the patient's views are known and understood.

- 9.17 An advance statement will only be relevant where a patient does not have capacity or cannot be consulted at the time when the treatment is proposed. However, even where a patient has made an advance statement and lacks capacity at the time when the treatment is proposed, he or she should, as far as is practicable, be involved in making decisions about his or her care and treatment.
If the professional judges that, at the time the wish was expressed, the patient lacked capacity to understand, this should also be recorded in the current notes along with the professional's reason.
- 9.18 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. Patients should be made aware that expressing their preference for a particular form of treatment for care in advance does not legally compel professionals to meet that preference.

Children

- 9.19 Advance statements made by children 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 that the issue arises. 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 that are set out in an advance statement should be followed.

Chapter 10

Confidentiality and information sharing

- 10.1 This chapter deals with issues about confidentiality and information sharing which arise in connection with the Mental Health Act 1983 (the Act). Guidance is given on the sharing of information by professionals and agencies.

Sharing information

- 10.2 Except where the Act itself says otherwise, the law on confidentiality is the same for patients subject to the Act as it is for any other patients. In Wales the Wales Accord on the Sharing of Personal Information¹⁰ applies. A brief summary of the most fundamental points of the general law is given below. These points are relevant to patients of all ages, although there are some additional considerations in relation to children and young people (see Chapter 19).

Confidentiality

- 10.3 There are particular considerations for healthcare professionals to whom the common law duty of confidentiality applies. The duty arises when one person discloses information to another in circumstances where it is reasonable to expect the information will be held in confidence.
- 10.4 There are circumstances when it is justifiable to share otherwise confidential patient information with people outside the immediate team treating a patient. Various public agencies may be involved in the provision of services to patients who are subject to compulsory measures under the Act, for example housing and social services and justice agencies.
- 10.5 Before considering the disclosure of confidential patient information, the individual's consent should normally be sought.
- 10.6 Professionals should be clear about how the sharing of such information could benefit the patient or help to prevent serious harm to others. However, the common law does not normally permit disclosure of confidential patient information solely in the patient's own interests if they have capacity to consent to the disclosure but refuse to do so. A person's right to have their privacy respected is protected by Article 8 of the European Convention on Human Rights (ECHR). Advocates and advice services can support patients in helping them decide what information should be shared.
- 10.7 If a person lacks the capacity to consent to the disclosure of confidential information, it may be acceptable and appropriate to disclose the information in the person's best interests. Healthcare professionals should use their professional judgement to determine what is in the patient's best interest. This should include consultation with colleagues, and the organisation's Caldicott Guardian and take into account the patient's previously expressed wishes and views. Independent sector providers of NHS-funded services must also have a Caldicott Guardian.

¹⁰ <http://www.waspi.org/>

- 10.8 Confidential patient information should only be disclosed:
- with the patient's consent
 - if there is a specific legal obligation or authority to do so, or
 - where there is an overriding public interest in disclosing the information.
- 10.9 Those disclosing confidential information should be confident that it is necessary and proportionate to do so. Care must also always be taken to ensure any information disclosed is accurate.
- 10.10 Where confidential patient information is involved, public interest justifications for overriding confidentiality could include (but are not limited to) protecting other people from serious harm, including psychological harm and preventing serious crime.
- 10.11 Information sharing between professionals can contribute to and support the care and treatment of patients and help to protect people from harm. Chapter 34 describes in detail care and treatment planning and the involvement of families, carers and relevant others.
- 10.12 Sharing information with families, carers and relevant others will usually contribute to and support the patient's care and treatment. Where patients have capacity to agree and are willing to do so, families, carers and relevant others should be given information about the patient's progress. A patient's agreement to such disclosure must be freely given. In the case of patients detained under Part 3 of the Act, people with a valid interest may include victims and the families of victims (see Chapter 40).

Disclosure of confidential patient information for the purposes of the Act

- 10.13 The Act creates a number of situations where confidential information about patients may be legally disclosed, even if the patient does not consent. These include:
- reports to the Tribunal when a patient's case is to be considered
 - reports to the HIW in relation to patients who have been treated on the basis of a certificate issued by a second opinion appointed doctor (SOAD), and
 - reports to the Secretary of State for Justice on restricted patients.
- 10.14 The Act also gives certain people and bodies – including HIW, SOADs and (in certain circumstances) independent mental health advocates (IMHAs) – the right to access records relating to patients.
- 10.15 In addition, where the Act allows steps to be taken in relation to patients without their consent, confidential patient information may be disclosed only to the extent it is necessary to take those steps. For example, confidential patient information may be shared for:
- medical treatment which may be given without a patient's consent under the Act
 - safely and securely transporting a patient to hospital (or anywhere else) under the Act
 - finding and returning a patient who has absconded from legal custody or who is absent without leave, or

- transferring responsibility for a patient who is subject to the Act from one set of people to another (e.g. where a detained patient is to be transferred from one hospital to another, or where responsibility for a patient is to be transferred between Wales and another jurisdiction)
- references by Welsh Ministers to MHRT for Wales.

Limitations on sharing information with families, carers and relevant others

- 10.16 Asking families, carers, and relevant others about a patient without that patient's consent need not involve any breach of confidentiality, provided the person requesting the information does not reveal any confidential personal information about the patient which the family member, carer or relevant others being asked would not legitimately know.
- 10.17 Apart from information which must be given to nearest relatives, the Act does not create any exceptions to the general law about disclosing confidential patient information to families, carers and relevant others.
- 10.18 Carers cannot be told a patient's particular diagnosis or be given any other confidential personal information about the patient unless the patient consents or there is another basis on which to disclose it in accordance with the law. However, carers, including young carers, should always be offered information which may help them understand the nature of mental disorder generally, the ways it is treated and the operation of the Act.
- 10.19 Families, carers, and relevant others have a right to expect any personal information about themselves, or any information about the patient which they pass on to professionals in confidence, will be treated as confidential in all but exceptional circumstances and they must be informed if the information is shared.

Sharing information to manage risk

- 10.20 Although information may be disclosed only in line with the law, professionals and agencies may need to share information to manage any serious risks which certain patients pose to others.
- 10.21 Where the issue is the management of the risk of serious harm, the judgement required is normally a balance between the public interest in disclosure, including the need to prevent harm to others, and both the rights of the individual concerned and the public interest in maintaining trust in a confidential service.
- 10.22 Sharing information about the patient's current, and past status under the Act, may be needed to help ensure properly informed risk assessment, risk formulation and management planning by the relevant authorities, families and carers.

Recording disclosure without consent

- 10.23 Any decision to disclose confidential information about patients should be fully documented. Reasons should be given by reference to the grounds on which the disclosure is to be justified.

Information for victims of crimes

- 10.24 As set out in Chapter 40, the victims of certain Part 3 patients (mentally disordered offenders) detained in hospital have rights to make representations and receive information about that patient's discharge under the Domestic Violence, Crime and Victims Act 2004 (DVCVA).
- 10.25 Professionals should consider whether sharing information would be of benefit to the victims or victim's families of other mentally disordered offenders not covered by the DVCVA.
- 10.26 Professionals should be ready to discuss with patients the benefits of enabling some information to be given by professionals to victims, within the spirit of the Code of Practice for Victims of Crime issued under the DVCVA.

Chapter 11

Visiting patients in hospital

- 11.1 This chapter looks at enabling patients to be visited in hospital and emphasises the importance of maintaining links with family, friends and community networks. All efforts should be made to make visitors as welcome as possible and encourage and facilitate visiting wherever possible.
- 11.2 The Mental Health Act 1983 (the Act) gives certain people the right to visit patients in private and arrangements must be in place to enable this to happen. This chapter includes particular considerations for child visitors and the circumstances where it may be necessary to consider excluding visitors.
- 11.3 Written policies and procedures concerning children and young people who visit patients and for visits to patients who are children or young people must be in place¹¹.

Arrangements for visiting patients

- 11.4 All patients have the right to maintain contact with, and be visited by, anyone they wish to see, subject to carefully limited exceptions. Maintaining contact with family, friends and community networks is recognised as an important element in a patient's care, treatment and recovery.
- 11.5 Article 8 of the European Convention on Human Rights (ECHR) protects the right to a family life and patients should usually be able to see all their visitors in private. The United Nations Convention on the Rights of the Child (UNCRC) serves to protect a child's rights to protection and development. Due consideration should be paid to these conventions when considering the visiting of patients.
- 11.6 Preventing a visit by anyone the patient has asked to visit and/or agreed to see should be regarded as an interference with the patient's rights. There are circumstances where hospital managers may restrict visitors, refuse them entry or require them to leave and this should be recorded in the individual's care and treatment plan. These instances should be exceptional.
- 11.7 Managers should have a policy on the circumstances in which visits to patients may be restricted and this information should be available in an accessible format to all patients and their visitors. Such policies should be risk-based and not impose blanket restrictions, e.g. no visitors for the first four weeks after admission.
- 11.8 Visits should be encouraged and made as comfortable and easy as possible for the visitor and the patient. Reasonable and flexible visiting times, access to refreshments, and pleasant and safe surroundings will facilitate visiting.
- 11.9 In addition to visits, every effort should be made to assist the patient, where appropriate, to maintain contact with relatives, friends and advocates in other ways. It is good practice and policy for patients to be placed in a hospital as close as reasonably practicable to their family given their clinical needs.

¹¹ [HSC 1999/222: LAC \(99\) 32](#) and [LAC 2000 \(18\)](#).

- 11.10 Patients should normally have readily accessible and appropriate daytime telephone and internet facilities to enable contact between them and their families (see Chapter 8). Where a patient is placed out of area the needs of family and carers who have to travel in order to visit should be considered.
- 11.11 If there are particular concerns for the safety of the visitor, they should be discussed with the visitor with a view to agreeing suitable security arrangements. For the safety of both visitors and patients, free access to all areas of the ward would not be appropriate at certain times.

People with a right to visit patients

- 11.12 The Act gives certain people the right to visit patients in private. This includes second opinion appointed doctors (SOADs), independent doctors or approved clinicians appointed to examine the patient in relation to an application or reference to the Tribunal, people visiting on behalf of HIW and independent mental health advocates (IMHAs). Hospital managers must ensure such visits can take place in private if that is what the patient wishes. These people should be given access to all areas where the patient lives, subject to the management of any risks to visitors and ensuring the dignity of other patients is preserved.
- 11.13 Hospital managers should also ensure patients can communicate with their legal representatives in private, and should facilitate visits by those representatives when they request them.

Children and young people

- 11.14 Contact for children and young people, with relatives, friends and community networks should be promoted. These children and young people could be either those whose parents, guardians or carers are inpatients in hospital or those who are themselves inpatients in hospital. 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.
- 11.15 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. This may include a designated place where children can visit. Those with parental responsibility should be consulted and be part of a risk assessment and a discussion with key members of the multi-agency team to agree the visit would be in the child's best interests. Decisions to allow such visits should be regularly reviewed. This will include ensuring other patients on the ward do not have unsupervised access to the child.
- 11.16 Where a child has been admitted to hospital, their wishes about receiving visitors should be taken into account. Chapter 19 discusses the capacity and competence of children to make decisions. Information about visiting should be explained to children in a way they are able to understand. Visiting arrangements should also be explained to parents/carers. Visiting arrangements must take into account the safeguarding needs of the child and of any other children and young people on the hospital unit.

- 11.17 Hospitals should have written policies on the arrangements for patients being visited by children, including the availability of suitable environments for such visits. They should be drawn up in consultation with local authorities and Local Safeguarding Children Boards, to ensure appropriate safeguarding.
- 11.18 The UNCRC is an international human rights treaty that grants a comprehensive set of rights to all children and young people (aged 17 and under). Due consideration should be paid to this convention when considering the arrangements for children and young people who visit patients and for visits to patients who are children or young people.

Exclusion or restriction of visitors

- 11.19 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 HIW and the Care Quality Commission where patients are detained in hospitals in England including the high secure estate.

Restriction or exclusion on clinical and/or security grounds

- 11.20 In addition to a legal imperative, for example, a Court Order preventing contact, there are two principal grounds which could justify the restriction or exclusion of a visitor: clinical grounds and security grounds.
- 11.21 The patient's responsible clinician may decide, after assessment and discussion with the patient and the multi-disciplinary team, some visits could be detrimental to the safety or wellbeing of the patient, the visitor, other patients or staff on the ward.
- 11.22 It may be a patient's relationship with a relative or friend is considered counterproductive to therapy - to the extent 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.
- 11.23 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.
- 11.24 In these circumstances, the responsible clinician may make special arrangements for the visit, impose reasonable conditions or if necessary exclude the visitor. In any of these cases, the reasons for the restriction should be recorded and explained to the patient and the visitor, both verbally and in writing (subject to the normal considerations of patient confidentiality). Wherever possible, 24 hours notice should be given of this decision.
- 11.25 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.

- 11.26 The decision to exclude a visitor on the grounds of their behaviour should be fully documented and explained to the patient verbally and in writing. Where possible and appropriate, the reason for the decision should also be explained to the person being excluded.
- 11.27 Patients should be informed how they can challenge a decision to prevent a visit and of the support available from an IMHA in such a challenge.

Restricting visitors to informal patients who lack capacity

- 11.28 The restriction of visitors to patients who lack capacity to decide whether to remain in hospital could amount to or contribute to an unlawful deprivation of liberty or a breach of the individual's human rights. It may indicate that a deprivation of liberty (DoL) authorisation or a Court of Protection order under the deprivation of liberty safeguards of the Mental Capacity Act 2005(MCA) may need to be sought, or formal admission under the Act considered (see Chapter 13).

Chapter 12

The Mental Health Review Tribunal for Wales

12.1 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 making applications, preparing reports and attending hearings¹².

Purpose of the Tribunal

12.2 The MHRT for Wales is an independent judicial body. Its main purpose is to review the cases of detained and conditionally discharged patients and those subject to community treatment orders (CTO). It also considers applications for discharge from guardianship and it can direct the discharge of any of these patients.

12.3 The MHRT for Wales provides a significant safeguard for patients who have had their liberty curtailed under the Mental Health Act 1983 (the Act). It is for those who believe a patient should continue to be liable to detention or remain subject to a CTO 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. Up to date and accurate clinical and social reports form the backbone of this evidence.

12.4 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 to the patient's wishes and feelings and ensuring the patient feels as comfortable with the proceedings as possible.

Informing the patient and nearest relative of their rights to apply to the Tribunal

12.5 Hospital managers and local authorities must ensure patients know about and understand their rights to apply to the MHRT for Wales. Patients should also be told they are entitled to free legal advice and representation. This should be done when:

- patients are first detained in hospital, received into guardianship or discharged onto a CTO
- whenever their detention or guardianship is renewed or CTO is extended, and
- whenever their status under the Act changes – e.g. if they move from detention under section 2 to detention under section 3 or if their CTO is revoked.

¹² In England, the MHRT became part of the Health and Social Care Chamber of the First-tier Tribunal (established under the Tribunals, Courts and Enforcement Act 2007) and is called the First Tier Tribunal (Mental Health). In Wales, the Mental Health Review Tribunal became the Mental Health Review Tribunal for Wales. There are separate Rules governing the procedures of the MHRT for Wales and the First-tier Tribunal. There is a right of appeal for both the MHRT for Wales and the First tier Tribunal on a point of law to the Upper Tribunal
<http://www.legislation.gov.uk/ukpga/2007/15/contents>

- 12.6 Subject to the normal considerations about nearest relatives – see Chapter 5), unless the patient requests otherwise (and the patient should always be asked), the information about their right to apply to the MHRT for Wales should be given to their nearest relative. It is good practice for hospitals and local authorities to hold a list of legal representatives who undertake Tribunal work for use by patients¹³.
- 12.7 Hospital managers and professionals should enable detained patients to be visited by their legal representatives at any reasonable time. Where the patient consents, legal representatives should be given prompt access to the patient's medical records.
- 12.8 In connection with an application (or a reference) to a Tribunal, an independent doctor or approved clinician, authorised by (or on behalf of) a patient, has a right to visit and examine the patient in private. Those doctors and approved clinicians also have a right to inspect any records relating to the patient's detention, treatment and (where relevant) after-care under section 117.
- 12.9 Nearest relatives with a right to apply to the Tribunal may authorise independent doctors or approved clinicians in the same way. The patient's consent is not required for authorised doctors or approved clinicians to see their records, and they should be given prompt access to the records they wish to see.
- 12.10 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 authorised by the patient to make a written application on their behalf.
- 12.11 Local protocols should be developed to ensure staff are available to help patients make an application - this is especially important for patients on CTOs who may not have daily contact with such staff. The patient's care co-ordinator and/or IMHA should provide the necessary support.

Hospital managers' duty to refer cases to the MHRT for Wales

- 12.12 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 37.

Reports

- 12.13 Responsible authorities (the hospital managers or the responsible local authority 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.
- 12.14 The responsible authority must ensure up-to-date reports 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.

¹³ http://ajtc.justice.gov.uk/docs/AJTC__CQC_First_tier_Tribunal_report_FINAL.pdf

- 12.15 Whilst the Practice Direction First-tier Tribunal Health Education and Social Care Chamber: Statements and Reports in Mental Health Cases¹⁴ relates to England only, it may be helpful to use this as the basis for report produced for the MHRT for Wales.
- 12.16 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 may need to ensure a report from such a specialist is provided.
- 12.17 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.
- 12.18 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 verbally at the hearing as required.
- 12.19 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.
- 12.20 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. Generally it is expected the professional submitting a report will have discussed the contents with the patient. Ultimately it is for the Tribunal to decide what should be disclosed to the patient.

Withdrawing an application

- 12.21 A request to withdraw an application may be made by the applicant in accordance with the Tribunal rules.
- 12.22 An application will also be considered to be withdrawn if the patient is discharged. The Tribunal must be notified of a patient's discharge as soon as possible. A reference made by the Welsh Ministers or the Secretary of State (where they are not obliged to make a reference under the Act) may be withdrawn by the Welsh Ministers or the Secretary of State, as the case may be, at any time before it is considered by the Tribunal. Where a reference is withdrawn in this manner, the Tribunal is required to inform the patient and the other parties that the reference has been withdrawn.

Tribunal Preliminary interview

- 12.23 Before the hearing, a medical member of the Tribunal must, so far as practicable, examine the patient and take other steps that member considers necessary to form an opinion on the patient's mental condition. Hospital managers must ensure the member is able to meet the patient in private and examine their case records relating to the detention or treatment of the patient and any after-care services.

¹⁴ <https://www.judiciary.gov.uk/publications/practice-direction-first-tier-tribunal-health-education-and-social-care-chamber-statements-and-reports-in-mental-health-cases/>

It is important the patient is told of the visit in advance. At any time before the final determination, the Tribunal (or any one or more of its members) may interview the patient in private.

Hearings

Before the hearing

- 12.24 The responsible authority must ensure 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

- 12.25 The managers of a hospital in which a Tribunal hearing is to be held should provide suitable accommodation. The hearing room should be private¹⁵, 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 any equipment left in the room would not interfere with the proceedings or adversely affect the patient.
- 12.26 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.
- 12.27 If a patient is being treated in the community, a venue other than a hospital may be more suitable.

Interpretation

- 12.28 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.
- 12.29 The MHRT for Wales should ensure Tribunal panel members have an understanding of, or are provided with training in, matters of equality and diversity.
- 12.30 Where necessary, the Tribunal will provide free-of-charge interpretation services for patients and their representatives. If patients or their representatives have hearing or speech difficulties the Tribunal will provide any services necessary. Responsible authorities should tell the Tribunal well in advance if they think such services might be necessary.

¹⁵ And this should ensure other persons cannot overhear the proceedings

Attendance at hearings

- 12.31 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. A family member, carer or an IMHA may accompany the patient to offer support. Where a patient is legally represented the IMHA will not usually speak on behalf of the patient.
- 12.32 A patient may appoint a representative (whether legally qualified or not) to represent them in the proceedings. The representative must not be:
- a person liable to be detained or
 - subject to guardianship or
 - a community patient under the Act, or
 - a person receiving treatment for mental disorder at the same hospital or registered establishment as the patient.
- 12.33 The Tribunal may appoint a legal representative for the patient if:
- the patient has not appointed a representative and the patient has stated that they do not wish to conduct their own case or
 - that they wish to be represented or
 - the patient lacks the capacity to appoint a representative but the Tribunal believes that it is in the patient's best interests for the patient to be represented.
- 12.34 The patient's responsible clinician should attend 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 a CTO. 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.
- 12.35 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.
- 12.36 Other people who prepare reports submitted by the responsible authority should attend the hearing to provide further up-to-date information about the patient, including (where relevant) their home circumstances and the aftercare available in the event of a decision to discharge the patient.
- 12.37 Hospital managers should provide patients and their carers with sufficient information to understand the matters the Tribunal is considering in a format and language patients and their carers understand.

Conducting a hearing

- 12.38 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.
- 12.39 The Tribunal may ask the author of a report to talk through their report, so the author should re-familiarise themselves with their report's content before the hearing. If the author is unable to attend, anyone attending on their behalf should have, where possible, a good knowledge of the patient's case and is familiar with the report.
- 12.40 Responsible authorities should ensure 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

- 12.41 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 the patient is told the decision as soon as practicable.

Other matters

- 12.42 Complaints about the Tribunal should be sent to the Tribunal office. The MHRT for Wales has procedures in place to deal with complaints promptly.
- 12.43 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
Welsh Assembly Government
Cathays Park
Cardiff CF10 3NQ

Chapter 13

Relationship between the Mental Health Act, the Mental Capacity Act and the Deprivation of Liberty Safeguards

- 13.1 This chapter gives guidance on the relationship between the Mental Health Act 1983 (the Act), the Mental Capacity Act (MCA) and the Deprivation of Liberty Safeguards (DoLS). It does not generally repeat the information contained in the MCA and DoLS Codes of Practice.

General matters

- 13.2 An understanding and application of the principles and provisions of the MCA and DoLS and of the common law relating to consent, is essential to enable decision makers to fulfil their legal responsibilities and to safeguard their patients' rights under the European Convention on Human Rights (ECHR).
- 13.3 The MCA empowers individuals to make their own decisions where possible and protects the rights of those who lack capacity. Where an individual lacks capacity to make a specific decision at a particular time, the MCA provides a legal framework for others to act and make that decision on their behalf, in their best interests, including where the decision is about care and/or treatment.
- 13.4 The MCA, in general, applies to individuals aged 16 years and over. However, a DoLS authorisation can only be made in respect of an individual aged 18 or over. A Court of Protection order and an order made under the inherent jurisdiction of the High Court; can be made in respect of individuals aged 16 or over. A person must be 18 to make an advance decision to refuse treatment or create a lasting power of attorney (LPA) under the MCA.
- 13.5 The principles embedded in the MCA are central to any decision making in relation to the Act and its provisions.

Five statutory principles of the Mental Capacity Act

Principle one

A person must be assumed to have capacity unless it is established that they lack capacity.

Principle two

A person is not to be treated as unable to make a decision unless all practicable steps to help them to do so have been taken without success.

Principle three

A person is not to be treated as unable to make a decision merely because they make an unwise decision.

Principle four

An act done, or decision made, on behalf of a person who lacks capacity, must be done, or made, in their best interests.

Principle five

Before the act is done, or the decision is made, regard must be had to whether the purpose of the act or the decision can be as effectively achieved in a way that is less restrictive of the person's rights and freedom of action.

Assessing Capacity

- 13.6 It should always be assumed that a patient subject to the Mental Health Act 1983 has capacity, unless it is established otherwise in accordance with the MCA. However there will be patients who require treatment for their mental disorder and may not have the capacity to consent to some or all aspects of their care and treatment at one time or another.
- 13.7 Under such circumstances the capacity to make a particular decision should be assessed using the framework set out in the MCA. Capacity relates to specific matters and can change over time, capacity should therefore be reassessed as appropriate and in respect of specific treatment decisions.
- 13.8 Where a capacity assessment is undertaken this should be recorded in the individual's care and treatment record. As well as the outcome of the test, the following should be recorded:
- the specific decision for which capacity was assessed
 - the salient points that the individual needs to understand and comprehend and the information that was presented to the individual in relation to the decision
 - the steps taken to promote the individual's ability to decide themselves including how the information was given, in the most effective way, to communicate with the individual
 - how the diagnostic test was assessed, and how the assessor reached their conclusions, and
 - how the functional test was undertaken, and how the assessor reached their conclusions.
- 13.9 If, following assessment, the patient does not have the capacity to make a particular decision, staff will need to consider under which legal framework their care and treatment should be provided. If a patient has fluctuating capacity, consideration should be given as to whether it is possible to defer the decision until such time as they might be able to consent.

Deprivation of liberty?

- 13.10 The first consideration should be whether a deprivation of the person's liberty is necessary to provide them with the care and treatment they are deemed to require. Consideration must be given at this stage to whether the patient's care and treatment plan can be amended to avoid any potential deprivation of liberty.
- 13.11 Consideration should be given to whether the circumstances of the proposed accommodation and treatment amount (or are likely to amount) to a deprivation of liberty.

- 13.12 In April 2014 the Supreme Court clarified that a deprivation of liberty will occur in circumstances where a person, is subject to continuous control and supervision and is not free to leave and lacks capacity to consent to these arrangements ('Cheshire West')¹⁶.
- 13.13 The Supreme Court stated that the following factors are not relevant in determining whether there is a deprivation of liberty:
- the person's compliance
 - a lack of objection
 - the reason or purpose behind particular care arrangements
 - the relative normality of the setting in which care is carried out.
- 13.14 It also stated a deprivation of liberty can occur in domestic settings where the state is responsible for such arrangements. In such cases, an order should be sought from the Court of Protection.
- 13.15 Additional guidance is available to assist in making the decision about what constitutes a deprivation of liberty¹⁷.
- 13.16 Any decision about a deprivation of liberty must be compliant with current legal frameworks and case law¹⁸.
- 13.17 As with all treatment given under the MCA staff will need to check:
- whether the patient has made any advance decisions (or indeed any advance statements) (see Chapter 9) or
 - has a Lasting Power of Attorney or
 - whether there is a Court of Protection order in respect of their care and treatment, or
 - whether there is a court appointed Deputy.
- 13.18 All assessments and decisions should be fully recorded and include the views of family members and or carers. If there is a disagreement between the clinical team and the family or carers, or if the relevant person objects to the arrangements believed to be necessary, consideration should be given to seeking a decision from the Court of Protection.

The Court of Protection

- 13.19 The Court of Protection is a specialist court set up by the MCA to deal with cases involving individuals lacking capacity. It operates on a 24-hour basis.
- 13.20 A Court of Protection order may be made under the MCA to authorise a deprivation of liberty. Such orders may also authorise care or treatment. In certain cases, a Court of Protection order is the only way to authorise a deprivation of liberty under the MCA.

¹⁶ http://supremecourt.uk/decided-cases/docs/UKSC_2012_0068_Judgment.pdf

¹⁷ <http://www.lawsociety.org.uk/support-services/advice/articles/deprivation-of-liberty/>

¹⁸ The Deprivation of Liberty Safeguards in their entirety are currently under review by the Law Commission

This includes where:

- the deprivation of liberty is to occur in a place other than a hospital or care home (DoLS authorisations can only be given in respect of a care home or hospital), or
- the person is aged 16 or 17 (DoLS authorisations can only be given in relation to persons aged 18 or over).

13.21 An application to the Court of Protection should also be made if decision-makers have not found it possible to determine the capacity or best interests of a person, or there are irresolvable disputes, in relation to a particular decision.

13.22 If having explored all other options it appears that a deprivation of liberty is necessary, staff must determine what the required treatment is for. If it is in relation to a physical condition unrelated to a patient's mental disorder and the individual does not have the capacity to consent, treatment can be provided under the MCA as long as it is in their best interests. In these circumstances a DoLS authorisation or a Court of Protection order should be sought.

Care and Treatment under the MCA

13.23 The five statutory principles of the MCA form a key part of developing a patient's care and treatment plan and should be integral to this process. The MCA can be relied upon to treat mental disorder where the patient lacks capacity to make the decision in question and such treatment is in the patient's best interests.

13.24 Professionals should seek to involve those who lack capacity in decisions about their care as much as they would involve those who have capacity. Care and treatment plans should be developed in collaboration with the patient as much as possible. Where professionals and patients disagree over elements of the plan the emphasis should be on discussion and compromise where possible.

13.25 However, situations will occur when carers, healthcare and social care staff will need to make decisions on behalf of individuals who lack capacity to make particular decisions themselves (including decisions that relate to care and/or treatment for mental and/or physical conditions), where agreement cannot be reached or deprivation of liberty is unavoidable.

13.26 In some circumstances it may be necessary to restrain a patient in order for them to receive the care and treatment they require. All acts of restraint under section 5 and 6 of the MCA must be in the best interests of the individual. In this particular context restraint means using force or making clear that force will be used to make a person do something they are resisting, or may resist, or restricting the person's liberty of movement, whether or not the person resists.

13.27 In each case a balanced decision will need to be taken between the individual's rights to liberty and autonomy against the need to restrain the patient, for example by locking doors or the appropriate use of proportionate physical restraint, to receive the care and treatment necessary.

- 13.28 Section 6 of the MCA states that, in addition to needing to be in the best interests of the person who lacks capacity in respect of the relevant decision, acts of restraint will only be permitted if:
- the person taking action reasonably believes that restraint is necessary to prevent harm to the person who lacks capacity, and
 - the amount or type of restraint used and the amount of time it lasts is a proportionate response to the likelihood and seriousness of that harm.
- 13.29 However, sections 5 and 6 of the MCA cannot be relied on if the overall care and treatment package will give rise to a deprivation of liberty. A deprivation of liberty will engage article 5 of the ECHR and must be specifically authorised under the MCA by a DoLS authorisation or a Court of Protection order, or otherwise made lawful by way of detention under the Mental Health Act 1983.
- 13.30 It is important to note that if a potential deprivation of liberty is identified, the first step should always be to review the care and treatment plan to see if a less restrictive approach could be taken that would prevent that deprivation of liberty from arising.

DoLS authorisations

- 13.31 A DoLS authorisation under Schedule A1 to the MCA is given by a 'supervisory body' (a local authority or a local health board), following a request from a 'managing authority' (the hospital or care home at which the individual is placed or is likely to be placed). An authorisation should be in place at the time the deprivation of liberty occurs. If a patient is likely to be moving from one place of care to another an application for the DoLS should be made before transfer if it is known that the new care circumstances will amount to a deprivation of liberty e.g. a patient being discharged from hospital to a care home.
- 13.32 An authorisation will only be given if the individual concerned is assessed to meet all six of the qualifying requirements; detailed guidance is given in the DoLS Code of Practice.

Detention under the Act or deprivation of liberty under a DoLS authorisation?

- 13.33 If a patient is objecting to being admitted to hospital, or to some or all the treatment they will receive there for mental disorder, only the Mental Health Act 1983 is available to authorise their detention (subject to all other qualifying requirements).
- 13.34 However, in principle, detention under the Act and a DoLS authorisation (or potentially a Court of Protection order) would both be available if an individual:
- has a mental disorder (within the meaning of the Act)
 - needs to be assessed and/or treated in a hospital setting for that disorder and/or for physical conditions related to that disorder
 - has a care and treatment package that may or will amount to a deprivation of liberty
 - lacks capacity to consent to being accommodated in the relevant hospital for the purpose of treatment, and
 - does not object to being admitted to hospital, or to some or all the treatment they will receive there for mental disorder.

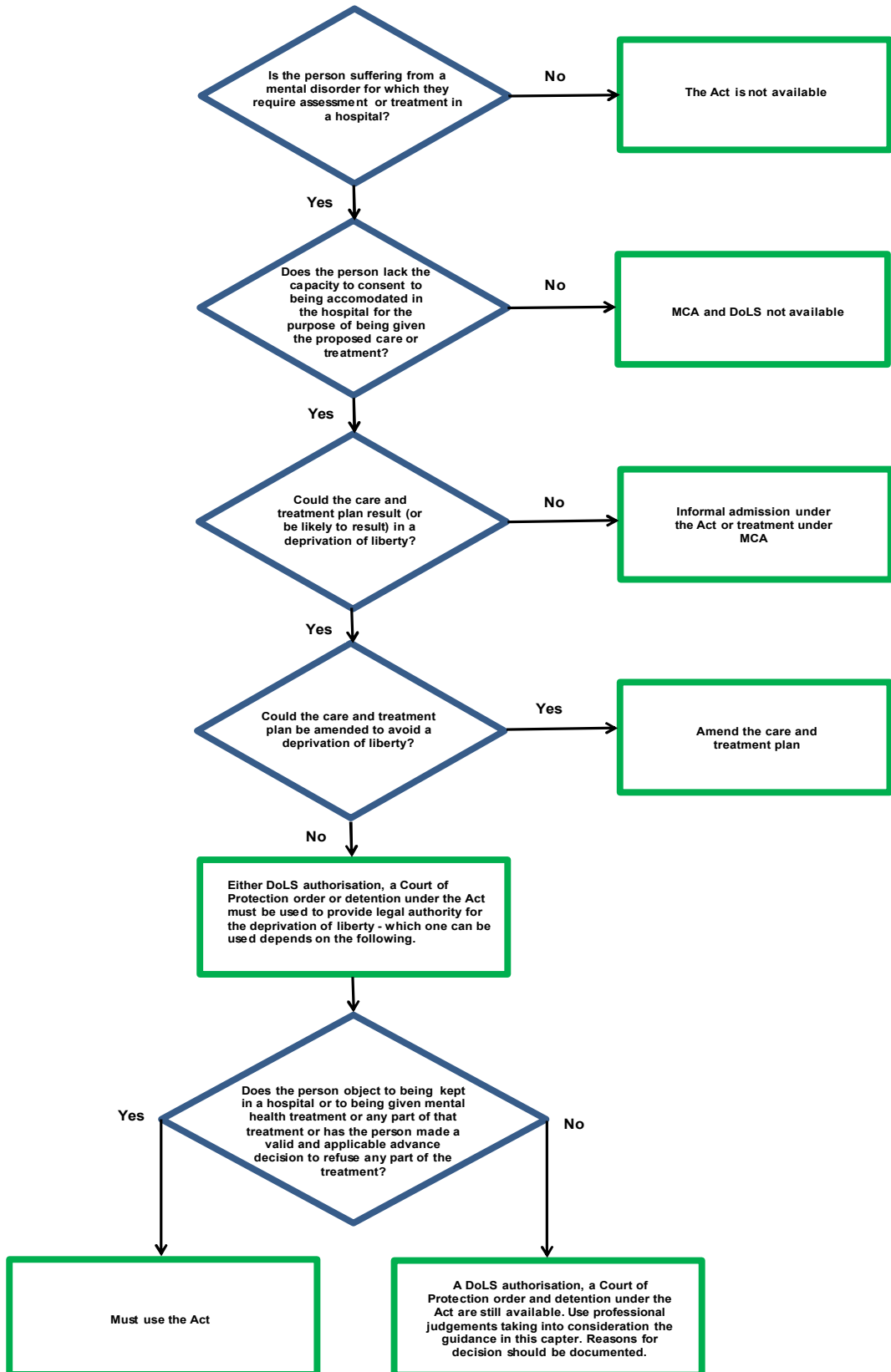
- 13.35 This situation requires a robust determination on the part of clinical staff who will need to make a decision about the most appropriate legal framework. It is important to note that a person cannot be detained under the Act in hospital for treatment of their mental disorder at the same time as being subject to a DoLS authorisation or a Court of Protection order for treatment of their mental disorder.
- 13.36 Whether a patient is objecting has to be considered in the round, taking into account all the circumstances, so far as they are reasonably ascertainable. The decision to be made is whether the patient objects, not the reasonableness or not of that objection.
- 13.37 In many cases the patient will be perfectly able to state their objection. In other cases the relevant person 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.
- 13.38 In deciding whether a patient objects to being admitted to hospital, or to some or all of the treatment they will receive there for mental disorder, decision-makers should err on the side of caution and, where in doubt, take the position that a patient is objecting.

Summary of the availability of the Act and of DoLS for the treatment of mental disorder

	Individual has the capacity to consent to being accommodated in a hospital for care and/or treatment	Individual lacks the capacity to consent to being accommodated in a hospital for care and/or treatment
Individual objects to the proposed accommodation in a hospital for care and/or treatment; or to any of the treatment they will receive there for mental disorder	Only the Act is available	Only the Act is available
Individual does not object to the proposed accommodation in a hospital for care and/or treatment; or to any of the treatment they will receive there for mental disorder	The Act is available. Informal admission will usually be the appropriate course of action. Neither DoLS authorisation nor Court of Protection order available.	The Act is available. DoLS authorisation is available, or potentially a Court of Protection order

Additional points for consideration

- 13.39 A person who lacks capacity to consent to being accommodated in a hospital for care and/or treatment for mental disorder and who is likely to be deprived of their liberty should never be informally admitted to hospital (whether they are content to be admitted or not).
- 13.40 Consideration should be given as to whether an individual deprived of their liberty may regain capacity or may have fluctuating capacity. Such a situation is likely to indicate use of the Act to authorise a deprivation of liberty is likely to be more appropriate than the use of a DoLS authorisation or Court of Protection order.
- 13.41 For those individuals where both detention under the Act and a DoLS authorisation or a Court of Protection order are available, a determination must be made as to which regime is the more appropriate. The following paragraphs detail factors that should feature in this decision-making process.
- 13.42 It may be apparent that one regime is likely to prove less restrictive. If so, this should be balanced against any potential benefits associated with the other regime.
- 13.43 The nature of the safeguards provided under the two regimes are different and decision-makers will wish to exercise their professional judgement in determining which safeguards are more likely to best protect the interests of the patient in the particular circumstances of each individual case.
- 13.44 The reasons for the final decision must be recorded and it is important that the patient concerned receives the safeguards afforded under either the Act or through a DoLS authorisation or a Court of Protection order.
- 13.45 Hospitals should have policies in place to deal with circumstances where disagreement results in an inability to take a decision as to whether the Act or DoLS should be used to give legal authorisation to a deprivation of liberty – to ensure that one is selected.
- 13.46 The following flowchart describes some of the decision-making steps when determining whether the Act and/or the MCA including the DoLS will be available to be used. The flowchart does not replace careful consideration of all relevant circumstances in individual cases.



- 13.47 This guidance does not seek to provide definitive answers in complex cases. Every individual case is unique with a complex mix of factors that need to be considered. A patient's eligibility for detention under the Act or for a deprivation of liberty under a DoLS authorisation or a Court of Protection order should always be considered. Chapter 14 gives additional guidance on some of the issues to be considered when considering admission under the Act.
- 13.48 In most cases, only one of the regimes will be available, professional judgement must be used to determine the most appropriate legal framework taking legal advice where necessary.
- 13.49 In the rare cases where neither the Act nor a DoLS authorisation nor a Court of Protection order is appropriate, then to avoid an unlawful deprivation of liberty it may be necessary to make an application to the High Court to use its inherent jurisdiction to authorise the deprivation of liberty.

Chapter 14

Applications for detention in hospital

14.1 An application for detention may only be made where the grounds in either section 2 or section 3 of the Act are met. An application for detention may be made by an approved mental health professional (AMHP) or the patient's nearest relative, and they should understand the criteria for detention and their responsibilities under the Act.

Grounds for making an application for detention

14.2 An application for detention may only be made where the grounds in either section 2 or section 3 of the Act are met. Before it is decided admission to hospital is necessary, consideration must be given to whether there are alternative means of providing the care and treatment which the patient requires. This includes consideration of whether there might be other effective forms of care or treatment which the patient would be willing to accept and whether guardianship would be appropriate instead.

Criteria for applications

- 14.3 A person can only be detained for assessment under section 2 if both the following criteria apply:
- 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 treatment) for at least a limited period, and
 - the person ought to be so detained in the interests of their own health or safety or with a view to the protection of others.
- 14.4 A person can only be detained for treatment under section 3 if all the following criteria apply:
- 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
 - it is necessary for the health or safety of the person or for the protection of other persons that they should receive such treatment and it cannot be provided unless the patient is detained under this section, and
 - appropriate medical treatment is available.
- 14.5 The criteria 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.
- 14.6 Detention under the Act should not be made on the basis of a person's religious, social or political beliefs, unless there are proper clinical grounds to believe that they are the symptoms or manifestations of the patient's mental disorder.

- 14.7 In all cases, when judging whether the statutory criteria are met and compulsory admission is appropriate, consideration should be given to:
- the patient's past and present wishes and feelings, which include the patient's view of their own needs
 - the patient's age and physical health
 - the patient's cultural background and social and family circumstances
 - the impact that any future deterioration or lack of improvement in the patient's condition would have on their children, other relatives or carers, especially those living with the patient, including an assessment of their ability and willingness to cope, and
 - the effect on the patient, and those close to the patient, of a decision to admit or not to admit under the Act.

Factors to consider – the health or safety of the patient

- 14.8 Factors to be considered in deciding whether a patient should be detained for their own health or safety include:
- the evidence suggesting the patient is at risk of suicide, self-harm, self-neglect or being otherwise unable to look after their own health or safety
 - whether the patient's mental disorder is otherwise putting their health or safety at risk
 - any evidence suggesting the patient's mental health will deteriorate if they do not receive treatment, including the views of the patient or carers, relatives or close friends (especially those living with the patient) about the likely course of the disorder
 - the patient's own skills and experience in managing their condition
 - the patient's capacity to consent to or refuse admission and treatment
 - whether the patient objects to treatment for mental disorder – or is likely to
 - the reliability of such evidence, including what is known of the history of the patient's mental disorder and the possibility of their condition improving
 - the potential benefits of treatment, which should be weighed against any adverse effects being detained might have on the patient's wellbeing, and
 - whether other methods of managing the risk are available.

Factors to consider – protection of others

- 14.9 In considering whether detention is necessary for the protection of other people, consideration should be given to the likelihood and nature of the risk to other people, and the severity of any potential harm, taking into account the following factors:
- it is not always possible to differentiate risk of harm to the patient from the risk of harm to others
 - the reliability of the available evidence, including any relevant details of the patient's clinical history and past behaviour, such as contact with other agencies and (where relevant) criminal convictions and cautions
 - the willingness and ability of those who live with the patient and those who provide care and support to the patient to cope with and manage the risk
 - whether other methods of managing the risk are available, and
 - harm to other people including psychological as well as physical harm.

Alternatives to detention under the Act

- 14.10 In deciding whether it is necessary to detain patients, doctors and AMHPs must always consider the alternative ways of providing the treatment or care they need. Decision-makers should always consider whether there are less restrictive alternatives to detention under the Act, which may include:
- informal admission to hospital of a patient based on that person's consent
 - management in the community, or
 - guardianship.
- 14.11 In considering whether it is necessary for the person to be detained under the Act, decision-makers must consider whether the person has capacity to consent to or refuse admission and treatment. This should be assessed in accordance with the Mental Capacity Act 2005 (MCA), which makes clear a person must be assumed to have capacity unless it is established that they do not.
- 14.12 Professionals must consider available alternatives, having regard to all the relevant circumstances, to identify the least restrictive way of best achieving the proposed assessment or treatment. This will include considering what is the person's best interests (if the person lacks capacity, this will be determined in accordance with the MCA).

Patients with capacity to give consent to admission

- 14.13 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 informally. 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 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 the protection other people.
- 14.14 Using the threat of detention to agreeing to admission to hospital or for treatment is likely to invalidate any apparent consent. If consideration is being given to the informal admission of a patient who is subject to Secretary of State restrictions, the Mental Health Casework Section of the Ministry of Justice should be contacted.

Patients who lack capacity to give consent to admission or treatment

- 14.15 Where the criteria for detention under the Act are met, the situations where an application for detention should be made under the Act instead of relying on the Deprivation of Liberty Safeguards (DoLS) include where:
- the patient has made a valid and applicable advance decision to refuse treatment which includes a necessary element of the treatment for which they are to be admitted to hospital
 - the use of the DoLS would conflict with a decision of the person's attorney, deputy, guardian or the Court of Protection, or
 - the patient is objecting to being admitted to (or remaining in) hospital for mental health treatment.

- 14.16 Whether a patient is objecting has to be considered in the round, taking into account all the circumstances, so far as they are reasonably ascertainable. The decision to be made is whether the patient objects, not the reasonableness or not of that objection.
- 14.17 In many cases the patient will be perfectly able to state their objection. In other cases the relevant person 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.
- 14.18 In deciding whether a patient objects to being admitted to hospital, or to some or all of the treatment they will receive there for mental disorder, decision-makers should err on the side of caution and, where in doubt, take the position that a patient is objecting.
- 14.19 Even if providing appropriate care or treatment will not unavoidably involve a deprivation of liberty, in some cases it may be necessary to detain a patient under the Act rather than rely on the MCA. For example, where the patient:
- has, by means of a valid and applicable advance decision, refused a necessary element of the treatment required, or
 - lacks capacity to make decisions on some elements of the care and treatment they need, but has capacity to decide about a vital element – e.g. admission to hospital – and has either already refused it or is likely to do so.
- 14.20 Whether or not the DoLS could be used, other reasons why it may be necessary to detain a patient under the Act and not rely on the MCA alone include the following:
- the patient's lack of capacity to consent or refuse is fluctuating or temporary and the patient is not expected to consent to admission or treatment when they regain capacity. This may be particularly relevant to patients having dementia, acute psychotic, manic or depressive episodes
 - a degree of restraint may need to be used which is justified by the risk to other people but which is not permissible under the MCA because, exceptionally, it cannot be said to be proportionate to the risk to the patient personally, and
 - there is some other specific identifiable risk that the person might not receive the treatment they need if the MCA is relied on and either the person or others might potentially suffer harm as a result.

Use of section 2 or section 3 of the Act

- 14.21 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 assessment as an inpatient is required 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.

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.

14.22 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
- a community treatment order will only be available if the patient has been admitted under section 3
- a patient's nearest relative objects to admission under section 3.

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

The assessment process

14.24 An application for detention may be made by an AMHP or the patient's nearest relative (for information on the nearest relative see Chapters 4 and 5). An AMHP is usually a more appropriate applicant than a patient's nearest relative, given their professional training and knowledge of the legislation and local resources. This also removes the risk that an application by the nearest relative might have an adverse effect on their relationship with the patient.

- 14.25 An application must be supported by two medical recommendations (other than an emergency application) given in accordance with the Act. Doctors who are approached directly by a nearest relative about the possibility of an application being made should advise the nearest relative of their right to require a local authority to arrange for an AMHP to consider the patient's case.

Responsibilities of local authorities

- 14.26 Local authorities are responsible for ensuring that sufficient AMHPs are available to carry out their roles under the Act, including assessing patients to decide whether an application for detention should be made. To fulfil their statutory duty, local authorities should have arrangements in place in their area to provide a 24-hour service that can respond to patients' needs.
- 14.27 Section 13 of the Act places a specific duty on local authorities to arrange for an AMHP to consider the case of any patient who is within their area if they have reason to believe that an application for detention in hospital may need to be made in respect of the patient. Local authorities must make such arrangements if asked to do so by (or on behalf of) the nearest relative.
- 14.28 If a patient is already detained under section 2 as the result of an application made by an AMHP, the local authority on whose behalf that AMHP was acting is responsible for arranging for an AMHP to consider the patient's case again if the local authority has reason to believe that an application under section 3 may be necessary. This applies even if the patient has been detained outside that local authority's area. These duties do not prevent any other local authority from arranging for an AMHP to consider a patient's case if that is more appropriate, for example, if the patient is located a considerable distance from the original detaining authority.

Setting up the assessment

- 14.29 Local arrangements should, as far as possible, ensure that assessments are carried out by the most appropriate AMHP and doctors in the particular circumstances.
- 14.30 Where a patient is known to belong to a group for which particular expertise is desirable (e.g. they are aged under 18 or have a learning disability), at least one of the professionals involved in their assessment should have expertise in working with people from that group, wherever possible.
- 14.31 If this is not possible, at least one of the professionals involved in the person's assessment should consult with one or more professionals who do have relevant expertise at the earliest opportunity and involve them as closely as the circumstances of the case allow.
- 14.32 Unless different arrangements have been agreed locally between the relevant authorities, AMHPs who assess patients for possible detention under the Act have overall responsibility for co-ordinating the process of assessment. In doing so, they should be sensitive to the patient's age, sex, gender identity, social, cultural or ethnic background, religion or belief, and/or sexual orientation.

- 14.33 They should also consider how any disability the patient has may affect the way the assessment needs to be carried out. AMHPs should seek the views of carers, family members and relevant others in determining the most appropriate way to conduct the assessment.
- 14.34 Given the importance of good communication, it is essential those professionals who assess patients are able to communicate with the patient effectively and reliably to prevent potential misunderstandings. AMHPs should establish, as far as possible, whether patients have particular communication needs or difficulties and take steps to meet these, by arranging, for example, a signer or a professional interpreter. AMHPs should also be in a position, where appropriate, to supply equipment to make communication easier with patients who have impaired hearing, but who do not have their own hearing aid.
- 14.35 Doctors and AMHPs undertaking assessments need to apply professional judgement and reach decisions independently of each other, but in a framework of co-operation and mutual support.
- 14.36 Unless there is good reason for undertaking separate assessments, patients should, where possible, be seen jointly by the AMHP and at least one of the two doctors involved in the assessment.
- 14.37 The patient should normally be examined by both doctors at the same time, where this is not feasible they should both discuss the patient's case with the person considering making an application for the patient's detention.
- 14.38 Everyone involved in an assessment should be alert to the need to provide support for colleagues, especially where there is a risk of the patient causing physical harm. People carrying out assessments should be aware of circumstances in which the police should be asked to provide assistance, in accordance with arrangements agreed locally with the police and how to use that assistance to maximise the safety of everyone involved in the assessment.
- 14.39 Local health boards, providers, local authorities, the ambulance and police services should have joint locally agreed arrangements on the involvement of the police. In cases where no warrant for the police to enter premises under section 135 is being applied for (see Chapter 16), the risk assessment should indicate the reasons and why police assistance is nonetheless necessary.

The role of Approved Mental Health Professional (AMHP)

- 14.40 The AMHP's role in the assessment is not confined to them making the determination about whether an application is necessary and should be made. They also bring a social perspective to the process and this expertise promotes a holistic approach to the consideration of a person's needs.
- 14.41 AMHPs may make an application for detention only if they:
- have interviewed the patient in a suitable manner
 - are satisfied that the statutory criteria for detention are met, and
 - are satisfied that, in all the circumstances of the case, detention in hospital is the most appropriate way of providing the care and medical treatment the patient needs.

- 14.42 Once an AMHP has decided that an application should be made, they must then decide whether it is necessary to make the application. If, having considered any views expressed by the patient's relatives and all the other relevant circumstances, they decide that it is, the AMHP must make the application.
- 14.43 At the start of an assessment, AMHPs should identify themselves to the person being assessed, members of the family, carers or friends and the other professionals present. AMHPs should ensure that the purpose of the visit, their role and that of the other professionals is explained. They should carry documents with them at all times which identify them as AMHPs and which specify both the local authority which approved them and the local authority on whose behalf they are acting.
- 14.44 Although AMHPs act on behalf of a local authority, they cannot be told by the local authority or anyone else whether or not to make an application. They must exercise their own judgement, based on social and medical evidence, when deciding whether to apply for a patient to be detained under the Act. The role of AMHPs is to provide an independent decision about whether or not there are alternatives to detention under the Act.
- 14.45 If a patient wants someone else (e.g. a familiar person or an advocate) to be present during the assessment and any subsequent action that may be taken, then ordinarily AMHPs should assist in securing that person's attendance, unless the urgency of the case makes it inappropriate to do so.
- 14.46 Patients should usually be given the opportunity of speaking to the AMHP alone. If an AMHP has reason to fear physical harm, they should insist that another professional is present.
- 14.47 It is not desirable for patients to be interviewed through a closed door or window, and this should be considered only where other people are at serious risk. Where direct access to the patient is not possible, but there is no immediate risk of physical danger to the patient or to anyone else, AMHPs should consider applying for a warrant under section 135 of the Act allowing the police to enter the premises (see Chapter 16).
- 14.48 Where patients are subject to the short-term effects of alcohol or drugs (whether prescribed or self-administered) which make interviewing them difficult, the AMHP should either wait until the effects have abated before interviewing the patient or arrange to return later. If it is not realistic to wait, because of the patient's disturbed behaviour and the urgency of the case, the assessment will also have to be based on information the AMHP can obtain from reliable sources. This will also apply if the patient is not willing to speak to the AMHP. This should be made clear in the AMHP's record of the assessment.

The AMHP and the nearest relative

- 14.49 AMHPs are required by the Act to attempt to identify the patient's nearest relative as defined in section 26 of the Act (see Chapter 5).

- 14.50 When AMHPs make an application for admission under section 2, they must take such steps as are practicable to inform the nearest relative that the application is to be (or has been) made and of the nearest relative's power to discharge the patient. The AMHP should also inform the main carer (if a different person from the nearest relative) that the application has been made.
- 14.51 Before making an application for admission under section 3, AMHPs must consult the nearest relative, unless it is not reasonably practicable or would involve unreasonable delay.
- 14.52 Circumstances in which the nearest relative need not be informed or consulted include those where:
- it is not practicable for the AMHP to obtain sufficient information to establish the identity or location of the nearest relative or where to do so would require an excessive amount of investigation involving unreasonable delay, and
 - consultation is not possible because of the nearest relative's own health or mental incapacity.
- 14.53 There may also be cases where, although physically possible, it would not be reasonably practicable to inform or consult the nearest relative because the detrimental impact of this on the patient would interfere with the patient's right to respect for their privacy and family life under Article 8 of the European Convention on Human Rights. Detrimental impact may include cases where patients are likely to suffer emotional distress, deterioration in their mental health, physical harm, or financial or other exploitation as a result of the consultation.
- 14.54 However consultation with the nearest relative that interferes with the patient's Article 8 right to privacy and family life may be justified to protect the patient's Article 5 right to liberty¹⁹. Consulting and notifying the nearest relative is a significant safeguard for patients. Therefore decisions not to do so on these grounds should not be taken lightly.
- 14.55 AMHPs should consider all the circumstances of the case, including:
- the benefit to the patient of the involvement of their nearest relative, including to protect the patient's Article 5 rights
 - the patient's wishes including taking into account whether they have the capacity to decide whether they would want their nearest relative involved and any statement of their wishes they have made in advance. However, a patient's wishes will not solely determine whether it is reasonably practicable to consult the nearest relative
 - any detrimental effect that involving the nearest relative would have on the patient's health and wellbeing; and
 - whether there is any good reason to think that the patient's objection may be intended to prevent information relevant to the assessment being discovered.
- 14.56 If they do not consult or inform the nearest relative, AMHPs should record their reasons. Consultation must not be avoided purely because it is thought that the nearest relative might object to the application.

¹⁹ See *TW v Enfield Borough Council*. 2014. EWCA Civ. 362

- 14.57 When consulting nearest relatives AMHPs should, where possible:
- ascertain the nearest relative's views about both 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 detention and what the effects of such an application would be, and
 - inform the nearest relative of their role and rights under the Act.
- 14.58 If the nearest relative objects to an application being made for admission for treatment under section 3, the application cannot be made. If it is thought necessary to proceed with the application to ensure the patient's safety or that of others and the nearest relative continues to object, the AMHP will need to consider applying to the county court for the nearest relative's displacement under section 29 of the Act.

Consultation with other people

- 14.59 Although there are specific requirements to consult the nearest relative, the value of involving other people in the decision-making process should be recognised, particularly the patient's carers, family members and advocates, who are often able to provide a particular perspective on the patient's circumstances. In so far as the urgency of the case allows, AMHPs should consider consulting with other relevant relatives, carers or friends and should take their views into account.
- 14.60 Where patients are under 18, AMHPs should, in particular, consider consulting with the patient's parents (or other people who have parental responsibility for the patient – see Chapter 19), assuming they are not the patient's nearest relative anyway.
- 14.61 In deciding whether it is appropriate to consult carers and other family members, AMHPs should consider:
- the patient's wishes
 - the nature of the relationship between the patient and the person in question, including how long the relationship has existed, and
 - whether the patient has referred to any hostility between them and the person in question, or there is other evidence of hostility, abuse or exploitation.
- 14.62 AMHPs should also consult wherever possible with other people who have been involved with the patient's care, including their care co-ordinator if they have one. This could include people working for statutory, voluntary or independent services and other service providers who do not specialise in mental health services but have contact with the patient.
- 14.63 Some patients may have an attorney or deputy appointed under the MCA who has authority to make decisions about their personal welfare. Where such a person is known to exist, AMHPs should take reasonable steps to contact them and seek their opinion. Where attorneys or deputies have the power to consent or refuse treatment for mental disorder on the patient's behalf, they should also be given the opportunity to talk directly to the doctors assessing the patient, where practicable.

Medical examination by doctors as part of the assessment

- 14.64 A medical examination must involve:
- direct personal examination of the patient and their mental state
 - consideration of all available relevant clinical information, including that in the possession of others, professional or non-professional.
- 14.65 If direct physical access to the patient is not immediately possible and it is not desirable to postpone the examination in order to negotiate access, consideration should be given to requesting that an AMHP apply for a warrant under section 135 of the Act.
- 14.66 Where practicable, at least one of the medical recommendations should be provided by a doctor with previous acquaintance with the patient. Preferably, this should be a doctor who has personally treated the patient. It is sufficient for the doctor to have had some previous knowledge of the patient's case. A patient's GP will usually have knowledge of the patient's physical health and family circumstances, which may be helpful in any assessment.
- 14.67 It is preferable that a doctor who does not have previous acquaintance with the patient be approved under section 12 of the Act. The Act requires that at least one of the doctors must be so approved.
- 14.68 Doctors must give reasons for the opinions stated in their recommendations. When giving a clinical description of the patient's mental disorder as part of these reasons, doctors should include a description of the patient's symptoms and behaviour, not merely a diagnostic classification.
- 14.69 Where patients are subject to the short-term effects of alcohol or drugs (whether prescribed or self-administered) which make interviewing them difficult, the doctors should either wait until the effects have abated before interviewing the patient or arrange to return later. If it is not realistic to wait, because of the patient's disturbed behaviour and the urgency of the case, the assessment will also have to be based on information the doctor can obtain from reliable sources. This will also apply if the patient is not willing to speak to the doctor. This should be made clear in the doctor's recommendation.
- 14.70 When making recommendations for detention under section 3, doctors are required to state that appropriate medical treatment is available for the patient.

Commissioning and section 140 of the Act

- 14.71 Local health boards are responsible for commissioning mental health services to meet the needs of their areas. Under section 140 of the Act, local health boards have a duty to notify local authorities in their areas of arrangements which are in force for the reception of patients in cases of special urgency or the provision of appropriate accommodation or facilities specifically designed for patients under the age of 18.
- 14.72 The Welsh Health Specialised Services Committee (WHSSC) is responsible for the commissioning of secure mental health services and other specialist services. Local health boards should work with providers to ensure that procedures are in place through which beds can be identified whenever required.

- 14.73 Local authorities, local health boards, police forces and ambulance services should ensure that they have in place a clear joint policy for the safe and appropriate admission of people in their local area agreed at board or board equivalent level by each party and each party should appoint a named senior lead.
- 14.74 Persons carrying out functions for these parties should understand the policies and their purpose, the roles and responsibilities of other agencies involved, and follow the local policy and receive the necessary training to be able to carry out fully their functions.
- 14.75 In order to promote a patient's recovery, health boards and care providers should work together to take steps, with appropriate input from section 12 doctors and AMHPs, to ensure that patients are detained in facilities as close as is reasonably possible to the patient's preferred location (e.g. near to their usual residence or family member).
- 14.76 This should take account of any risk assessment undertaken, the availability of services which can meet the patient's individual needs, any assessment in respect of the likely duration of the patient's stay, and any other factors raised by the patient and their family. The location of the placement, and considerations relevant to that decision, should be monitored and reviewed regularly.
- 14.77 In cases where the patient lacks capacity to make clear their preferred location, a best interests decision on their preference should be taken.
- 14.78 Local health boards should ensure as far as is possible that the carers are involved in the decision about where to locate an individual, and are informed of the reasons for the decision taken. Health Boards should have in place a policy so that the patient and/or the patient's carers are able to challenge a decision.
- 14.79 Local recording and reporting mechanisms should be in place to record the details of any delays in placing patients, and the impacts on patients, their carers, provider staff and other professionals are reported to local health board and local authority

Action when it is decided to make an application

- 14.80 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.
- 14.81 Before making an application, AMHPs should ensure that appropriate arrangements are in place for the immediate care of any dependent children the patient may have and any adults who rely on the patient for care. Their needs should already have been considered as part of the assessment. Where relevant, AMHPs should also ensure that practical arrangements are made for the care of any pets and for the local authority to carry out its other duties under the Social Services and Well-being (Wales) Act 2014 to secure the patient's home and protect their property.

- 14.82 Applications for detention must be addressed to the managers of the hospital where the patient is to be detained. An application must state a specific hospital. An application cannot, for example, be made to a multi-site provider without specifying which of the provider's sites the patient is to be admitted to.
- 14.83 Where units under the management of different bodies exist on the same site (or even in the same building), they will be separate hospitals for the purposes of the Act, because one hospital cannot be under the control of two sets of managers.
- 14.84 Where there is potential for confusion, the respective hospital managers should ensure that there are distinct names for the units. In collaboration with local authorities, they should take steps to ensure that information is available to AMHPs who are likely to be making relevant applications to enable them to effectively distinguish the different hospitals on the site and to describe them correctly in applications.
- 14.85 Once an application has been completed, the patient should be transported to hospital as soon as possible, if they are not already in the hospital, but patients should not be moved until it is known that the hospital is willing to accept them.
- 14.86 A properly completed application supported by the necessary medical recommendations provides the applicant with the authority to transport the patient to hospital even if the patient does not wish to go.
- 14.87 The AMHP should provide an outline report for the hospital at the time the patient is first admitted or detained, giving reasons for the application and any practical matters about the patient's circumstances which the hospital should know. Where possible, the report should include the name and telephone number of the AMHP or a care co-ordinator who can give further information. Local authorities should use a standard form on which AMHPs can make this outline report.
- 14.88 Where it is not realistic for the AMHP to accompany the patient to the hospital it is acceptable for them to provide the information outlined above by agreed means compatible with transferring confidential information. If providing the information by telephone, the AMHP should ensure that a written report is sent to the admitting hospital as soon as possible.
- 14.89 An outline report does not take the place of the full report which AMHPs are expected to complete for their employer (or the local authority on whose behalf they are acting – if different).
- 14.90 Where it is known that the patient is a restricted patient; the AMHP should ensure that the Mental Health Casework Section of the Ministry of Justice is notified of the detention as soon as possible. This information should be left during office hours, although a duty officer is available at all times for urgent queries.
- 14.91 If the patient is a looked after child under the Children Act 1989, AMHPs should inform the local authority's children's services as soon as possible. If this patient is placed out of the area of the local authority that looks after the child ('responsible authority'), AMHPs should inform the children's services in both the responsible authority and the local authority in which the child is placed.

- 14.92 An application cannot be used to admit a patient to any hospital other than the hospital stated in the application.
- 14.93 In exceptional circumstances, if patients are transported to a hospital which has agreed to accept them, but there is no longer a bed available, the managers and staff of that hospital should assist in finding a suitable alternative for the patient. This may involve making a new application to a different hospital.

If the application is under section 3, new medical recommendations will be required, unless the original recommendations already state that appropriate medical treatment is available in the proposed new hospital. The hospital to which the original application was made should assist in securing new medical recommendations if they are needed. A situation of this sort should be considered a serious failure and should be recorded and investigated accordingly.

Communicating the outcome of the assessment

- 14.94 Having decided whether or not to make an application for admission, AMHPs should inform the patient, giving their reasons. Subject to the normal considerations of patient confidentiality, AMHPs should also give their decision and the reasons for it to:
- the patient's nearest relative
 - the doctors involved in the assessment
 - the patient's care co-ordinator (if they have one), and
 - the patient's GP, if they were not one of the doctors involved in the assessment.
- 14.95 An AMHP should, when informing the nearest relative that they do not intend to make an application, advise the nearest relative of their right to do so instead. If the nearest relative wishes to pursue this, the AMHP should suggest that they consult with the doctors to see if they would be prepared to provide recommendations.
- 14.96 Where the AMHP has considered a patient's case at the request of the nearest relative, the reasons for not applying for the patient's admission must be given to the nearest relative in writing. Such a letter should contain, as far as possible, sufficient details to enable the nearest relative to understand the decision while at the same time preserving the patient's right to confidentiality.

Action when it is decided not to apply for admission

- 14.97 There is no obligation on an AMHP or nearest relative to make an application for admission just because the statutory criteria are met.
- 14.98 Where AMHPs decide not to apply for a patient's detention they should record the reasons for their decision. The decision should be supported, where necessary, by an alternative framework of care or treatment (or both). AMHPs should decide how to pursue any actions which their assessment indicates are necessary to meet the needs of the patient. That might include, for example, referring the patient to social, health or other services.
- 14.99 The steps to be taken to put in place any new arrangements for the patient's care and treatment, and any plans for reviewing them, should be recorded in writing and copies made available to all those who need them. The patient's care co-ordinator, if they have one, should be fully involved in decisions about meeting the patient's needs.

- 14.100 Arrangements should be made to ensure that information about assessments and their outcome is passed to professional colleagues where appropriate, e.g. where an application for admission is not immediately necessary but might be in the future. This information will need to be available at short notice at any time of day or night.
- 14.101 More generally, making out-of-hours services aware of situations that are ongoing – such as when there is concern for an individual but no assessment has begun or when a person has absconded before an assessment could start or be completed – assists out-of-hours services in responding accordingly.

Resolving disagreements

- 14.102 If there are differences of opinion between professionals, doctors and AMHPs should consult other professionals, especially care co-ordinators and others involved with the patient's current care, and to consult carers and family, while retaining for themselves the final responsibility for their decision. Where disagreements do occur, professionals should ensure that they discuss these with each other.
- 14.103 Where there is an unresolved dispute about an application for detention they should explore and agree an alternative plan – if necessary on a temporary basis. Such a plan should include a risk assessment and identification of the arrangements for managing the risks. The alternative plan should be recorded in writing, as should the arrangements for reviewing it. Copies should be made available to all those who need it (subject to the normal considerations of patient confidentiality).

Agency responsibilities – the local health board

- 14.104 The Welsh Ministers have delegated to local health boards (LHBs) the function of approving medical practitioners under section 12(2) of the Act. 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 local authorities.
- 14.105 LHBs 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. LHBs 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 authorities

14.106 LHBs, Trusts and local authorities 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.

Patients who are deaf

14.107 AMHPs and doctors assessing a deaf person should, wherever possible, have had deaf awareness training, including basic training in issues relating to mental health and deafness. Where required, they should also seek assistance from specialists with appropriate expertise in mental health and deafness. This may be available from one of the specialist hospital units for deafness and mental health. Contact with such units may, in particular, help to prevent deaf people being wrongly assessed as having a learning disability or another mental disorder.

14.108 Unless different arrangements have been agreed locally, the AMHP involved in the assessment should be responsible for booking and using registered qualified interpreters with expertise in mental health interpreting, bearing in mind that the interpretation of thought-disordered language requires particular expertise. Relay interpreters (interpreters who relay British Sign Language (BSL) to hands-on BSL or visual frame signing or close signing) may be necessary, such as when the deaf person has a visual impairment, does not use BSL to sign or has minimal language skills or a learning disability.

14.109 Reliance on unqualified interpreters or health professionals with only limited signing skills should be avoided. Subject to the normal considerations about patient confidentiality family members may occasionally be able to assist a professional interpreter in understanding a patient's idiosyncratic use of language. Family members should not be relied upon in place of a professional interpreter, even if the patient is willing for them to be involved.

14.110 Pre-lingual deafness may cause delayed language acquisition, which may in turn influence social behaviour. People carrying out assessments under the Act should have an awareness and knowledge of how mental health problems present in pre-lingually deaf people.

Patients with dementia

14.111 Individuals who are presenting signs and symptoms of dementia as well as those with a confirmed diagnosis of dementia can fall within the Act's definition of mental disorder. Dementia can pose particular challenges and understanding of the condition is essential to delivery of quality care.

14.112 Generally, people who have dementia present a range of behaviours, for example:

- dementia is generally progressive, meaning symptoms gradually get worse over time. How quickly it progresses varies from person to person

- people with dementia experience memory loss, have problems recalling things that happened recently and can sometimes repeat themselves
- people with dementia often have difficulty communicating, including through speech, but many have difficulty reading and understanding written material
- some people with dementia experience problems concentrating, are confused about time or place, and/or have difficulty problem solving and sequencing tasks
- some people experience sight or visual difficulties, for example judging distances or misinterpreting reflections in mirrors, and/or
- people with dementia can have problems controlling their emotion, experience mood changes and lose interest in things, for example become unusually sad or frightened, angry or upset or withdrawn.

14.113 People with dementia may present and behave in very different ways from those with other kinds of mental disorder. It is important that such behaviours are understood properly if the Act is to be used appropriately. Effective communication is key to supporting people to understand the assessment process, e.g. giving people time to answer questions and using non-verbal aids where appropriate.

14.114 Where possible, professionals with specialist skills and knowledge to support people who have dementia should be involved in any decision to use the Act.

14.115 Professionals working in hospital or the community to support patients who have dementia should have appropriate skills, knowledge and expertise, or be able to acquire these, to support patients with dementia effectively.

14.116 Especially in times of crisis, decisions about the use of the Act for people with dementia may have to be made by professionals who are not specialists in the field. AMHPs and doctors assessing the person should have a sufficient understanding of signs and symptoms of dementia as well as other forms of mental disorder.

Patients detained under the Immigration Act 1971 or Nationality, Immigration and Asylum Act 2002

14.117 Section 48 of the Act empowers the Secretary of State to direct the removal from custody to hospital of individuals who are detained under particular provisions of the Immigration Act 1971 or under section 62 of the Nationality Immigration and Asylum Act 2002, who are suffering from a mental disorder of a nature or degree which makes it appropriate for them to be detained in a hospital, are in need of urgent medical treatment and where appropriate medical treatment is available. Section 53 makes further provision in relation to such detainees and their transfer to hospital or back to custody, and when a transfer direction ceases to have effect.

14.118 Providers should ensure that in supporting individuals in immigration removal centres they are alert to the need to identify individuals' mental health needs as early as possible. Where transfers to hospital for assessment and treatment have been deemed appropriate, they should be made in a timely manner to the most suitable location based on clinical need.

- 14.119 Professionals should be aware that immigration detainees may be particularly vulnerable patients – for example, they may be victims of violence, war or torture; they may have limited access to friends or relatives to support them and that they may need additional support, e.g. interpretation services. Consideration should be given to any special support they might require as a result of their background, including their culture, ethnicity or religion. Consideration should also be given to why they may behave in certain ways (e.g. why they might be unwilling to disclose mental health problems).
- 14.120 Due consideration should be given to appropriate discharge planning and care following the discharge of a patient from an in-patient setting, including if they are returning to an immigration removal centre.

Chapter 15

Emergency applications for detention

- 15.1 An application for admission for assessment under section 4 of the Mental Health Act 1983 (the Act) can be made on the basis of a single medical recommendation. Such an application should only be made when the matter is urgent and it would be unsafe to wait for a second medical recommendation for admission under section 2.

Application for assessment in an emergency (section 4)

- 15.2 An application for detention under section 4 may be made only when:
- the criteria for detention for assessment under section 2 are met
 - the patient's detention is required as a matter of urgent necessity, and
 - obtaining a second medical recommendation would cause undesirable delay.
- 15.3 An application under section 4 may also only be made if the applicant has seen the patient personally within the previous 24 hours. The duties of approved mental health professionals (AMHPs) in respect of applications are the same as for applications under section 2.
- 15.4 The guidance given in Chapter 14 about the way in which assessments should be carried out applies equally to applications under section 4 other than there will only be one doctor involved.

Urgent necessity

- 15.5 Section 4 should only be used in an 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.
- 15.6 An emergency arises where the mental state or behaviour of a patient cannot be immediately and safely managed. To be satisfied 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

- 15.7 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 at all possible.

- 15.8 If a second medical recommendation is not available within the timescale required this should be considered a serious matter. Should timely second medical recommendations regularly be unavailable the AMHP should have access to an officer in the local authority who is sufficiently senior to take up the matter with the relevant local health board and NHS Trust as applicable.
- 15.9 The local authority, on whose behalf the AMHP is acting, should make it clear to the AMHP the matter must be reported to a senior officer.

Actions to be taken on admission under section 4

- 15.10 The authority to transport a patient to hospital and to start their detention lasts for 24 hours from the time the doctor examined the patient for the purposes of the application, or from the time the application is made – whichever is the earlier. A patient may then be detained for a maximum of 72 hours unless a second medical recommendation is provided to the hospital managers in accordance with the Act.
- 15.11 Those detained under section 4 should be informed of the availability of an Independent Mental Health Advocate (IMHA) to support them under section 130I.
- 15.12 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 local authority should be informed of the 'conversion' into a section 2 application so the AMHP can inform the patient's nearest relative.
- 15.13 If the second examining doctor decides the patient meets the criteria for detention under section 3, a new 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 and two new medical recommendations will be required. However, the first medical examiner may provide a further recommendation if he or she also considers the criteria for detention under section 3 are met.
- 15.14 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 as an informal patient in respect of consent to treatment. Patients detained under section 4 who lack capacity to consent to treatment may be treated under the Mental Capacity Act 2005 (MCA) if it is deemed to be in their best interests and within the scope of the MCA.
- 15.15 Hospital managers should monitor the use of section 4 and ensure second doctors are available to visit a patient within a reasonable time after being requested. This will also be monitored by HIW.

Chapter 16

Police powers and places of safety

- 16.1 This chapter provides guidance on police powers to remove a person to a place of safety under the provisions of the Mental Health Act 1983 (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.

Warrant to search for and remove patients

Section 135(1) warrant

- 16.2 The section 135(1) warrant provides police officers with a power of entry to private premises, in order to remove a person to a place of safety for a mental health assessment or for other arrangements to be made for their treatment or care.
- 16.3 The warrant must be applied for by an Approved Mental Health Professional (AMHP) and can be granted by a magistrate when a person is believed to be suffering from mental disorder and is being ill-treated, neglected or kept otherwise than under proper control, or is living alone and unable to care for themselves.
- 16.4 Local authorities should ensure that there is guidance to AMHPs on how and when to apply for a warrant both during and outside court hours and that this is also available to the relevant partner agencies (including the relevant local health board and police force).
- 16.5 The guidance should describe the necessary processes, the evidence which individuals may be reasonably expected to produce, and the documents that should be prepared.
- 16.6 Magistrates have to be satisfied that it is appropriate to issue a warrant. They are likely to ask applicants why they are applying for a warrant, whether reasonable attempts to enter without a warrant have been made and, if not, why not. Although it is not necessary for permission to enter to have been refused in order for a section 135(1) warrant to be granted, applicants should provide documented reasons for seeking a warrant if they have not already tried to gain access.
- 16.7 Two copies of the warrant should be made and the copies clearly certified as copies. One copy should be retained by the police and the other handed to the occupier of the premises. A third copy may be taken for retention by the person in charge of the place of safety to which the patient is removed.
- 16.8 The warrant gives any police officer the right to enter the premises, by force if necessary. The police officer may remain even if asked to leave, and may also search the premises for the person believed to be suffering from a mental disorder. When acting on the warrant, the officer must be accompanied by an AMHP and a doctor. It may be helpful if the doctor who accompanies the police officer is approved for the purposes of section 12(2) of the Act. A person should be told the reasons for the removal before they are removed.

- 16.9 The police officer may then remove the person to a place of safety, where they can be detained for up to 72 hours from the time of their arrival. The actual transportation of the individual will be in line with locally agreed policies, which should ensure that the most appropriate form of transport is available.
- 16.10 Police transport should be the last resort and the use of police transport should be considered only when all other options are exhausted. Where it is reasonably practicable, before a warrant is applied for, the intended place of safety should be identified, and the necessary arrangements made. It should never be necessary to use a police station as a place of safety for people removed under section 135(1), other than in the most exceptional circumstances.
- 16.11 Before the execution of the warrant, the AMHP and any relevant others, should contribute to the risk assessment carried out by the police, in order to mitigate any risks identified and to help to keep the person safe during the process of their assessment or removal.
- 16.12 Following entry under section 135(1), the AMHP and doctor between them should determine whether the person needs to be taken to a place of safety for further assessment or for other arrangements to be made for their treatment or care. The power to detain a person under section 135(1) ceases once an application for further detention has been made under the Act, or other arrangements have been made for their treatment or care, or it has been decided that no further action is to be taken in respect of the person.
- 16.13 The AMHP and the doctor may convene a mental health assessment in the person's home if the person consents and it is safe and appropriate to do so. In taking this decision, consideration should be given to who else is present.
- 16.14 Reliance upon section 135 to gain entry in an emergency situation may be inappropriate due to the time it can take to obtain the necessary warrant. The police may use their power of entry under Section 17(1) (e) of the Police and Criminal Evidence Act 1984 (PACE) for the purposes of saving life or limb or preventing serious damage to property: however this does not confer on the police any power to remove the person to a place of safety or to detain them.

Section 135 (2) warrant

- 16.15 The section 135(2) warrant provides police officers with a power of entry to private premises for the purposes of removing a patient who is liable to be taken or returned to hospital, or any other place, or into custody under the Act. The warrant must be granted by a magistrate. It enables a police officer to enter the premises, search for, and remove the patient so they can be taken to, or returned to, where they ought to be.
- 16.16 When a warrant issued under section 135(2) is being used, the patient should be told why they are being detained, taken or retaken to hospital, before this happens. It is generally good practice for the police officer to be accompanied by a person with authority from the managers of the relevant hospital (or local authority if applicable) to detain the patient and to take or return them to where they ought to be.

- 16.17 For patients subject to a community treatment order (CTO) it is good practice for this person to be the care co-ordinator or another member of the multi-disciplinary team responsible for the patient's care or other relevant individual involved such as a support worker or advocate.
- 16.18 When taking the person to a place of safety by virtue of a section 135(2) warrant, the AMHP, hospital managers or the local authority, as appropriate, should ensure transport is available in accordance with the locally agreed policy for the transport of patients under the Act. The police should not normally be needed to transport the person or to escort them following the execution of a section 135(2) warrant.

Section 136: mentally disordered people found in public places

- 16.19 Section 136 is an emergency power which allows for the removal of a person who is in a place to which the public have access, to a place of safety if a police officer considers it necessary in the interests of that person, or for the protection of others. The person must appear to the police officer to be suffering from a mental disorder and be in immediate need of care or control. The person should then receive a mental health assessment, and any necessary arrangements should be made for their on-going care.
- 16.20 'A place to which the public have access' includes places to which members of the public:
- have open access
 - access if a payment is made; or
 - access at certain times of the day.
- It does not include private premises, such as the person's own place of residence or private homes belonging to others in which case a section 135 warrant is needed. It is not appropriate to encourage a person outside in order to use section 136 powers.
- 16.21 A police officer may use section 136 if they encounter the person in a public place, including if they are already on scene, responding to a call, are approached, or otherwise come into contact with them.
- 16.22 The police should not generally be called to a hospital to use their section 136 powers. A hospital ward is not a place to which the public has access and section 136 should not be used in such circumstances.
- 16.23 However, it may be appropriate for the police to attend a hospital if the person is in the grounds, or another public part of the hospital, such as a part of the accident and emergency department to which the public have access.
- 16.24 When considering the use of police powers to detain people under the Act, less restrictive alternatives to detention should be considered. Health and/or social care professionals may be able to identify alternative options. For example, with the person's consent, the police, or any other qualified person may convene a mental health assessment without using section 135 or section 136 powers, by requesting that a section 12-approved doctor attend in order to assess the person and make any arrangements for their on-going care. Where appropriate, and depending on specific circumstances, consultation with family members and carers may also help, particularly in the case of children and young people.

- 16.25 A police officer may, without the use of section 136 powers, decide to escort a person who is voluntarily seeking urgent mental healthcare to an appropriate service. The police may also benefit from seeking advice before using section 136 powers in cases where they are unsure that the circumstances are sufficiently serious for using these powers. Local protocols should set out how this advice can be provided and who the police should contact, including out of hours.
- 16.26 The use of physical restraint or force may be required when removing a person, or in a place of safety, for the protection of the person or others. If physical restraint is used, it should be necessary and unavoidable to prevent harm to the person or others, and be proportionate to the risk of harm if restraint was not used. The least restrictive means of controlling and restraining the person should always be used and the person should be treated in line with the guiding principles detailed in Chapter 1.
- 16.27 There should be a clear local protocol about the circumstances when, very exceptionally, police may be asked to use physical restraint in a health-based place of safety²⁰.
- 16.28 Subject to further national guidance, if police are required to attend in order to assist in restraining a patient, then officers should be briefed on the patient's medical condition. A clear strategy should be developed between the police and mental health care practitioners on what would be the least restrictive method of restraint to be used, given the patient's physical and mental health condition. Additionally, suitably trained medical staff should be present to ensure patients' physical wellbeing.
- 16.29 The purpose of removing a person to a place of safety in these circumstances is to enable the person to be examined by a doctor and interviewed by an AMHP, so that the necessary arrangements can be made for the person's care and treatment. It should not be used as a substitute for, or affect the use of, other police powers.
- 16.30 The maximum period a person may be detained under section 136 is 72 hours, beginning at the time of arrival at the first place of safety. The person should be assessed by a doctor and interviewed by an AMHP as soon as possible after the person is brought to the place of safety.
- 16.31 As soon as practicable after the assessment and interview, the person should either be discharged, informally admitted, further detained under the Act, or other arrangements made for the person's treatment or care in the community. The person may continue to be detained while these arrangements are being made, provided that the maximum period of detention is not exceeded.
- 16.32 People detained under section 136 are sometimes far from home. Arrangements should be in place so that the police can take a patient to the nearest available health-based place of safety, which should admit the person even when the person resides in another area.
- 16.33 Local authorities should also have arrangements in place so that the nearest AMHP can attend, although consideration should always be given to whether an AMHP from the person's home authority, with the benefit of local knowledge and understanding of any relevant history, could reasonably travel to assess the person.

²⁰ The College of Policing will be providing guidance on police attendance at places of safety

16.34 These arrangements should also ensure that, when a place of safety serves an area that includes more than one local authority, the relevant AMHP services work together to ensure continuity of care and timely attendance.

Local policies on use of police powers and places of safety

16.35 Local authorities, local health boards, NHS commissioners, police forces, ambulance services and, if appropriate, the third sector should ensure that they have a clear and jointly agreed policy for use of the powers under sections 135 and 136, as well as the operation of agreed places of safety within their localities, and should ensure that:

- all professionals involved in implementation of the powers understand them, their purpose, the roles and responsibilities of other agencies involved, and follow the local policy
- professionals involved in implementation of the powers receive the necessary training to be able to carry out their role
- the parties to the local policy meet regularly to discuss its effectiveness in the light of experience and review the policy where necessary
- partner agencies decide when relevant information about specific cases can be shared between them for the purposes of safeguarding the person and the protection of others, if there is thought to be a risk of harm
- responsibilities are allocated to those who are best placed to discharge them
- police officers know who to contact prior to the removal of a person to a place of safety under section 136, in order to help secure their acceptance into a health-based place of safety.

16.36 The local policy should define responsibilities for:

- commissioning and providing sufficient safe and secure health-based places of safety, including places for people under the age of 18
- identifying and agreeing the most appropriate places of safety in local areas, including contingency arrangements for those cases where the preferred place of safety is not available
- escalating and reviewing decisions, particularly in the event of disagreement
- providing prompt assessment (including how soon the doctor and AMHP should attend) and, where appropriate, admission to hospital for further assessment or treatment
- securing the attendance of police officers at health-based places of safety, where appropriate, for the patient's health or safety or the protection of others
- the safe, timely and appropriate transport of the person to and between places of safety
- deciding whether it is appropriate to transfer the person from the place of safety to which they have been taken to another place of safety
- ensuring that people who are intoxicated can be safely managed in any place of safety or an emergency department, and receive an assessment of both their physical and mental health needs and the circumstances in which it may be that the patient may not be safely managed in the health-based place of safety
- ensuring that people who are behaving, or have behaved, violently can be safely managed in a place of safety
- arranging access to a hospital emergency department for assessment for people who need it, and having an agreed list of circumstances when this will be necessary, such as where a person is self-harming, has a high body temperature, physical injury or pain

- record keeping, monitoring and audit of practice against policy
- the release, transport and follow-up of people assessed under section 135 or 136 who are not then admitted to hospital or immediately accommodated elsewhere
- preparing multi-agency care plans for people who are repeatedly detained under section 136
- determining the circumstances when police officers will remain in attendance when a person arrives at a place of safety, deciding when health care staff will take responsibility for the person and confirming that the police officers can leave once the situation is agreed to be safe
- deciding how all cases of children and young people detained in police custody, in line with the admission guidance for children and young people , and those deemed particularly vulnerable are reviewed.

16.37 In developing local policy due consideration should be given to the commitment made and principles contained within any relevant national guidelines.

Places of safety

16.38 The locally agreed policy should contain a list of identified places of safety and should clearly outline the process for identifying the most appropriate place of safety to which a particular person is to be removed. This should be a health-based place of safety where mental health services are provided and these places should ensure that they have arrangements in place to cope with periods of peak demand.

16.39 Other options which might be appropriate to the individual's needs should be considered. For example, a residential care home, the home of a relative or friend of the person who is willing to accept them temporarily or agreed third sector provision. Other areas of a psychiatric hospital (such as a ward) may be used as a temporary place of safety, provided that it is appropriate to use that place in the individual case.

16.40 A police station should never be used as a place of safety except in exceptional circumstances and must not be used as the automatic second choice if there is no local health-based place of safety immediately available.

16.41 If, exceptionally, a police station is used, the locally agreed policy should set out the time within which the appropriate health and social care professionals will attend the police station to assess the person. In most cases this will be within 3 hours and should be a priority for the doctor and AMHP.

16.42 Alternatively, a transfer to a more appropriate place of safety should be made as soon as one becomes available, unless it is clearly in the best interests of the person not to move them. In these circumstances, wherever practicable, detention in a police station under section 136 should not exceed a maximum period of 12 hours.

16.43 If, in exceptional circumstances, a police officer needs to take a person to an emergency department after detaining that person under section 136, for the emergency medical assessment or treatment of their physical health this should not be treated as an admission to a place of safety. Detention under section 136 will begin when the person is taken to the appropriate place of safety for the assessment of their mental health.

- 16.44 In identifying the most appropriate place of safety for an individual, consideration should be given to the impact that the proposed place of safety and the journey to it may have on the person. In the event a person is taken to a police station, it should be clearly explained to them they are not suspected of any crime or other wrongdoing, and they are being kept there until they can be assessed to see if they need any care or treatment.
- 16.45 Where an individual is removed to a place of safety by the police, the following policy applies:
- to allow arrangements to be made for the person to be interviewed and examined as soon as possible, the police should make contact as soon as is practicable with the hospital and local authority before the person's arrival at the place of safety
 - intoxication (whether through drugs or alcohol) should not be used as a basis for exclusion from places of safety, except in the circumstances set out in the local policy agreed within the framework of the Mental Health Care in Crisis concordant for Wales. Health-based places of safety should not conduct tests to determine intoxication as a reason for exclusion
 - If the person is dangerously intoxicated and requires medical attention, it is important that they receive these services
 - if a child or young person is taken to a place of safety in a police station this will constitute a NHS serious and untoward incident and be reported as such. Areas will commit to review each case.

Assessment at a place of safety

- 16.46 Doctors examining patients should, wherever possible, be approved under section 12 of the Act. Where the examination has to be conducted by a doctor who is not approved under section 12, the doctor concerned should record the reasons.
- 16.47 The local policy should set out the expected time limits within which the assessment at a place of safety should commence. Where possible, the assessment should be undertaken jointly by the doctor and the AMHP and should begin as soon as possible after the arrival of the individual at the place of safety.
- 16.48 It is good practice for the doctor and AMHP to attend within three hours²¹. In all cases, the person detained must be told that the maximum period of detention is 72 hours.
- 16.49 Either a consultant psychiatrist in learning disabilities or an AMHP with knowledge and experience of working with people with learning disabilities should, wherever practicable, be available to make the assessment where it appears that the detained person has a learning disability.

²¹ Royal College of Psychiatrists. Position Statement PS2/2013. Guidance for commissioners: service provision for section 136 of the Mental Health Act 1983, April 2013

- 16.50 Where the person detained is under the age of 18, or is known to have moved recently to adult mental health services, they should be taken to an appropriate place of safety where either a child and adolescent mental health services (CAMHS) consultant or an AMHP with knowledge and experience of caring for this age group should, wherever practicable, undertake the assessment. If arranging for a CAMHS specialist to assess the person would result in a substantial delay, then those assessing the person should at least discuss the case with an appropriately qualified person. Where there is no local place of safety specifically for under 18s, the local health-based place of safety should be used.
- 16.51 The authority to detain a person ends as soon as the assessment under section 135(1) or 136 has been completed and suitable arrangements have been made. If a doctor assesses the person and concludes that the person is not suffering from a mental disorder then the person must be discharged, even if not seen by an AMHP.
- 16.52 If the doctor sees the person first and concludes that they have a mental disorder and that compulsory admission to hospital is not necessary, but that they may still need treatment or care (whether in or out of hospital), the person should still be seen by an AMHP. The AMHP should consult the doctor about any arrangements that might need to be made for the person's treatment or care.
- 16.53 If the assessment by a doctor reveals that the person is not suffering from a mental disorder, but there are physical symptoms which require treatment, then the person should be released and appropriate steps taken to manage the physical condition.

Transfer between places of safety

- 16.54 A person removed to a place of safety under section 135(1) or section 136 may be moved to a different place of safety within the maximum 72-hour period, this time cannot be extended if the person is transferred to another place of safety. It is expected that even when a person is transferred to an alternate place of safety the time limits referred to in paragraph 16.42 should still apply.
- 16.55 The person may be taken to the second or subsequent place of safety by transport arranged by a police officer, the AMHP or a person authorised by either a police officer or the AMHP.
- 16.56 A person may be transferred before their assessment has begun, while it is in progress, or after it is completed and they are waiting for any necessary arrangements for their care or treatment to be put in place. If it is unavoidable, or it is in the person's interests, an assessment begun by one AMHP or doctor may be taken over and completed by another, either in the same location or at another place to which the person is transferred.
- 16.57 The decision in each case should reflect the individual circumstances, including the person's needs and the level of risk. For example, where the purpose of the transfer would be to move a person from a police station to a more appropriate health-based place of safety, the benefit of that move needs to be weighed against any delay it might cause in the person's assessment and any distress that the journey might cause them. Any delays resulting from transferring the person cannot result in an overall period of detention which exceeds 72 hours.

- 16.58 Unless it is an emergency, a person should not be transferred without the agreement of an AMHP, a doctor or another healthcare professional that is competent to assess whether the transfer would put the person's health or safety (or that of other people) at risk.
- 16.59 A person should never be moved from one place of safety to another unless it has been confirmed that the new place of safety is willing and able to accept them and it is in the best interests of the person to be moved.
- 16.60 A record of the person's time of arrival must be made immediately when they reach the place of safety and as soon as detention in a place of safety under section 135(1) or 136 ends, the individual must be told that they are free to leave. The organisation responsible for the place of safety should ensure that proper records are kept of the end of the person's detention under these sections. In cases where alternative places of safety are used, local policies should define responsibilities to ensure that proper records are kept of the time of arrival, and the time the detention ends.
- 16.61 The time of arrival at the first place of safety should be shared between the transferring and receiving place of safety. When admitted to a place of safety in a hospital, a record of the admission, and of the outcome of the assessment, should be made.
- 16.62 If a person is excluded from a place of safety in a hospital and taken to a police station as a place of safety, a record should be made of the decision, of who made the decision, and the reason it was made.

Monitoring

- 16.63 It is expected the Mental Health Act 1983 monitoring committee or equivalent will review all cases where a person is taken to a police based place of safety.
- 16.64 The locally agreed policy should include arrangements for the use of section 136 (in particular) to be monitored effectively so that:
- analysis can be made of the circumstances in which the section is used and the outcomes of its use, including in relation to children and young people, and people with protected characteristics as defined under the Equality Act 2010 (see Chapter 3), and
 - the parties to the policy can consider any changes to the mental health services or police operations or any other matters that might result in a reduction of its use.
- 16.65 Monitoring Information is collected by local health boards and received by Welsh Government. This information will be shared with all interested parties including HIW.

Chapter 17

Transport of patients

17.1 This chapter provides guidance on the transport (which may also referred to as conveyance) of patients from one place to another under the provisions of the Mental Health Act 1983 (the Act).

General matters

17.2 Patients should always be transported in the manner which is the least intimidating to them and most likely to preserve the dignity of the patient and their family. This should be consistent with managing any risk to the health and safety of the patient or other people.

17.3 This applies in all cases where patients are compulsorily transported under the Act, including:

- taking patients to hospital to be detained for assessment or treatment
- transferring patients between hospitals
- returning patients to hospital if they are absent without leave
- taking and returning patients who are subject to guardianship to the place their guardian requires them to live
- taking patients to, and between, places of safety
- returning people to hospital if they are on community treatment order (CTO), or conditional discharge, and have been recalled
- transferring patients between hospital, including special hospitals, court and/or prison.

17.4 Patients should be informed as soon as possible of the reasons for any planned transfers and their views on the planned transfer taken into consideration. If the patient does not have the capacity to either agree to a method of conveyance or express their views, a decision based upon their best interests should be made.

17.5 Patients should be supported, where appropriate, to discuss the planned transfer with family members, friends or carers. The nearest relative should be informed of the transfer. A record of these discussions should be made in the patient's notes.

17.6 If, under exceptional circumstances, a patient is being transported to a hospital out of area to receive assessment and/or treatment, the commissioning local health board should consider whether they can provide assistance to support the family and/or friends to contact and/or visit the patient. This is particularly relevant when the patient is a child or young person.

Factors to be considered

17.7 When deciding on the most appropriate method for transporting a patient, factors to be taken into account include:

- the guiding principles in Chapter 1
- the wishes and views of the patients, including any relevant care and treatment plan or advance statement

- the nature of the mental disorder, including the patient's needs for support and supervision during travel
- the patient's age and gender
- cultural sensitivities
- any physical disability which the patient has
- the impact that any particular transport will have on the patient's relationship with the community to which he or she may return
- any risks to the health and safety of the patient – including their need for support, supervision and clinical care or monitoring during the journey. This is particularly important where sedation has been, or may be, used
- the likelihood of the patient behaving in a violent or dangerous manner
- the risk of the patient absconding and the risk of harm in the event of the patient absconding before admission to hospital
- the effect on the patient of who accompanies them (e.g. whether the presence or absence of the approved mental health professional (AMHP) or one of the doctors involved in the decision to detain them may have a detrimental or beneficial effect)
- the health and safety of the people transporting the patient and anyone else accompanying them
- the availability of various transport options
- the distance to be travelled
- the availability of transport to return those who accompany the patient, and whether an alternative to transporting the patient is available and appropriate, e.g. video conferencing for a court appearance.

17.8 it is expected an ambulance or other suitable vehicle, with health staff, will normally be the most appropriate method of transporting an individual in need of or receiving mental health services. Police vehicles should therefore only be used when this is the most appropriate method of transport.

Locally agreed arrangements

17.9 Local health boards (LHBs) commission ambulances and patient transport services to meet the needs of the people living within their area. This includes services for transporting patients to and from hospital. LHBs should ensure appropriate transport will be made available in a timely manner where it is needed to transport patients under the Act.

17.10 Local agreements should be in place so those who need assistance in transporting patients under the Act can obtain such assistance without delay. Agencies, including local health boards and NHS Trusts responsible for hospitals and ambulance and transport services, any NHS-funded providers and the police and local authorities, should agree joint local policies and procedures.

17.11 These should include:

- a clear statement of the respective roles and obligations of each agency (and their staff) to transport patients in different circumstances and how any conflicts should be resolved
- the form of any authorisation to be given by AMHPs (and others) when authorising other persons to transport patients on their behalf

- the assistance managers and staff of receiving hospitals will provide to AMHPs to make the necessary arrangements for the transport of patients who are to be admitted to their hospital
- guidance and training (including refresher training) for staff and managers on the legal powers in relation to transporting patients
- a clear statement of how risk assessment and risk management should be conducted and how the outcomes will influence decisions in relation to the transport of patients
- agreement on the appropriate use of different methods of restraint in transporting patients and how decisions on their use will be made in any given case
- any special arrangements where patients need to be transported outside the local area, and
- processes for reviewing and monitoring the involvement of the different agencies, including standards against which delivery will be monitored and how any complaints should be handled.

17.12 Policies should ensure AMHPs are not left to negotiate arrangements with providers of transport services on an ad hoc basis. Policies should also be consistent with those agreed in relation to the use of the police powers in sections 135 and 136 of the Act (see Chapter 16).

17.13 The following table explains who has the authority to take and convey the patient. In practice this person is likely to co-ordinate transport. How the co-ordination of transport is managed locally should be clearly described in the local arrangements.

Reason for transport	Legal authority	Who has the authority to take and convey the patient
Admission to hospital	Section 6(1)	The applicant (i.e. the AMHP or nearest relative)
Transfer between hospitals	Section 19 and associated regulations	Hospital
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)	Can be Police or AMHP or person authorised by them, depending on place of safety
Return of patients absent without leave (including those who have absconded)	Section 8(7) Section 138	Can be Police, AMHP, hospital staff or hospital manager
Recall from CTO or conditional discharge	Section 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

Transporting to hospital for admission

- 17.14 A properly completed application for admission under the Act gives the applicant, whether an AMHP or nearest relative, the authority to take the patient to the hospital named in the application.
- 17.15 If an AMHP is the applicant, he or she should ensure all the necessary arrangements are made for the patient to be taken to hospital. All relevant agencies should co-operate fully with the AMHP to ensure safe transport to hospital.
- 17.16 If the nearest relative is the applicant and they need help to ensure the safe transport of their relative, the local authority should ensure the availability of an AMHP to help them. If this is not possible, other professionals involved in the admission to hospital should help.
- 17.17 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 16.
- 17.18 If the patient is likely to be violent or dangerous, the police may be asked to help. An ambulance or other appropriate vehicle should be used. 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.
- 17.19 Patients who have been sedated before being transported should always be accompanied by a health professional that is knowledgeable and experienced in the care of such patients, able to monitor the patient closely, identify and respond to any physical distress which may occur and who has access to the necessary emergency equipment to do so.
- 17.20 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.
- 17.21 Where it is necessary to use a police vehicle because of the risk involved, it may be necessary for a qualified member of an ambulance crew or other suitably qualified health professional to accompany the patient, with the appropriate equipment, to deal with any immediate physical health problems that may arise. In such cases, the ambulance should follow directly behind to provide any further support that is required.
- 17.22 AMHPs should only agree to a patient being transported by private vehicle if they are satisfied the patient and others will be safe from risk of harm and it is the most appropriate way of transporting the person. In these circumstances there should be a clinical escort for the patient other than the driver.

- 17.23 People authorised by the applicant to transport patients act in their own right and not as the agent of the applicant. They may act on their own initiative to restrain patients and prevent them absconding, if absolutely necessary. However, when they are the applicant, AMHPs retain a professional responsibility to ensure the patient is transported in a lawful safe and dignified manner and should give guidance to those asked to assist.
- 17.24 Patients may be accompanied by another person (e.g. a family member or friend), provided the AMHP and the person in charge of the vehicle are satisfied this is in the patient's best interests and will not increase the risk of harm to the patient or others.
- 17.25 The AMHP should telephone the receiving hospital to ensure the patient is expected and give the likely time of arrival. If possible, the name of the person who will be formally receiving the patient and their admission documents should be obtained in advance.
- 17.26 The AMHP should ensure 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 member of staff authorised to receive them.
- 17.27 If the AMHP is not travelling with the patient, he or she should arrive at the hospital at the same time as the patient or as soon as possible afterwards. The AMHP should ensure the admission documents have been delivered, the admission of the patient is under way and any relevant information is passed to the hospital staff. The AMHP should stay in the hospital with the patient until satisfied the patient has been detained properly.
- 17.28 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. Local authorities, LHBs and 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 within hospital case records.
- 17.29 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 28 may be delivered by telephone other means which comply with local or national procedures for passing confidential information.

Transporting patients between hospitals and returning patients who abscond

- 17.30 Where a patient requires transport between hospitals, it is for the managers of the hospitals concerned to make sure appropriate arrangements are put in place. The managers of the hospital from which the patient is being transferred remain responsible for the patient until the patient is admitted to the new hospital.

- 17.31 Where a patient who is absent without leave from a hospital is taken into 'lawful custody' by someone working for another agency, the managers of the hospital from which the patient is absent are responsible for making sure any necessary transport arrangements are put in place for the patient's return.
- 17.32 However, the agency which temporarily has 'lawful custody' of the patient is responsible for them in the interim and should therefore assist in ensuring the patient is returned in a timely and safe manner.
- 17.33 When making arrangements for the return of patients temporarily held in police custody, hospital managers should bear in mind police transport to return them to hospital will not normally be appropriate. Decisions about the kind of transport to be used should be taken in the same way as for patients being detained in hospital for the first time.
- 17.34 A section 135(2) warrant provides police officers with a power of entry to private premises for the purposes of removing a patient who is liable to be taken or returned to hospital or any other place or into custody under the Mental Health Act 1983.
- 17.35 When taking the person to a place of safety by virtue of a section 135 warrant, the AMHP, hospital managers or the local authority, as appropriate, should ensure transport is available in accordance with the locally agreed policy for the transport of patients under the Act. The police should not normally be needed to transport the person or to escort them following the execution of a section 135 warrant.

Transporting patients recalled from a Community Treatment Order (CTO)

- 17.36 The responsible clinician will be responsible for coordinating the patient's recall. The responsible clinician's decision to recall a patient on a CTO 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. Further guidance is given in Chapter 29.

Conveying patients between hospitals or places of safety

- 17.37 Patients taken to a place of safety under sections 135 and 136 can be moved between places of safety, the reasons and justification for the transfer should be recorded (see Chapter 16).

Transporting patients subject to part 3 of the Act

- 17.38 Information on transporting patients subject to part 3 of the Act, including children and young people, is given in Chapter 22.

Chapter 18

Holding powers

18.1 This chapter provides guidance about the use of 'holding powers' available to doctors, approved clinicians and nurses, and how they should be exercised.

Holding powers of doctors and approved clinicians under section 5(2)

18.2 Section 5(2) authorises the detention of the patient in the hospital for a maximum of 72 hours so the patient can be assessed with a view to an application for detention under the Mental Health Act 1983 being made. It should only be used if, at the time, it is not practicable or safe to initiate an application for detention without also detaining the patient in the interim. That is the patient must be unwilling to remain in hospital in order for the assessment for detention to be made and it must be necessary for the person to remain in hospital until the assessment can be undertaken.

18.3 Section 5(2) should not be used as an alternative to making an application, even if it is thought the patient will only need to be detained for 72 hours or less.

18.4 Section 5(2) can only be used where the person in charge of the treatment of a hospital in-patient, a doctor, approved clinician, or their nominated deputy, having personally examined the patient, concludes that an application under sections 2 or 3 of the Act should be made.

18.5 The identity of the person in charge of a patient's medical treatment at any time will depend on the particular circumstances; however, a professional who is treating the patient under the direction of another professional should not be considered to be in charge.

18.6 There may be more than one person who could reasonably be said to be in charge of a patient's treatment e.g. where a patient is receiving treatment for both a physical and a mental disorder. In such a case, the psychiatrist or approved clinician in charge of the patient's treatment for the mental disorder is the preferred person to use the power in section 5.

18.7 The period of detention starts at the moment the doctor's or approved clinician's report is given to the hospital managers (e.g. when it is handed to an officer who is authorised by the managers to receive it, or when it is put in the hospital's internal mail system - this should be recorded in the patient's notes).

18.8 Arrangements for an assessment to consider an application under section 2 or section 3 of the Act should be put in place as soon as the report is given to the hospital managers.

- 18.9 In this context, a hospital in-patient means any person who is receiving in-patient treatment in a hospital and who is not already liable to be detained or who is a subject to a community treatment order. Patients who are in hospital by virtue of a deprivation of liberty authorisation under the Mental Capacity Act 2005 (MCA) may be detained under section 5(2), as they would now be objecting to remaining in hospital. It does not matter whether the patient was originally admitted for treatment primarily for either a mental disorder or a physical condition.
- 18.10 If the doctor invoking the 5(2) power is not a psychiatrist or approved clinician or nominated deputy they should make immediate contact with a psychiatrist or an approved clinician to obtain confirmation of their opinion the patient needs to be detained so that an application can be made.

Nomination of deputies

- 18.11 Section 5(3) allows the doctor or approved clinician in charge of an in-patient's treatment to nominate a deputy to independently exercise section 5(2) powers in their absence.
- 18.12 Only a doctor or approved clinician on the staff of the same hospital may be a nominated deputy. The deputy does not have to be a member of the same profession as the person nominating them. Only one deputy may be authorised at any time for any patient, and it is unlawful for a nominated deputy to nominate another.
- 18.13 Doctors and approved clinicians should only be nominated as a deputy if they are competent to perform the role. Nominated deputies should report the use of section 5(2) to the person for whom they are deputising as soon as practicable.
- 18.14 It is permissible for deputies to be nominated by title, rather than by name – e.g. the junior doctor on call for particular wards – provided there is only one nominated deputy for any patient at any time and it can be determined with certainty who that nominated deputy is.
- 18.15 Doctors and approved clinicians may leave instructions with ward staff to contact them (or their nominated deputy) if a particular patient wants or tries to leave. However, they may not leave instructions for their nominated deputy to use section 5(2), nor may they complete a section 5(2) report in advance to be used in their absence. The deputy must exercise their own professional judgment. Patients should not be admitted informally with the sole intention of then using the holding power.

Ending section 5(2)

- 18.16 Although the holding power lasts for a maximum of 72 hours, it should not be used to continue to detain patients after:
- the doctor or approved clinician decides an assessment for a possible application no longer needs to be carried out, or
 - following assessment, a decision is taken not to make an application for the patient's detention.

18.17 Patients should be informed immediately they are no longer detained under the holding power and that they are free to leave the hospital or that they have been detained under some other authority, such as an authorisation under the deprivation of liberty safeguards in the MCA and this should be fully explained

Holding powers of nurses under section 5(4)

18.18 Nurses of the 'prescribed class'²² may detain a hospital in-patient under section 5(4) of the Act. The decision to invoke the power is the personal decision of the nurse, who cannot be instructed to exercise the power by anyone else. This power may only be used where the nurse considers:

- the patient is suffering from mental disorder to such a degree it is necessary for the patient to be immediately prevented from leaving the hospital, either for the patient's health or safety or the protection of other people, and
- it is not practicable to secure the attendance of a doctor or approved clinician who can submit a report under section 5(2).

18.19 Before using the power, nurses should make as full an assessment as possible in the circumstances, but sometimes it may be necessary to invoke the power on the basis of only a brief assessment.

18.20 They should assess:

- the likely arrival time of the doctor or approved clinician
- 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
- the harm that might occur to the patient or others if the patient were to leave the hospital before the doctor or approved clinician arrives. In this regard the nurse should consider all aspects of the patient's communication and behaviour, including:
 - the patient's expressed intentions
 - the likelihood of the patient harming themselves or others and/or behaving violently
 - any evidence of disordered thinking
 - any changes to their usual behaviour and any history of unpredictability or impulsiveness
 - dates of special significance for the patient
 - any recent disturbances on the ward and/or any relevant involvement of other patients
 - any formal risk assessments which have been undertaken; and
 - any other relevant information.

18.21 The use of the holding power permits the patient's detention for up to six hours or until a doctor or approved clinician with the power to use section 5(2) arrives at the place the person is being detained, whichever is the earlier. It cannot be renewed.

²² See the Mental Health (Nurses) (Wales) Order 2008.
<http://www.legislation.gov.uk/wsi/2008/2441/contents/made>

- 18.22 The patient is detained from the moment the nurse makes the necessary record. The reasons for invoking the power and the time this was done should be entered in the patient's notes. The record must then be sent to the hospital managers. A nurse using section 5(4) should use the least restrictive intervention to prevent the patient leaving the hospital.
- 18.23 Hospital managers should ensure suitably qualified, experienced and competent nurses are available to all wards where there is a possibility of section 5(4) being invoked.
- 18.24 The use of section 5(4) is an emergency measure, and the doctor or approved clinician with the power to use section 5(2) in respect of the patient should treat it as such and arrive as soon as possible. The doctor or approved clinician should not wait the maximum time of six hours before attending.

Ending section 5(4)

- 18.25 If the doctor or approved clinician arrives before the end of the six-hour maximum period, the holding power lapses on their arrival. If the doctor or approved clinician then uses their own holding power, the maximum period of 72 hours runs from when the nurse first made the record detaining the patient under section 5(4).
- 18.26 If no doctor or approved clinician able to make a report under section 5(2) has attended within six hours, the patient is no longer detained and may leave if not prepared to stay voluntarily. The failure to attend should be considered as a serious failing, and should be reported and investigated locally.

Medical treatment of patients

- 18.27 The rules in Part 4 of the Act do not apply to patients detained under section 5 and as such there is no power under the Act to treat them without their consent. 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

- 18.28 Patients detained under section 5 cannot be transferred to another hospital under section 19 (because they are not detained by virtue of an application made under part 2 of the Act). This includes transfer between hospitals managed by the same hospital managers.
- 18.29 A patient who is subject to section 5(2) of the Act but needs to go to another hospital urgently for treatment, security or other exceptional reasons, can only be taken there if they consent to the transfer. If the patient lacks capacity to consent to the transfer, any transfer must be carried out in accordance with the MCA.
- 18.30 If, following transfer, the patient tries to leave the receiving hospital, a new situation will have arisen. In this circumstance, the receiving hospital may need to use section 5(2) to provide authority to detain the patient in that hospital.

18.31 In all cases, if the conditions are met, an emergency application for detention under section 4 of the Act could be made by the sending hospital. The patient could then be transferred to the receiving hospital under section 19. Alternatively, an emergency application under section 4 could be submitted to the managers of the receiving hospital.

Monitoring use

- 18.32 Hospital managers should monitor the use of section 5, including:
- how quickly patients are assessed for detention and discharged from the holding power
 - the attendance times of doctors and approved clinicians following the use of section 5(4), and
 - the proportion of cases in which applications for detention are, in fact, made following use of section 5.

Chapter 19

Children and young people under the age of 18

- 19.1 This chapter is concerned with:
- the guiding principles which, taken together with the first chapter of the Code, should inform decision-making for all children whether or not they are subject to compulsion, which may include their detention under the Mental Health Act 1983 (the Act)
 - assessing, caring for and treating children subject to compulsion, including their detention, using powers given by the Act
 - choosing between the Act and the Children Act 1989 as amended; and
 - guidance on consent to treatment of children and young people, including issues of competence and capacity.
- 19.2 Those responsible for the assessment and care and treatment of children should be familiar with the relevant legislation, including the Children Acts 1989 and 2004, the Rights of Children and Young Persons (Wales) Measure 2011, the Social Services and Well-being (Wales) Act 2014, the Mental Capacity Act (MCA) 2008 and the Human Rights Act (HRA) 1998. They should be aware of the United Nations Convention on the Rights of the Child (UNCRC), and keep up-to-date with relevant case law and guidance.
- 19.3 A child is a person under the age of 18 years. The Code uses the overarching terms 'child' and 'children' for those aged under 18 years and young person if matters only apply to those aged 16-18 years.

Guiding principles and overarching matters

- 19.4 Chapter 1 of the 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.
- 19.5 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.
- 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.

19.6 When assessing, caring for and treating children under 16, including where the use of compulsion under the Act is indicated, the following questions should as a minimum be considered:

- 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, where relevant, 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 2004 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?
- 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?

Confidentiality

- 19.7 Children have a right to confidentiality. Where children are competent, and young people have the capacity, to make decisions about the use and disclosure of information they have provided in confidence, their views should be respected. However, in certain circumstances, confidential information must be disclosed even if the child's consent has not been obtained; for example if there is reasonable cause to believe the child is suffering, or is at risk of suffering, significant harm or there is a risk of significant harm to others.
- 19.8 Where a child does not wish their parent(s) to be involved in their care every effort should be made to understand the child's reasons, with a view to establishing whether the child's concerns can be addressed. For example, the child may not want a parent to know about the details of counselling/therapy sessions, but be happy for their parents to be informed about more general aspects of their care and treatment.

Decisions on admission and treatment of those under 18

- 19.9 In all cases concerning hospital admission and/or treatment, practitioners must determine whether the proposed intervention can be undertaken on an informal basis. Consent should always be sought, irrespective of the child's status under the Act.
- 19.10 The following four concepts are relevant to admission and treatment decisions of both children and young people:
- consent
 - assessing capacity (young people) or competence (children) to make decisions
 - parental responsibility; and
 - deprivation of liberty (DoL).
- 19.11 There are differences in the legal framework supporting hospital admission and treatment of young people aged 16 and 17 years and children under 16 years.

Consent

- 19.12 A person's ability to consent to treatment applies equally to children provided they have the capacity and competence to make that decision. Therefore, the consent of a competent child with capacity will be sufficient authority for their admission to hospital and/or treatment for mental disorder, and additional consent by a person with parental responsibility will not be required. However, it is good practice²³ to involve the child's parents and/or others involved in their care in the decision making process, if the child consents to information about their care and treatment being shared.
- 19.13 Consent should be sought for each aspect of the child's admission, care and treatment as it arises. Consent forms that purport to give consent to 'any proposed treatment' are not acceptable and should not be used.

²³ [http://www.assembly.wales/Laid%20Documents/GEN-LD8880%20-%20Code%20of%20Practice%20to%20Parts%202%20and%203%20of%20the%20Mental%20Health%20\(Wales\)%20Measure%202010-23042012-232786/gen-ld8880-e-English.pdf](http://www.assembly.wales/Laid%20Documents/GEN-LD8880%20-%20Code%20of%20Practice%20to%20Parts%202%20and%203%20of%20the%20Mental%20Health%20(Wales)%20Measure%202010-23042012-232786/gen-ld8880-e-English.pdf)

- 19.14 Unlike adults, the refusal by a competent child aged under 18 years with capacity may, in certain circumstances, be overridden by a court. For example, the court has jurisdiction to override the refusal of a child of treatment in circumstances that will, in all probability, lead to the death of the child or to severe permanent injury; or where there is a serious and imminent risk the child will suffer grave and irreversible mental or physical harm. However, as with any person with capacity, the child's refusal is an important consideration when deciding whether or not treatment should be given, and its importance increases with their age and maturity.

Capacity & Competence

- 19.15 Before relying on the consent of a child it is necessary to ascertain whether they can give valid consent. The capacity of a young person aged 16 or 17 to consent is assessed in accordance with the Mental Capacity Act 2005 (MCA) (see Chapters 13 and 19). The test for children under 16 is determined by considering whether they are 'competent' (Gillick competent). Practitioners with expertise in working with children and young people should be consulted in relation to these assessments.

16 & 17 year olds

- 19.16 The MCA applies to people aged 16 years or over. As for adults, young people over 16 years must be assumed to have capacity to make the decision about a proposed admission to hospital and/or treatment unless it is established they lack capacity.
- 19.17 A young person must be regarded as able to understand the information relevant to the decision if they are able to understand an explanation of it given in a way that is appropriate to their circumstances. It is essential that all possible steps are taken to enable a young person to understand information, such as using simple language and visual aids if needed.
- 19.18 Where there are concerns about the capacity of a young person, the young person's capacity should be assessed by a professional with expertise in working with children and young people. Wherever possible, consideration should be given to whether the decision could be delayed to a time when the young person might be able to make the decision.
- 19.19 Every effort should be made to ensure the young person is supported in making the decision (e.g. by involving those with parental responsibility and/or advocates). Unless the case requires urgent action, the young person should be given the time they need to think things over and ask for clarification.
- 19.20 If it is not clear whether the young person's inability to decide is because of an 'impairment of, or a disturbance in the functioning of, the mind or brain' or whether due to some other reason, a specialist opinion should be sought from a professional with expertise in working with children and young people.
- 19.21 Whether or not the lack of capacity is primarily due to mental disorder or from other causes creating "an impairment of disturbance in the functioning of the mind or brain", the young person will lack capacity within the meaning of the MCA and the MCA will apply in the same way as it does for adults. It may therefore be possible for the particular decision to be made in accordance with the MCA for, and in the best interests of, the young person.

Children under 16

- 19.22 Children under 16 years should be assessed to establish whether they have competence to make a particular decision at the time the decision needs to be made. Children whose intelligence and understanding have developed sufficiently to enable them to understand fully what is involved in a proposed intervention will also have the competence to consent to that intervention (Gillick competent). A child may be competent to consent to admission to hospital, medical treatment, research, or any other activity that requires their consent.
- 19.23 The concept of Gillick competence reflects the child's increasing development to maturity. The understanding required to make decisions about different interventions will vary considerably. A child may have the competence to consent to some interventions but not others. The child's competence to consent should be assessed carefully in relation to each decision that needs to be made.
- 19.24 A child may lack the competence to make the decision in question either because they have not as yet developed the necessary maturity and understanding to make that particular decision; or for another reason, e.g. because their mental disorder adversely affects their ability to make the decision. In either case, the child will be considered to lack Gillick competence.

Parental responsibility

- 19.25 Those with parental responsibility have a central role in relation to decisions about the admission and treatment of their child and should be established in line with the relevant circumstances of the child and associated legislation.
- 19.26 However parental consent should not be relied upon when the child is competent or the young person has capacity to make the particular decision. Parental consent cannot be relied upon to override a young person's decision about their admission. Similarly, in relation to children, it is not advisable to rely on the consent of a parent with parental responsibility to admit or treat a child who is competent to make the decision and does not consent to it.
- 19.27 If parental consent is to be used as the legal basis for treatment of a child under 16 years old, practitioners must be satisfied it is appropriate to rely on parental consent. There are limits to both the types of decisions that can be made by those with parental responsibility on behalf of their child, and the circumstances in which these decisions can be made. Parents must act in their child's best interests.
- 19.28 Practitioners will need to consider two key questions which must be addressed:
- First, is this a decision that a parent should reasonably be expected to make? If the decision goes beyond the kind of decisions parents routinely make in relation to the medical care of their child, clear reasons as to why it is acceptable to rely on parental consent to authorise this particular decision will be required.
- 19.29 When considering this question, relevant human rights decisions made by the courts should be taken into account. Significant factors in determining this question are likely to include:

- the type and invasiveness of the proposed intervention – the more extreme the intervention, the greater the justification that will be required. (e.g. careful consideration should be given to the appropriateness of relying on parental consent to authorise electro-convulsive therapy (ECT))
- the age, maturity and understanding of the child or young person. The role of parents in decision-making should diminish as their child develops greater independence, with accordingly greater weight given to:
 - the views of the child or young person
 - the extent to which the decision accords with the wishes of the child or young person, and whether the child or young person is resisting the decision; and
 - whether the child or young person had expressed any views about the proposed intervention when they had the competence or capacity to make such decisions.

19.30 Secondly are there any factors that might undermine the validity of parental consent? For example:

- the parent is not able to make the relevant decision; e.g. the parent lacks capacity as defined in the MCA, (in cases of doubt, the parent's capacity will need to be assessed in accordance with the MCA)
- where the parent is not able to focus on what course of action is in the best interests of their child
- where the poor mental health of the child or young person has led to significant distress and/or conflict between the parents, so they feel unable to decide on what is best for their child and/or cannot agree on what action should be taken
- where one parent agrees with the proposed decision but the other is opposed to it; and
- there are concerns the parent is unlikely to act in the child's best interest.

19.31 Although parental consent is usually needed from only one person with parental responsibility, it may not be appropriate to rely on parental consent if another person with parental responsibility disagrees strongly with the decision to admit and/or treat their child, and is likely to take action to prevent the intervention, such as removing the child from hospital or challenging the decision in court.

Deprivation of liberty

19.32 The Deprivation of Liberty Safeguards do not apply to under 18 year olds, but Article 5 (the right to liberty) of the European Convention on Human Rights (ECHR) applies to individuals of all ages. However determining whether the admission to hospital and assessment and/or the treatment proposed amounts to a deprivation of liberty is as important for admission and treatment decisions concerning children and young people as it is for adults.

19.33 The role of parental control and supervision should be considered when deciding whether the proposed intervention in relation to a child is a restriction of liberty or amounts to a deprivation of liberty. Practitioners will need to determine whether the care regime for, and restrictions placed on, the child or young person accord with the degree of parenting control and supervision that would be expected for a child or young person of that age. Account would also need to be taken of the particular experience and developmental stage of the child or young person.

- 19.34 When determining whether a person with parental responsibility can consent to the arrangements which would, without their consent, amount to a deprivation of liberty, practitioners will need to consider and balance:
- the child's right to liberty under Article 5, which should be informed by Article 37 of the UNCRC
 - the parent's right to respect for the right to family life under Article 8, which includes the concept of parental responsibility for the care and custody of minor children, and
 - the child's right to autonomy which is also protected under Article 8.
- 19.35 Decision makers should seek their own legal advice in respect of cases before them.

Emergency treatment

- 19.36 A life-threatening emergency may arise when treatment needs to be given but it is not possible to rely on the consent of the child or person with parental responsibility and there is no time to seek authorisation from the court or (where applicable) to detain and treat under the Act.
- 19.37 Treatment may be given without their consent, even if this means overriding their refusal when they have the competence (children) or the capacity (young people and those with parental responsibility), to make this treatment decision if the failure to treat the child would be likely to lead to their death or to severe permanent injury.
- 19.38 In such cases, doubt should be resolved in favour of the preservation of life, and it will be acceptable to undertake treatment to preserve life or prevent irreversible serious deterioration of the child's condition and these decisions can be taken under the common law.
- 19.39 The treatment given must be no more than necessary and in the best interests of the child. Once the child's condition is stabilised, legal authority for on-going treatment must be established; this might be on an informal basis or in accordance with either a court order or, if the child is detained, under Part 4 of the Act

Informal Admission and Treatment

- 19.40 Children and young people may be admitted to hospital as informal patients on the basis of their consent. Informal admission and treatment can be authorised by either the child's consent, parental consent (where a child lacks competence or a young person lacks capacity) or in accordance with the MCA (where a young person lacks capacity).
- 19.41 Where admission cannot be authorised on an informal basis the criteria for detention under the Act must be met for the child or young person to be admitted under the Act. In circumstances where admission is recommended but informal admission cannot take place and criteria for detention under the Act are not met, legal advice should be obtained on whether to seek assistance from the court.

16 and 17 year olds

- 19.42 When a young person aged 16 or 17 years has capacity to consent to being admitted to hospital for treatment of mental disorder, they can consent to admission. If they give consent they can be admitted irrespective of the views of the person with parental responsibility (who cannot refuse admission). If the young person with capacity refuses consent to admission, then a person with parental responsibility cannot override their decision and cannot consent on their behalf.
- 19.43 Where a young person aged 16 or 17 years lacks capacity then under s131 of the Act they may be admitted informally on the basis of parental consent, unless the admission and treatment amounts to a deprivation of liberty, in which case consideration should be given to whether criteria for admission under the Act are met. If the Act is not applicable, legal advice should be sought on the need to seek authorisation from the court before further action is taken.

Children under 16

- 19.44 A child under 16 years who is Gillick competent to decide about their admission to hospital for assessment and/or treatment of their mental disorder, and who consents to this, may be admitted as an informal patient.
- 19.45 Where a child under 16 years who is Gillick competent refuses to be admitted for treatment, consideration should be given to whether admission under the Act is necessary. In such cases, it will often be inadvisable to rely on the consent of the person with parental responsibility.
- 19.46 Where a child under 16 years is not Gillick competent then it may be possible for a person with parental responsibility to consent, on their behalf, to their informal admission. If parental consent can be relied upon and consent is given by a person with parental responsibility, then the child can be admitted and treated as an informal patient.
- 19.47 If it is not considered appropriate to rely on parental consent, the child cannot be admitted and treated informally. In such cases consideration should be given to whether admission under the Act is necessary, and if so, whether criteria are met. If the Act is not applicable, legal advice should be sought on the need to seek authorisation from the court before further action is taken.

Choosing between the Mental Health Act 1983 and the Children Act 1989 (as amended)

- 19.48 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 medical treatment needed and the environment that is most appropriate for each child.

- 19.49 In considering the appropriate legislative framework to meet a child's needs, it is 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.
- 19.50 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 under the Children Act 1989. Section 25 of the latter Act allows the court to make an order for a child to be detained in secure accommodation, but this does not authorise medical treatment to be given.
- 19.51 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

- 19.52 As well as in the circumstance described above it may also be appropriate to seek the court's assistance in determining whether the proposed care or treatment is in the child's best interests 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.

Children and the Mental Health Act 1983

- 19.53 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.
- 19.54 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 14 gives fuller information on the assessment process.
- 19.55 Guidance on the administration of medication and electroconvulsive therapy (ECT) to children, including informal patients, is given in Chapter 25.

Admission to appropriate services

- 19.56 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. Detailed guidance is given in the Admission Guidance for Children and Young People²⁴.
- 19.57 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.
- 19.58 If possible, all staff involved in the care and treatment of children should be child specialists. All staff should have been vetted satisfactorily with the Disclosure and Barring Service. 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.
- 19.59 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 of that environment for their age. There is a clear difference between a suitable environment for a child in an emergency and a suitable longer-term environment. In an emergency, such as when a patient is in crisis, the important thing is that they are in a safe environment.
- 19.60 Once the initial emergency has abated 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.
- 19.61 If a young patient's presence on a ward with other children might have a detrimental effect on these children, the hospital managers must ensure the interests of the other children are also protected. However, these children's 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.

Education

- 19.62 Local authorities must make arrangements to provide suitable education for all children of compulsory school age. Children and young people admitted to hospital under the Act should have access to education that is on a par with that of mainstream provision, including appropriate support for those with special educational needs.
- 19.63 Practitioners and local authorities should work together to minimise any disruption to education and, in order to ensure that local authorities can meet their duty to provide suitable education, when a child or young person is admitted under the Act, they should be notified as soon as possible, ideally in advance of the admission.

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The duty on local authorities to ensure suitable education also applies when a child or young person is receiving treatment in a geographical area where they are not normally resident.

- 19.64 Young people over the school leaving age should have access to appropriate education and training irrespective of their circumstances or residence. Educations providers and health professionals should work together to ensure such provision is available.
- 19.65 When a child or young person with a statutory education or care and support plan is admitted to hospital under the Act, the local authority who maintains the plan should be informed, so they can ensure support continues to be provided. If necessary, the plan may be reviewed and amended to ensure targets and provisions remain appropriate. The local authority should also be involved in creating the discharge plan, so that the statutory plan is revised as necessary to continue to reflect the child or young people educational, health and social care needs. In most cases these plans will be incorporated into the child or young persons care and treatment plan.

Welfare of children admitted to hospital

- 19.66 Local authorities should arrange for visits to be made to:
- children looked after by them who are in hospital
 - 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 Act).
- 19.67 Local authorities should also:
- promote contact between children in need and their families, if they live away from home and it is 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.
- 19.68 The provision of financial support to cover the travel costs of visiting might be essential for some families, particularly those on low incomes, especially if their child has been placed out of area (see paragraphs 8A and 16 of schedule 2 of the Children Act 1989). In 2015 the Welsh Government agreed to extend its Discretionary Assistance Fund to include the provision of support for family members to undertake visits to their children receiving CAMHS inpatient treatment throughout the duration of their treatment. Information on the scheme should be available from the CAMHS clinical staff responsible for the child's ongoing care and treatment.
- 19.69 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.
- 19.70 Hospital managers should set up systems to ensure that directors of children's services are notified of cases in which their duty to visit and consider the welfare of children and young people in hospital arises.

Chapter 20

People with learning disabilities or autistic spectrum disorder

- 20.1 This chapter provides guidance on the application of the Mental Health Act 1983 (the Act) to people with a learning disability or an autistic spectrum disorder (ASD). Both conditions are developmental disorders (present from childhood) and although are mental disorders as defined by the Act it is generally more appropriate to consider them as a disability.
- 20.2 This chapter should be read and understood in the context of the Code as a whole and with particular regard to the guiding principles (see Chapter 1) People with learning disabilities or an ASD are particularly vulnerable to restrictive practices and are likely to require a range of reasonable adjustments, to ensure they benefit from these guiding principles. These reasonable adjustments will usually require additional support to be provided.

People with learning disabilities

- 20.3 The term learning disability has been used in this chapter although other terms such as intellectual disability, recently adopted by the Royal College of Psychiatrists, may be used by some professionals to describe the same condition.
- 20.4 A learning disability is an impairment of intellectual functioning, which significantly affects development and can lead to problems in understanding and using information, learning new skills and managing to live independently. A learning disability has been defined as a reduced intellectual ability and difficulty with every day activities, which affects someone for their whole life²⁵.
- 20.5 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.
- 20.6 Identifying a person with a learning disability should be informed by an assessment of social and intellectual functioning by those qualified to undertake the assessment. For most people this assessment will have occurred in childhood. In some cases however this may not have occurred and a detailed assessment may be required to identify a person with a learning disability if the use of the Act is being considered.
- 20.7 During any examination or assessment, in relation to the Act, people with learning disabilities should be provided with appropriate support. This may be from someone they know well and could include an advocate. Due consideration will need to be given to matters of confidentiality.

²⁵ Mencap-mencap.org.uk

- 20.8 When assessing or examining the person the following can be considered as 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.
 - Significant impairment of intelligence - a specialist in the assessment of cognitive and social development, such as a clinical psychologist, should 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.

Abnormally aggressive behaviour or seriously irresponsible conduct

- 20.9 A person with a learning disability can only be considered to have a mental disorder for the purposes of the provisions specified in section 1(2b) of the Act, without another co-occurring mental disorder, where the learning disability is associated with either of the following further features:
- abnormally aggressive behaviour, or
 - seriously irresponsible conduct.
- 20.10 For the purposes of those provisions, which include applications for detention for treatment or guardianship, or the making of hospital orders or community treatment orders, a person must not be considered to be suffering from a mental disorder solely because they have a learning disability: the disability must be associated with abnormally aggressive or seriously irresponsible conduct.
- 20.11 In assessing whether any behaviour is abnormally aggressive relevant factors may include:
- when such aggressive behaviour has been observed, and how persistent and severe it has been
 - whether it has occurred without a specific trigger or seemed disproportionate to the circumstances that triggered it
 - whether, and to what degree, it has resulted in harm or distress to the person themselves, other people, or actual damage to property
 - how likely it is to recur, and
 - how common similar behaviour is in the population generally given the context in which the behaviour occurred.
- 20.12 Similarly, in assessing whether a person's learning disability is associated with conduct that is not only irresponsible but seriously irresponsible, relevant factors may include:
- whether behaviour has been observed which suggests a disregard or an inadequate regard for its serious or dangerous consequences

- how recently such behaviour has been observed and, when it has been observed, how persistent it has been
- how seriously detrimental to the individual, or to other people, the consequences of the behaviour were or might have been
- whether, and to what degree, the behaviour has actually resulted in harm to the person or the person's interests, or in harm to other people or to damage to property, and
- how likely it is to recur.

20.13 Bizarre or unusual behaviour is not the same as abnormally aggressive or seriously irresponsible behaviour. When assessing whether a person with a learning disability should be detained for treatment under the Act, it is important to establish whether any abnormally aggressive behaviour or seriously irresponsible conduct identified stems from difficulties in communication or an underlying condition or syndrome or unmet need.

20.14 The term challenging behaviour, widely used in practice is not synonymous with either abnormally aggressive behaviour or irresponsible conduct. Challenging behaviour can be defined as:

“Culturally abnormal behaviour(s) of such an intensity, frequency or duration that the physical safety of the person or others is likely to be placed in serious jeopardy, or behaviour which is likely to seriously limit use of, or result in the person being denied access to, ordinary community facilities.”²⁶

20.15 The majority of people with learning disabilities who may show challenging behaviour would not meet the criteria in the Act for seriously abnormally aggressive behaviour or seriously irresponsible conduct.

20.16 Unless very urgent action is required, it would not be good practice to diagnose a person as having a learning disability associated with abnormally aggressive behaviour or seriously irresponsible conduct (or both) without a comprehensive multidisciplinary assessment.

20.17 Whenever possible an approved mental health professional (AMHP) who assesses someone with a learning disability under the Act should have experience and training in working with people with learning disabilities or ASD. If this is not possible they should seek assistance from specialists with appropriate expertise, but this should not be allowed to delay action that is immediately necessary.

20.18 People with learning disabilities will usually have a care plan describing their needs and support which may include a Care and Treatment Plan which should be used to inform the assessment process.

20.19 Professionals should record on the relevant form their reasons for concluding the individual's behaviour is abnormally aggressive or their conduct seriously irresponsible, and why it relates to the person's learning disability and is not attributable to others factors for example, any deterioration in the person's physical or mental health.

²⁶ Emerson, 1995, cited in Emerson, E (2001, 2nd edition): Challenging Behaviour: Analysis and intervention in people with learning disabilities. Cambridge University Press

20.20 For children or young people aged under the age of 18 (and for many people up until the age of 25), the fact that they are at an age where they are learning to manage their emotions should be taken into consideration. Children and young people with and without learning disabilities often experience and express their emotions more strongly than other people, and they need support to understand what might be happening to them (see Chapter 19).

Autistic spectrum disorder

20.21 Autistic spectrum disorder (ASD) can be defined as a lifelong developmental disability that affects the way a person communicates with, and relates to, other people. It also affects how the person understands the world around them. It is a spectrum condition which means each individual will have different needs.

20.22 The Act's definition of mental disorder includes the full range of autistic spectrum disorders, including those existing alongside a learning disability or any other kind of mental condition. It is possible for someone with an ASD to meet the criteria in the Act for detention without having any other form of mental disorder, even if the ASD is not associated with abnormally aggressive behaviour or seriously irresponsible conduct. See paragraph 20.28.

20.23 Compulsory treatment in a hospital setting is rarely likely to be helpful for a person with ASD, who may be very distressed by even minor changes in routine and is likely to find detention in hospital anxiety provoking. Wherever possible, less restrictive alternative ways of providing the treatment or supporting a person should be found and provided by staff who have the appropriate skills.

20.24 ASD occurs from early stages in development where a person shows marked difficulties with social communication, social interaction and social imagination. They may be preoccupied with a particular subject of interest. This spectrum includes high functioning people who need person-centred care as well as those with little or no verbal communication.

20.25 People with ASD may have additional or related problems, which frequently include anxiety. These may be related to social factors associated with frustration or communication problems or rigid or literal patterns of thought and behaviour. People with ASD may also have co-morbid mental disorders and in particular depression.

20.26 A person with ASD may have additional sensory and motor difficulties, which make them behave in an unusual manner which is in fact a coping mechanism. These include sensitivity to light, sound, touch and balance and may result in a range of regulatory behaviours, including rocking, self-injury and avoidance, such as running away.

20.27 A person with ASD may behave in ways that seem unusual to other people. There may also be a repetitive or compulsive element to the behaviour of people with ASD. The person may appear to be choosing to act in a particular way, but their behaviour may be distressing even to themselves. It may be driven or made worse by anxiety and could lead to harm to self or others. Repetitive behaviour does not in itself constitute a mental disorder.

- 20.28 A person with ASD may show a marked difference between their intellectual and their emotional development. Their behaviour may occasionally seem aggressive or seriously irresponsible. They may be able to discuss an act intellectually and express a desire to do or not do it, but they may not have the instinctive social empathy to keep to their intentions. This should be understood and responded to by professionals, who should recognise that specialist structured approaches to communication, may be required. When a person is unable to prevent them self from causing severe harm to them self or others, compulsory measures under the Act may be needed.
- 20.29 If people with ASD do need to be detained under the Act, they should be treated in a setting appropriate to their social and communication needs as well as being able to treat their mental condition. Practitioners working with or detaining people with ASD should have relevant specialist training and experience.
- 20.30 Those who have been detained may require, and be entitled to, aftercare (see Chapter 33). Discharge planning for people with ASD should begin when the person is admitted and involve health and local authorities to work together in the interests of an individual to ensure appropriate community-based support is in place before discharge. Reference should be made to the Autistic Spectrum Disorder (ASD) Strategic Action Plan for Wales.²⁷

Mental Capacity Act 2005

- 20.31 In addition to the information in Chapter 13, the following should be considered:
- where a person with learning disabilities or autism who is detained under the Act has a physical illness or condition which is unrelated to their mental disorder for which they need treatment (e.g. cancer treatment or pregnancy), the Mental Capacity Act 2005 (MCA) will apply to assessing whether they have the capacity to give consent to that treatment. If they are assessed to lack capacity to consent, any treatment given must be in accordance with the MCA, and
 - where a decision needs to be made about where a person with learning disabilities or autism is discharged to, and they lack the capacity to make that decision, then the MCA needs to be applied to reach a best interests decision for the person.
 - an Independent Mental Capacity Advocate may be required to represent a person when they are discharged from hospital. This includes when decisions about accommodation is made under section 117, if there is no requirement for the person to live in the proposed accommodation i.e. the person, if they had capacity, would be able to exercise a choice.

Equality Act 2010 and reasonable adjustments

- 20.32 If a person with a learning disability or ASD is detained under the Act, a comprehensive assessment of their needs should be undertaken to ensure reasonable adjustments required by the Equality Act 2010 are made (see Chapter 3).
- 20.33 As well as the following points, reasonable adjustments relate to many other areas of the Code, such as access to advocates, the Tribunal, and information giving. Reasonable adjustments should include:
- access to appropriate communication support

²⁷ <http://gov.wales/topics/health/publications/socialcare/reports/asd/?lang=en>

- information in an accessible format. This could include, for example, easy read leaflets or simple videos, although this does not replace the need for clear and simple verbal explanation by professionals
- sufficient time for the person and any others supporting them for preparation before meetings
- accessible information explaining rights and how to raise safeguarding concerns or complaints
- treatment goals and support plans in an accessible format
- adapted treatment programmes including psychological therapies
- adapted therapeutic environment
- ensuring meetings are held in an environment which is not intimidating
- health needs assessment and identification of any specific reasonable adjustments needed to meet any identified health problems
- risk assessment of personal safety (due to increased vulnerability), and
- prioritised access to and involvement of carers and/or advocates, unless the individual had indicated they do not want this.

20.34 The examination or assessment of someone with learning disabilities or ASD requires special consideration of how to communicate effectively with the person being assessed. Carers will often be able to assist clinicians with this and should be consulted where appropriate. Whenever possible the people carrying out assessments should have experience and training in working with people with learning disabilities or ASD. If this is not possible they should seek assistance from specialists with appropriate expertise, but this should not be allowed to delay action that is immediately necessary.

Practice considerations

Risks relating to people with learning disabilities or ASD

- 20.35 All those involved in examining, assessing, treating or taking other decisions in relation to people with learning disabilities or ASD should bear particular risks in mind, including:
- incorrect assumptions they do not have capacity to make decisions for themselves and a tendency to be over-protective. The MCA makes clear a person must be assumed to have capacity unless it is established they do not
 - incorrect assumptions that a tendency to acquiesce is the same as informed consent
 - failing to consult or fully listen to carers who, as ‘experts by experience’, can play an important role in providing relevant information about the person’s past, or about effective communication methods
 - over-reliance on carers, both for support and for decision-making. The considerable expertise of carers should be acknowledged, and appropriately used in partnership with the clinical team. This should not mean clinicians rely on carers to take decisions inappropriately and on their own on behalf of the person
 - a lack of appreciation of the potential abilities of people with learning disabilities or ASD, including their potential to make decisions for themselves
 - the risk the person may be denied access to decision-making processes, meetings about them or information
 - the person’s limited life experiences to draw on when making choices, and

- attributing the person's symptoms and behaviours to their learning disability or ASD rather than underlying undiagnosed and/or unmet physical or mental health needs or to something traumatic that happened to them in their past, this is known as diagnostic overshadowing.

Role of Hospital Managers

- 20.36 Hospitals providing treatment and care for people with learning disabilities or ASD should have policies and practices which specifically address:
- staff training and supervision in how to effectively communicate with people with learning disabilities or ASD, particularly in understanding their wishes and feelings
 - specialist staff who create communication books for individual in-patients and who teach staff how to develop personalised care for people who have learning disabilities or ASD
 - training of staff to ensure sufficient awareness and knowledge of learning disability, ASD, behaviour that challenges, and mental health, and training in positive behavioural support
 - training in the safe and effective management of commonly associated physical health conditions, such as epilepsy
 - ensuring physical health needs are met (e.g. annual health check and associated action plan)
 - reasonable adjustments and capable environments, and
 - regular audits of incidents involving restrictive practices to see whether less restrictive methods could be used.
- 20.37 People with learning disabilities, their families, carers and advocates should be helped to access information and (if necessary) legal advice on how to access the Tribunal and, if the person lacks capacity, the Court of Protection.
- 20.38 It cannot be assumed people with learning disabilities or ASD necessarily understand how to access information and advice about their rights, for example in relation to consent to admission and treatment, applications for discharge and accommodation decisions on discharge. Steps must be taken to ensure people with learning disabilities or autism can access information and advice, including access to additional support such as IMHAs or, if applicable, IMCAs.

Chapter 21

People with personality disorders

21.1 The Mental Health Act 1983 (the Act) applies equally to all people with mental disorders, including those with a diagnosis of personality disorder. This chapter is an aid to professionals and practitioners working with people with such disorders.

General Matters

21.2 Many people who have personality disorders present a complex range of mental health and other problems. They may:

- have a diagnosis of more than one personality disorder
- have other mental health problems such as depression, anxiety or post-traumatic stress syndrome
- experience suicidality, self-harm, substance misuse problems and eating disorders
- experience severe, periodic emotional distress in response to stressful circumstances and crisis
- at times display a form of psychosis that is qualitatively different from that displayed by people with a diagnosis of another mental disorder
- often have long-standing and recurrent relationship difficulties
- be more likely than other population groups to experience housing problems and long-term unemployment.

21.3 In addition, anti-social personality disorder is strongly associated with offending, and it is estimated there is a high prevalence of persons with personality disorders within offender populations.

Personality disorders and mental health legislation

21.4 People with personality disorders who are subject to compulsory measures under the Act may include individuals who:

- have a primary diagnosis of personality disorder and present a risk to themselves or others (or both)
- have complex mental disorders, including personality disorder, presenting risk to themselves or to others (or both)
- have primary diagnoses of personality disorder or complex disorders including personality disorder and are transferred from prison for treatment in secure psychiatric or personality disorder inpatient services
- are transferred from prison or other secure settings for treatment in hospitals
- are personality disordered offenders who have completed inpatient treatment, but who may need further treatment in the community.

Practice considerations

Assessment

- 21.5 Decisions made under the provisions of the Act in relation to people with personality disorders will often have to be made by professionals who are not specialists in the field, particularly in times of crisis. Approved mental health professionals (AMHPs) and doctors carrying out initial assessments should have a sufficient understanding of personality disorder as well as other forms of mental disorder, which may include an understanding of the impact of past trauma and distress.
- 21.6 Individuals who have historically been described as having a personality disorder may never have had a thorough clinical assessment. There are a number of validated assessment tools which enable a more precise diagnosis and/or formulation of specific personality disorders to be made. Professionals will need to ensure any treatment and aftercare plans are shaped by appropriate clinical assessments conducted by suitably trained practitioners.
- 21.7 In emergency or very high-risk situations, including where the patient is experiencing uncontainable levels of distress, where such an assessment has not already been carried out and an application for detention under the Act is being considered, responding to the immediate risk to the health or safety of the patient or to other people is the first priority. However, as for all patients, achieving an appropriate clinical assessment and/or formulation should be an immediate aim of detention.

Appropriate medical treatment

- 21.8 What constitutes appropriate medical treatment should always be based upon the individual needs of the patient. This is no different for those diagnosed with a personality disorder.
- 21.9 Any care and treatment plan will be for the purpose of alleviating or preventing a worsening of the patient's mental disorder, its symptoms or manifestations (see Chapters 23 and 34). The care and treatment plan may usefully include plans to: ensure safety; help with emotional/psychological distress; establish or maintain the basis for ongoing treatment; treat any other mental disorders and stabilise the patient's living environment.
- 21.10 Generally, treatment approaches for personality disorder need to be relatively intense and long term, structured and coherent. Sustainable long-term change is more likely to be achieved when the patient is engaged voluntarily.
- 21.11 People with personality disorders may take time to engage and develop motivation for such longer-term treatment. Where a patient is meaningfully engaged in such an intervention prior to admission, every effort should be made to maintain this intervention during the admission and to continue or re-establish it on discharge. Patients who are not engaged in that kind of treatment may also need other forms of treatment, including nursing and specialist care, to manage the continuing risks posed by their disorders, and this may constitute appropriate medical treatment.

- 21.12 In the majority of cases the primary model of intervention for personality disorder is rooted in a psycho-social model. This should be a consideration in decisions about the most appropriate professional to fulfil the responsible clinician role.
- 21.13 Patients who have been detained may often need to continue treatment in a community setting on discharge. Where there are continuing risks to themselves or others which cannot otherwise safely be managed, a community treatment order (CTO), guardianship or (for restricted patients) conditional discharge may provide a framework within which their treatment in the community can be continued. In deciding whether treatment under the Act can safely be delivered in the community, account should be taken of:
- where the specific model of treatment intervention can be most effectively and safely delivered
 - if management of personal and social relationships is a factor in the intervention, how the appropriate day-to-day support and monitoring for the patient's social as well as psychological needs can be provided
 - to what degree the psycho-social model of intervention requires the active participation of the patient for an effective and safe outcome;
 - the degree to which the patient has the ability to take part in a psycho-social intervention that protects their own and others' safety
 - the degree to which 24-hour access to support will be required, and
 - the need for the intervention plan to be supervised by a professional who is appropriately qualified in the model of intervention and in risk assessment and management in the community.
- 21.14 In the case of personality disordered offenders who may already have received long-term treatment programmes within secure or prison settings, treatment in the community may well still be required while they resettle in the community.

Chapter 22

Patients concerned with criminal proceedings

22.1 This chapter offers guidance on the use of the Mental Health Act 1983 (the Act) for the assessment and treatment for mentally disordered people who come before the criminal justice system (often known as Part 3 patients). It provides guidance on admission and discharge.

General matters

22.2 People subject to criminal proceedings have the same right to assessment and treatment for a mental disorder 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.

22.3 If criminal proceedings are discontinued it may be appropriate for the relevant local authority to arrange for an approved mental health professional (AMHP) to consider making an application for admission under Part 2 of the Act.

22.4 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 harming 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, treatment cannot be given in a prison without the patient's consent (if the patient does not have the capacity to consent, treatment can be provided under the Mental Capacity Act 2005 as long as it is in their best interests (see Chapter 13).

Criminal Justice Liaison Services

22.5 Any approach to service delivery should recognise the individual and complex needs of people coming into contact with the criminal justice system with a mental health problem and/or learning disability, and should be responsive and non-discriminatory.

22.6 Wherever possible, people who appear to police custody officers or the court to be mentally disordered should have their treatment needs considered at the earliest possible opportunity. Vulnerable people may be at greatest risk of self-harm while in custody and prompt access to specialist treatment may prevent significant deterioration in their condition²⁸.

22.7 A Criminal Justice Liaison Service (CJLS) should be provided to all who come into contact with the criminal justice system regardless of offence, ethnicity, nationality, language spoken, age, sexual orientation, religion, disability or social background.

²⁸ <http://www.nationalelfservice.net/mental-health/suicide/the-largest-ever-study-of-self-harm-in-prisons-prevalence-risk-clustering-and-subsequent-suicide/> and <https://www.google.co.uk/url?url=https://www.justice.gov.uk/downloads/offenders/psipso/psi-2011/psi-64-2011-safer-custody.doc&rct=j&frm=1&q=&esrc=s&sa=U&ved=0CBQQFjAAahUKEwi9qsWGlorGAhWMaxQKHU8FAPY&usg=AFQjCNEcTd2d0DFEe92-VTRJX6esM12jQ>

Assessment

Assessment by a doctor

- 22.8 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 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.
- 22.9 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. They should explain that any information disclosed, and the medical opinion, could be relevant not only to medical disposal by the court but also to the imposition of a non medical sentence, or to its length, and
 - request relevant pre-sentence reports, the person's medical record and 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); and
 - use other independent sources of information, where possible, about the person's history including, any previous convictions, general practitioner (GP) records, and information about psychiatric treatment and patterns of behaviour.
- 22.10 If the doctor (or one of them, if two doctors are preparing reports) proposes to recommend an admission to hospital within the period of 28 days beginning with the date of the making of the order under section 37, section 38 or section 45A of the Act, they should have access to a bed or take responsibility for referring the case to another doctor who does
- 22.11 If the court is making an order under the Criminal Procedure (Insanity) Act 1964, and Domestic Violence, Crime and Victims Act 2004 (DVCVA) the Court does not need a 'bed offer' as it does for other court orders but it is good practice for any doctor providing a recommendation of a hospital disposal to contact the anticipated named hospital in the order.
- 22.12 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.
- 22.13 Assessment for the patient's admission is the responsibility of the doctor but other members of the clinical team who may 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.
- 22.14 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.

This order provides for the person to be admitted to hospital for up to 12 weeks (which may be extended for further periods of up to 28 days to a maximum total period of 12 months) so that the court can reach a conclusion on the most appropriate and effective disposal. In this situation, the most appropriate setting for the person is a hospital, not a prison.

- 22.15 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.

Hospital orders/remands to hospital

- 22.16 Assessments for remands to hospital or for hospital orders still require assessment by a section 12 approved registered medical practitioner. Her Majesty's Courts and Tribunal Services (HMCTS) commission these reports in accordance with the Costs in Criminal Cases (General) Regulations 1986.

Mental health treatment requirement (MHTR)

- 22.17 The legislative changes introduced by Legal Aid, Sentencing and Punishment of Offenders Act 2012 (LASPO) introduces a simplified procedure for the assessment of an individual for a MHTR, this may now be undertaken by a mental health practitioner, rather than a section 12 approved registered medical practitioner. MHTRs must be administered under the direction of a registered medical practitioner or a chartered psychologist.
- 22.18 In cases where the doctor cannot state with confidence at the time of sentencing whether a hospital order or MHTR will be appropriate, they should consider recommending an interim hospital order under section 38 of the Act. In this situation, the most appropriate setting for the person is a hospital, not a prison.

Independent reports

- 22.19 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 to support their application to the court to end the remand. This is at the patient's own expense, or where applicable, through Legal Aid.

Assessment by an approved mental health professional (AMHP)

- 22.20 If an AMHP is asked 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 should 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

- 22.21 Clinical opinion is particularly important in helping courts determine the sentence. In particular it will help to inform the decision whether to divert the person from punishment by way of a hospital order, or whether a prison sentence is more suitable. Clinicians providing assessments should have experience of working with mentally disordered offenders.
- 22.22 A medical report should set out clearly:
- the sources of information 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 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.
- 22.23 The report should include an assessment of the patient's fitness to plead but not comment on guilt or innocence. The Good Practice Guidance: Commissioning, administering and production of psychiatric reports for sentencing²⁹, issued by HMCTS and the Ministry of Justice in 2010 drafted in conjunction with the judiciary and the Royal College of Psychiatrists provides further detailed guidance.

Recommendations on disposal

- 22.24 Section 157 of the Criminal Justice Act 2003 requires the court (unless it considers it to be unnecessary) to obtain a medical report which relates to the person's mental condition, before passing a custodial sentence, other than one fixed by law. Before passing such a sentence, the court must consider any information before it which relates to the offender's mental condition and the likely effect of such a custodial sentence on that condition and on the treatment which may be available for it.
- 22.25 It may, therefore, be appropriate to include recommendations on the disposal of the case. In making recommendations for disposal 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 a prison sentence is appropriate, the person should initially be admitted to hospital through a hospital direction under section 45A and a limitation direction which involves the patients being made subject to special restrictions; and
 - whether a community order with a mental health treatment requirement may be appropriate.

²⁹ Good Practice Guidance: commissioning, administering and production of psychiatric reports for sentencing. Her Majesty's Courts and Tribunal Service. 2012. <http://www.ohm.nhs.uk/resource/policy/GoodPracticeGuidePsychReports.pdf>

22.26 Consideration of longer term implications is especially important where the court considers the offender to be dangerous under the Criminal Justice Act 2003 and where an extended determinate sentence or a life sentence is appropriate. The medical reports, particularly with respect to the person's level of responsibility for the offence, will form an important element in the court's consideration of whether a hospital order under section 37 or a hybrid order (hospital direction and prison sentence) under section 45A is appropriate.

Restrictions, hospital orders and hospital directions

22.27 Where a Part 3 patient is made subject to special restrictions ('restricted patients'), 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.

22.28 It will be for the court (or the Secretary of State for Justice, as the case may be) to confirm the unit or hospital covered by the detention authority in each case where it makes use of the power.

22.29 When transferring a prisoner to hospital with a restriction direction attached, the Secretary of State for Justice may direct the patient be detained in a specific hospital unit. This will normally be to a named ward to prevent patients being moved to lower levels of security within a hospital without the Secretary of State for Justice's agreement.

22.30 Admission to a named unit will mean the consent of the Secretary of State for Justice will be required for any leave of absence or transfer from the named unit, even if the transfer is to the same level of security, or transfer is to another part of the same hospital or to another hospital. If however, the transfer involves no change to either the named unit or hospital prior agreement from the Secretary of State for Justice is not required. For example, if the detention authority covers a named hospital, to move patients between units within that hospital will not require the permission of the Secretary of State for Justice. The mental health casework section (MHCS) should be informed of the move.

22.31 A hospital order, with (section 37/41) or without restrictions (section 37) diverts the person from a custodial sentence to a hospital for treatment. There is no limit to the time a hospital order is in force so that the period of detention will be determined by the need for treatment in hospital.

22.32 A hospital direction, under section 45A, accompanies a prison sentence and means that from the start of the sentence the offender will be managed in hospital in the same way as a prisoner who has been transferred to hospital subject to special restrictions under sections 47 and 49 of the Act. The responsible clinician can propose transfer to prison to the Secretary of State for Justice at any time before the prisoner's release date if, in their opinion, they no longer require treatment in hospital and/or no effective treatment can be given.

Provision of information as to hospitals to courts

- 22.33 Section 39 of the Act provides that whenever the court is considering making a hospital order, a hospital and a limitation direction or an interim hospital order it may ask the appropriate LHB, or where it is appropriate, the Welsh Ministers, to provide information as to the availability of suitable hospital places for the offender in question. It also enables the court to request information about the availability of hospital places for child offenders in respect of whom the court is considering a remand under sections 35 or 36 or, in respect of a magistrates' court, a committal to hospital under section 44 of the Act
- 22.34 Section 39A provides that where a court is minded to make a guardianship order in respect of any offender, it may request the local authority for the area in which the offender resides or last resided, or any other local authority that appears to the court to be appropriate to inform the court whether it or any other person approved by it is willing to receive the person into guardianship and, if so, how the guardian's powers would be exercised.
- 22.35 Local authorities 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

- 22.36 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 services from the community. Any unacceptable delays in transfer after identifying a need should be actively monitored and investigated.
- 22.37 Prisoners with mental disorder who have given informed consent to treatment can 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 or another prison setting is able to provide for the prisoner's care if they are too unwell or vulnerable to return to residential wings.

Transfer and admission

- 22.38 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
 - an up to date forensic psychology report if available
 - a report from the prison health care service covering the patient's day-to-day care and management including a care and treatment plan if secondary mental health services had previously been provided.
 - any risk assessment, formulation and/or management plan
 - any relevant pre-sentence probation service reports which should be provided by the court, prison or immigration detention centre as appropriate.

22.39 All information should be made available to the patient's responsible clinician and other professionals concerned at the earliest opportunity.

Information

22.40 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.

Conveyance of patients on remand/subject to an interim hospital order

22.41 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. Secure hospitals that hold patients under part 3 of the Act and prisons responsible for the transfer of patients subject to part 3 of the Act should have their own security protocols.

Treatment without consent (patients remanded for assessment)

22.42 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 (MCA). For children under the age of 16, who are not competent to consent to the proposed treatment, it may be possible for a person with parental responsibility for the child to consent on their behalf.

22.43 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

22.44 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.

22.45 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 to escort the patient may be requested if the risk assessment indicates it is necessary and in line with national guidelines.

Return to prison

22.46 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.

Children and young people concerned with criminal proceedings

22.47 For children and young people 'custody' and 'youth detention accommodation' have the same meaning as prison and the detention accommodation will comprise:

- secure training centres (STC)
- secure children's homes (SHC)
- young offender institutions (YOI)
- local authority accommodation
- accommodation provided under subsection (5) of section 82 of the Children Act 1989, and
- other accommodation as specified by the Secretary of State.

Medical assessment

22.48 Medical assessments in the case of a defendant under the age of 18 should be undertaken by a professional with current clinical expertise, including specialist knowledge of child and adolescent mental health services (CAMHS). If this is not possible, professionals with the appropriate expertise and experience should be consulted.

22.49 A mental health assessment should be undertaken within three to five days of admission to a custodial setting. The Manual for the Comprehensive Health Assessment Tool (CHAT): Young People in the Secure Estate June (version 3)³⁰ provides guidance on undertaking the assessment.

22.50 Guidance on assessing the competence (of children under the age of 16) and the capacity (of young people aged 16 or 17) to make decisions about their admission to hospital and/or treatment is provided in Chapter 19.

³⁰ www.ohrn.nhs.uk/OHRNResearch/CHATToolV3June2013.pdf

Provisions for children and young people under the Act

- 22.51 The courts should be provided with comprehensive information regarding CAMHS beds which are, or could be made, available for patients. Details should also be provided of multi-agency after-care arrangements that will be or are likely to be needed when a child is no longer subject to the Act
- 22.52 The Ministry of Justice expects support and after-care to be provided by appropriate authorities in the event of return from a secure hospital to detention. The section 117 meeting provides an opportunity to ensure co-ordination.
- 22.53 Courts are unable to use section 45A of the Act in respect of children and young people (those under the age of 21 at the time of conviction) as they are not subject to a term of imprisonment.
- 22.54 Young people can become 'looked after children' if they become accommodated under section 20 of the Children Act 1989 or are the subject of a care order under section 31 of the Act or alternatively, for a period of their remand to youth detention accommodation or local authority accommodation under part 3 of the Legal Aid, Sentencing and Punishment of Offenders Act 2012.

Restricted patients

- 22.55 The Secretary of State for Justice has certain obligations with regard to the management of patients who are subject to restrictions (restricted patients) under the Act. The mental health casework section (MHCS) of the Ministry of Justice, on behalf of the Secretary of State for Justice, carries out these functions. Requests in respect of restricted patients will be considered and processed as quickly as possible. Detailed guidance is available on the Ministry of Justice website.³¹
- 22.56 Restricted patients are those who are subject to:
- a hospital order with restrictions (sections 37 and 41 of the Act)
 - a hospital and limitation direction (section 45A and section 45b)
 - a transfer direction with a restriction order (section 47 (sentenced prisoners); or
 - a transfer direction under section 48 (remand or civil prisoners and immigration detainees).
- 22.57 In respect of transferred prisoners, the restrictions are applied via the order under section 49.
- 22.58 A person charged with an offence before the Crown Court but found not guilty by reason of insanity, or found unfit to plead, may also receive a hospital and restriction order under sections 37 and 41. The restriction order carries no time limit so the patient will remain detained in hospital for as long as they require treatment. Where the patient is also subject to a prison sentence and the patient is a restricted patient by virtue of section 45A (a limitation direction) or section 49, the restriction will cease on the date the patient would be released from prison.
- 22.59 All decisions about restricted patients, including about community leave, transfer, remission or discharge are taken by the Secretary of State for Justice.

³¹ <http://www.justice.gov.uk/offenders/types-of-offender/mentally-disordered-offenders>

22.60 The Mental Health Review Tribunal for Wales has a statutory duty to review the detention of a restricted patient and order discharge if it is not satisfied the criteria for detention under the Act are met. The Tribunal does not have the power to discharge transferred prisoners, but can decide whether the patient would be ready for discharge if they were not a prisoner, and can make a recommendation that they should be returned to prison or, if appropriate, a referral should be made to the parole board.

Community leave

22.61 Section 41(3)(c)(i) requires a responsible clinician to obtain consent from the Secretary of State for Justice before granting section 17 leave to a restricted patient. The Secretary of State for Justice will often consent to programmes of leave which give responsible clinicians discretion as to leave arrangements. The expectation however is that the leave will be designed and conducted in such a way as to preserve public safety and, where appropriate, respect the feelings and fears of victims and others who may have been affected by the offences.

22.62 Leave request forms are provided on the Ministry of Justice website which outlines the information required, however the attachment of leave plans may also be useful. In the event consent for leave is given, responsible clinicians should be aware the Ministry of Justice may request additional reports on the restricted patient as considered necessary. Should there be any concerns or doubts about the leave being taken, it should be suspended and MHCS informed.

Hospital transfers

22.63 Section 19 and regulations made under it, enable a restricted patient who is detained in hospital to be transferred to another hospital and to be detained in that hospital on the same basis by virtue of section 41(3)(c) of the Act with the consent of the Secretary of State for Justice.

22.64 The Secretary of State for Justice's role is to ensure transfers between hospitals preserve public safety, and, where appropriate, respect the feelings and fears of victims and others who may have been affected by the offences. The Secretary of State for Justice may also stipulate a specific hospital or unit when agreeing to the transfer of a patient and any movement outside this 'named' hospital or ward will require the permission of the Secretary of State for Justice.

22.65 It is useful for the MHCS forms accessed via the website to be used when requesting a restricted patient be transferred between hospitals. In urgent situations, it may be sufficient for the transferring and receiving clinicians to provide confirmation of their assessments and the availability of appropriate treatment in writing to MHCS. Situations where an urgent transfer may be required include those where there is a serious risk of self-harm or harm to others which cannot be safely managed in the current hospital or unit. Where the clinical team have concerns, contact with the casework manager should be made in the first instance.

Patients transferred from prison under sections 47/49 and 48/49

- 22.66 Section 47 of the Act empowers the Secretary of State for Justice by warrant to direct the removal to and detention in hospital for treatment of a person who is serving a sentence of imprisonment. The 'transfer direction' may be made with or without restrictions under section 49 and if transferred to hospital by virtue of a transfer direction only, the patient is treated as if they were a civil patient and the Secretary of State for Justice will have no further role.
- 22.67 When prisoners have been transferred under section 47 and remain detained in hospital after their release date, they cease to be restricted patients but remain detained as if on a hospital order without restrictions. The responsible clinician's options under the Act are modified accordingly, and the patient may, for example, be discharged onto a community treatment order (CTO), guardianship or discharged.
- 22.68 Section 48 empowers the Secretary of State for Justice by warrant to direct the removal to and detention in hospital for treatment of certain people such as those on remand, civil prisoners and immigration detainees. Restrictions may also be added under section 49. Subsequent attendance at court will require the Secretary of State for Justice's consent and will usually be given at the time of admission.
- 22.69 Should the patient be subsequently acquitted by the court or the legal proceedings discontinued, the section 48/49 restricted transfer direction will cease and the responsible clinician in charge of the patient's care must either discharge or consider detention under part 2 of the Act.
- 22.70 Professionals should be aware immigration detainees may be particularly vulnerable and may need additional support, including reasonable adjustments. Examples include the use of interpreters and an understanding of their culture, ethnicity or religion.
- 22.71 Should a transfer request be made for a prisoner under sections 47 and 49 who is near the end of his or her sentence, the Secretary of State for Justice will apply heightened scrutiny to such a request to ensure the criteria for transfer under the Act is satisfied and taking into account the potential lengthening of detention.
- 22.72 In exceptional circumstances, the Secretary of State for Justice may 'direct' a restricted patient's admission into hospital, outside of NHS commissioning arrangements. This is usually where it is critical the patient receive treatment and identifying a suitable bed is difficult.

Patients directed to hospital by a Crown Court under section 45A

- 22.73 Section 45A (hospital direction) permits a court to impose a prison sentence upon a person and at the same time order immediate admission to hospital for medical treatment. A limitation direction accompanies a hospital direction and applies in the same way as a restriction order under section 41.

- 22.74 In cases where clinicians are of the view the conditions for hospital treatment are met, they may want to consider advising the court of the availability of a disposal under section 45A. It is then for the court to decide whether the culpability of the person is such that a section 45A direction is appropriate.
- 22.75 The intention of the hospital direction is to increase the flexibility of options when dealing with mentally disordered offenders and it enables the court to impose a custodial sentence (determinate or indeterminate) whilst at the same time securing medical treatment without delay.
- 22.76 The granting of a hospital and limitation direction is a decision for the court and there can be no presumption one will be made even if the evidence suggests it is appropriate. A hospital and limitation direction may be imposed where it is considered the person, although suffering from a mental disorder, can be considered to be responsible, to a degree, for the offence. Generally, courts have adopted the test that there has to be a 'significant degree' of culpability for a hospital direction to be appropriate, although this test is not always applied.

Notional section 37 patients

- 22.77 For transferred determinate sentence offenders, restrictions added by the Secretary of State for Justice will cease on expiry of the custodial part of the sentence (i.e. the date the person would have been released had he or she remained in prison). If the patient continues to require further treatment, they can remain detained within the hospital as if subject to an unrestricted section 37 hospital order. Patients detained under a hospital and limitation direction (under sections 45A and 45B of the Act) will fall into this category if they have reached the end of their sentence but still require treatment. These patients are all commonly referred to as 'notional section 37' patients.
- 22.78 All unrestricted patients, including 'notional section 37 patients' have been entirely diverted from the criminal justice system to the health system for treatment. Treatment is the purpose of their detention in hospital and the Secretary of State for Justice has no say in the patient's disposal. Decisions on granting community leave, movement through the hospital system and discharge will be taken by the responsible clinician and hospital managers. The Tribunal also has a statutory duty to discharge if not satisfied the criteria for detention are met.
- 22.79 When a transferred offender becomes unrestricted, there is still a period when, if released, they will be subject to licence conditions and management by the National Probation Service. Hospitals should remain in contact with the offender manager and victim liaison officer therefore until the end of sentence.

Discharge of restricted patients

- 22.80 The Secretary of State for Justice may authorise the discharge of a restricted patient. The discharge will either be with conditions, a 'conditional discharge' or 'absolutely' in which case the restrictions will cease and there will be no further involvement of the Secretary of State for Justice. In addition the Tribunal has a statutory duty to discharge patients if not satisfied the criteria for detention are met (see Chapter 12).

22.81 Conditionally discharged restricted patients will in most cases be subject to community supervision and be monitored by a clinical supervisor and a social supervisor, both of whom are required to submit reports, generally quarterly, to the Ministry of Justice detailing the patient's progress, current presentation and any concerns. These reports should be comprehensive including defining clearly any risks being presented by the patient either to themselves or others.³²

Recall to hospital

22.82 After being granted a conditional discharge by either the Secretary of State for Justice or the Mental Health Review Tribunal for Wales), the Secretary of State may recall a patient under section 42(3) if something has happened since the conditional discharge of sufficient significance to justify doing so.

22.83 A patient will be recalled where it is necessary to protect the public from the actual or potential risk posed by that patient and that the risk is linked to the patient's mental disorder. It is not possible to specify all the circumstances when recall may be appropriate and public safety will always be the most important factor. Key points include:

- the decision on whether to recall will largely depend on the degree of danger posed by the patient, the gravity of the potential or actual risk and how imminent the risk is
- recall does not necessarily require any evidence of deterioration in the patient's mental state, but evidence is required that a 'change' has occurred since the discharge decision. This is so the Secretary of State for Justice can be satisfied recall is a proportionate and lawful action. Other than in an emergency, medical evidence will be required that the patient is currently mentally disordered
- recall will not be used to deal with anti-social or offending behaviour that is unconnected with the patient's mental disorder
- recall decisions always give precedence to public safety considerations. This may mean the Secretary of State for Justice will decide to recall on public safety grounds even if the supervisors are of the view recall would be counter-therapeutic for the patient
- recall will be considered to protect others from harm because of a combination of the patient's mental disorder and behaviour, including potential behaviour where there is evidence that indicates the imminent likelihood of risk behaviours
- in an emergency the Secretary of State for Justice may recall for assessment in the absence of fresh evidence as regards mental disorder
- the support for recall from the patient's social supervisor is important but not determinative and the Secretary of State for Justice can, if satisfied recall is necessary, make the decision to recall in the absence of any recommendation
- where however recall is recommended by at least one supervisor, then the expectation is the patient should be recalled unless there are compelling reasons not to recall, and
- admission under sections 2 or 3 – if a restricted patient requires compulsory detention in hospital under the Act then recall will almost invariably be appropriate.

³² <https://www.justice.gov.uk/offenders/types-of-offender/mentally-disordered-offenders>

- 22.84 The only circumstances where recall may not be indicated would be where discharge was imminent (within days rather than weeks), or where the admission is solely due to self-harm or suicide issues and the admission is likely to last less than a month.
- 22.85 Should recall be indicated, the clinical team should initially discuss their concerns with MHCS and identify a suitable bed at an appropriate security level for the patient to be admitted to. Once the arrangements are confirmed, MHCS will issue a Secretary of State for Justice warrant for the recall of a patient to a named hospital or unit.
- 22.86 The social supervisor requesting the recall will be advised by MHCS that the patient should be briefly informed of the Secretary of State for Justice's reasons for the recall at the time the recall is effected unless it is not practicable to do so. The Secretary of State for Justice then expects full reasons to be communicated to the patient within 72 hours of re-admission.

Contacting the MHCT

- 22.87 Verbal authorisation can be given for recalls or transfers with warrants and written authorisations provided during office hours. The MHCS can also be contacted on an on-call basis between the hours of 17:00 to 09:00 and on weekends and bank holidays. Details are given on the Ministry of Justice website

Multi-agency public protection arrangements (MAPPA)

- 22.88 Under section 325(3) of the Criminal Justice Act 2003, health services have a duty to co-operate with the MAPPA responsible authorities in assessing and managing the risk of MAPPA eligible mentally disordered offenders.
- 22.89 MAPPA are the framework of statutory arrangements operated by criminal justice and other agencies that seek to manage and reduce the risk presented by sexual and violent offenders in order that re-offending is reduced and the public are protected. This is done by the sharing of information and the establishment of a coordinated risk management plan that will allow offenders, including part 3 patients, to be effectively managed.
- 22.90 There are three categories of offender eligible for MAPPA, all of which may come to the attention of health services as part 3 patients:
- Category 1 – registered sexual offenders
 - Category 2 – violent offenders: offenders sentenced to imprisonment or detention for a period of 12 months or more, or subject under hospital orders following conviction for a violent offence at Schedule 15 of the Criminal Justice Act 2003. This category includes a small number of sexual offenders who do not qualify for registration and offenders disqualified from working with children, and
 - Category 3 – other dangerous offenders: offenders who do not qualify under Categories 1 or 2 but who have been assessed as currently posing a risk of serious harm to themselves or others which requires active inter-agency management. The person must have been committed an offence or have received a formal caution.
- 22.91 MAPPA offenders can be managed at one of three levels based upon the level of multi-agency co-operation that is required to implement the offender's risk management plan effectively. Offenders move up and down levels as appropriate.

22.92 The levels are:

- Level 1 – ordinary management: These offenders are subject to the usual management arrangements applied by whichever agency is responsible for their supervision them (e.g. the NHS). This does not rule out information sharing between agencies; the MAPPA framework provides for important information to be shared by and between agencies. Risk of harm presented by Level 1 offenders, even where assessed as high, can be managed effectively without a multi-agency meeting
- Level 2 – active multi-agency management: The risk management plans for these offenders require the active involvement of several agencies via regular multiagency public protection (MAPP) meetings, and
- Level 3 – active multi-agency management: As with Level 2 offenders the risk management plans for these offenders require the active involvement of several agencies via regular MAPP meetings. In addition, these cases require the involvement of senior officers from the relevant agencies to authorise the use of special resources, such as police surveillance or specialised accommodation, or to provide ongoing senior management oversight of the case.

22.93 Providers should ensure all responsible clinicians receive regular refresher professional development on the requirements in the MAPPA framework and are satisfied staff are adhering to the requirements set out in it. Professional development should particularly include the need to adopt a properly investigative approach to any concerns that arise during supervision for restricted part 3 patients within the MAPPA framework where they have been convicted of serious offences.

22.94 Further guidance on MAPPA and the responsibilities of health providers is available.³³

³³<https://www.gov.uk/government/publications/multi-agency-public-protectionarrangements-mappa>—

Chapter 23

Appropriate medical treatment

- 23.1 Where a person is detained under the Mental Health Act 1983 (the Act), appropriate medical treatment must be available. This chapter gives guidance on what constitutes medical treatment for a mental disorder, and what constitutes appropriate medical treatment under the Act.

Medical treatment for mental disorder

- 23.2 In the Act, unless the context otherwise requires: Medical treatment in relation to mental disorder means 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 (section 145(4)); and medical treatment includes nursing, psychological intervention and specialist mental health habilitation, rehabilitation and care (section 145(1)).
- 23.3 'Symptoms' and 'manifestations' of the mental disorder may be evident in the person's thoughts, emotions, communication, behaviour and actions and may include the way a disorder is experienced by the individual concerned. Not every thought or emotion, nor every aspect of the behaviour of a patient suffering from mental disorder, will be a manifestation of that disorder.
- 23.4 The treatment being offered should always be grounded in and guided by best practice e.g. NICE Guideline documents. Those providing such treatment should receive up to date training on evidence based practice.
- 23.5 There may well be a range of interventions which would represent appropriate medical treatment for the person living with a mental disorder even if, despite treatment, that particular mental disorder is likely to persist or worsen.
- 23.6 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.

The 'appropriate medical treatment test'

- 23.7 The purpose of the 'appropriate medical treatment test' is to ensure that no one is detained (or remains detained) for treatment, unless they are actually to be offered medical treatment for their mental disorder. Treatment must be available to the patient: it is not sufficient that appropriate treatment could theoretically be provided.
- 23.8 There may be patients whose particular circumstances mean their appropriate treatment consists solely of nursing and specialist day-to-day care under the clinical supervision of an approved clinician, for example those with very advanced dementia. Appropriate treatment does not have to involve medication or individual or group psychological therapy.

- 23.9 There may be some patients with persistent mental disorders for whom management of the undesirable effects of their disorder and the optimisation of their ability to continue to make choices and decisions for themselves will be the primary consideration.
- 23.10 Treatment must be appropriate, taking into account the nature and degree of the person's mental disorder and particular circumstances, including cultural, ethnic, religious considerations and other considerations which would ensure a person receives an equitable service in accordance with the provisions of the Equality Act 2010.
- 23.11 The appropriate medical treatment test therefore requires a clinical judgement about whether an appropriate package of treatment for mental disorder is available and accessible for the individual within the setting in which they are receiving that treatment.
- 23.12 In determining whether appropriate medical treatment is available the following should be taken into consideration:
- the patient's views and wishes about their treatment and the outcomes of treatment, including any advance decision or advance statement by those that may not have capacity to make decision regarding their treatment
 - how the patient's physical health 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 or sensory impairments the patient has
 - any other disabilities or communication needs
 - the patient's culture and ethnicity
 - the patient's age
 - the patient's gender, gender-identity, sexual identity and sexual orientation
 - the patient's religion or beliefs
 - the location of the available treatment
 - the implications of the treatment for the patient's family and social relationships, including their role as parent (where applicable);
 - its implications for the patient's education or work; and
 - the consequences of the patient not receiving the treatment available including the risks to themselves and /or others. For mentally disordered offenders about to be sentenced for an offence, the consequence will sometimes be a prison sentence.
- 23.13 A patient's attitude towards proposed treatment may be relevant when determining whether the appropriate medical treatment test is met. However, an indication of unwillingness to cooperate with treatment generally, or a specific aspect of treatment, does not make such treatment inappropriate.
- 23.14 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.

23.15 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 the medical treatment which is available is appropriate, given the patient's condition and circumstances as they are currently understood.

Chapter 24

Medical treatment

- 24.1 This chapter gives guidance on medical treatment for mental disorder under the Mental Health Act 1983 (the Act), and what treatment can be given without patients' consent. It also gives guidance on promoting good physical healthcare for patients subject to the Act.

Definitions

- 24.2 In the Act, 'medical treatment' includes nursing, psychological interventions and specialist mental health habilitation, rehabilitation and care.
- 24.3 The Act defines medical treatment for mental disorder as medical treatment which is for the purpose of alleviating or preventing a worsening of a mental disorder or one or more of its symptoms or manifestations.
- 24.4 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.

Appropriate medical treatment

- 24.5 Chapter 23 gives guidance on what constitutes medical treatment for a mental disorder and the application of the 'appropriate medical treatment' test under the Act.
- 24.6 There are treatments to which special rules and procedures apply: sections 57, 58) and 58A of the Act guidance is given on these sections in in Chapter 25,

Treatment of detained patients and CTO patients recalled to hospital (part 4 of the Act)

- 24.7 Part 4 of the Act deals mainly with the treatment of people who are liable to be detained in hospital and include patients who have been recalled to hospital from CTOs and conditional discharge. They are referred to in this chapter as 'detained patients'.
- 24.8 Some patients detained in hospital are not covered by these rules; these patients are outlined in the box below. Their position is the same as any other citizen in terms of their consent to, or refusal of medical treatment.

Exceptions to the meaning of 'detained patients'

- 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)
- Qualifying patients within the meaning of section 22 who have remained in custody for six months or longer in total

- 24.9 Unless section 57, section 58 or 58A apply, section 63 of the Act (treatment not requiring consent) means detained patients may be given medical treatment for any kind of mental disorder, whether they:
- consent to it; or
 - have not consented to it;
 - but the treatment must be given by or under the direction of the approved clinician in charge of the treatment in question.
- 24.10 If sections 57, 58 or 58A apply, detained patients may be given the treatment only if the rules in those sections are followed (see chapter 25).

Treatment of CTO patients not recalled to hospital (part 4A patients)

- 24.11 Part 4A of the Act sets out different rules for treatment for patients on CTOs who have not been recalled to hospital by their responsible clinician. This includes patients on CTOs who are in hospital without having been recalled (e.g. if they have been admitted to hospital informally).
- 24.12 For convenience, this chapter refers to patients on CTOs who have not been recalled to hospital (i.e. admitted to hospital informally) as 'part 4A patients'.
- 24.13 The rules for part 4A patients differ depending on whether or not they have the capacity to consent to the treatment in question. Except where otherwise stated, references in the paragraphs below to a person who lacks capacity to consent to treatment includes patients aged under 16 who lack the competence to consent to treatment.

- 24.14 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.
- 24.15 For those patients with the capacity (or competence, for patients under 16) to consent to a treatment and who have done so, the Act also requires a Second Opinion Approved Doctor or the approved clinician in charge of the patient's treatment to certify the treatment on a 'part 4A certificate'. 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 in hospital (see Chapter 25).
- 24.16 For part 4A patients, aged 18 and over, who lack the capacity to consent to or refuse a treatment; it may be given if someone who has the relevant lasting power of attorney (an attorney) or a Court of Protection appointed deputy consents on their behalf. Similarly it may be given in the case of those aged 16 and over if a deputy consents to the treatment on their behalf. A specific capacity assessment in relation to the proposed treatment should be recorded and that the treatment is deemed to be in the best interest of the patient should be documented.
- 24.17 Part 4A patients who lack capacity to consent to a 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 (see Chapter 9)
 - in the case of a patient aged 18 or over, the treatment would be against the decision of someone with the authority under the MCA 2005 to refuse it on the patient's behalf (an attorney, a deputy or the Court of Protection), or
 - in the case of a patient aged 16 or over, the treatment would be against the decision of a deputy who has authority to refuse it on the patient's behalf, or force needs to be used in order to administer the treatment and the patient objects to the treatment.
- 24.18 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 of the objection is not relevant. In any situation where force is used, if it amounts to a restrictive intervention then the provisions within Chapter 26 apply.
- 24.19 Whether a patient is objecting has to be considered in the round, taking into account all the circumstances, so far as they are reasonably ascertainable. The decision to be made is whether the patient objects, not the reasonableness or not of that objection.
- 24.20 In many cases the patient will be perfectly able to state their objection, for example, verbally or by their dissenting. In other cases, especially where patients are unable to communicate (or only able to communicate to a limited extent), the relevant person 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.
- 24.21 In deciding whether a patient objects, decision-makers should err on the side of caution and, where in doubt, take the position that a patient is objecting.

24.22 Occasionally, a patient's behaviour may suggest an objection to a treatment. If it is subsequently determined that it is not the treatment that the patient was objecting to but some other factor, the patient should not be taken to be objecting to the treatment and the treatment can therefore be administered.

Emergency treatment under section 64G for CTO patients not recalled to hospital (part 4A patients)

24.23 In an emergency, treatment can also be given to part 4A patients who lack capacity to consent to a treatment (and who have not been recalled to hospital) by a person, whether or not they are acting under the direction of an approved clinician, but only if the treatment is immediately necessary to:

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

24.24 Where treatment is immediately necessary in these terms, it can be given even though it conflicts with an advance decision or the decision of someone who has the authority under the Mental Capacity Act 2005 (MCA) to refuse it on the patient's behalf.

24.25 Force may be used provided:

- the treatment is necessary to prevent harm to the patient, and
- the force used is proportionate to the likelihood of the patient suffering harm and to the seriousness of that harm.

24.26 These are the only circumstances in which force may be used to treat patients on CTOs who object, without recalling them to hospital. This exception is for situations where the patient's interests would be better served by being given urgently needed treatment by force outside hospital rather than being recalled to hospital. This might, for example, be where the situation is so urgent that recall is not realistic, or where taking patients to hospital would exacerbate their condition, damage their recovery or cause them unnecessary anxiety or suffering. Situations like this should be exceptional.

Treatment of other patients

24.27 The special rules and procedures in section 57 apply to all patients, and the special rules and procedures in section 58A apply to all patients under the age of 18. See Chapters 19 and 25.

Capacity and consent

24.28 The Act frequently requires healthcare professionals to determine whether a patient has the capacity to consent to a particular form of medical treatment, and if so, whether the patient does in fact consent.

Capacity to consent: people aged 16 or over

24.29 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:

- People must be assumed to have capacity unless it is established 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 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 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 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).

For further information see the Code of Practice to the MCA and relevant case law

- 24.30 When taking decisions about patients under the Act, it should be remembered:
- Mental disorder does not necessarily mean a patient lacks capacity to give 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.

Competence to consent to treatment – children under 16

- 24.31 The MCA does not apply to medical treatment for children under 16. Children who have sufficient understanding and maturity to enable them fully to understand what is involved in a proposed treatment are considered to be competent (or 'Gillick competent') to consent to it. Further information on assessing a child's competence to make treatment decisions is provided in Chapter 19.

Consent

Principles

- 24.32 Consent to treatment 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'.
- 24.33 A person who lacks capacity to consent does not consent to treatment, even if they cooperate with the treatment or actively seek it.
- 24.34 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.
- 24.35 Simply giving standard information leaflets to the patient will not discharge the duty. The information which should be given to the particular patient should be relevant to that particular patient, the particular treatment and the relevant clinical knowledge and practice.

- 24.36 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.
- 24.37 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.
- 24.38 Independent mental health advocates (IMHA) 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.
- 24.39 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. Any decision not to disclose information must be justifiable and recorded with reasons.
- 24.40 The patient should be informed 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 Act. A record should be kept of the information given to patients.

Treatment without consent – general points

- 24.41 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.
- 24.42 Clinicians authorising or administering treatment without consent under the Act are performing a function of a public nature and are therefore subject to provisions of the Human Rights Act 1998.
- 24.43 In particular, the following should be noted:
- Compulsory administration of treatment may engage Article 8 of the Convention (respect for family and private life) but treatment may be justified under Article 8(2) 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 may engage 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.
- 24.44 Scrupulous adherence to the requirements of the legislation and good clinical practice should ensure that there is no incompatibility with a patient's rights under the European Convention on Human Rights.

24.45 If clinicians have concerns about a potential breach of a person's human rights they should seek senior clinical and, if necessary, legal advice.

Treatment Plans

24.46 Treatment plans are essential for patients being treated for mental disorder under the Act. A patient's responsible clinician is responsible for ensuring that a treatment plan is in place for that patient.

24.47 A treatment plan should include a description of the immediate and long-term goals for the patient and should give a clear indication of the treatments proposed and the methods of treatment.

24.48 The treatment plan should form part of a coherent care and treatment plan (or its equivalent), and be recorded in the patient's notes (see Chapter 34).

24.49 Psychological therapies should be considered as a routine treatment option at all stages, including the initial formulation of a care and treatment plan and each subsequent review of that plan. Any programme of psychological intervention should form part of the agreed care and treatment plan and be recorded in the patient's notes as such.

24.50 Wherever possible, the whole care and treatment plan should be discussed with the patient. Patients should be informed of and assisted to make use of advocacy support available to them, if they want it. This includes, but need not be restricted to, independent mental health advocacy services. Where patients cannot (or do not wish to) participate in discussion about their care and treatment plan, any views they have expressed previously should be taken into consideration (see Chapter 9).

24.51 Subject to the normal considerations of patient confidentiality, the care and treatment plan should also be discussed with their carers, with a view to enabling them to contribute to it and express agreement or disagreement.

24.52 Discussion with carers is particularly important where carers will themselves be providing care to the patient. Plans should not be based on any assumptions about the willingness or ability of carers to support patients.

24.53 Carers have an important role to play in maintaining the patient's contact with home and community life and providing emotional support when the patient is detained. In some cases carers' willingness and ability to contribute to the provision of care may be dependent on additional support and they should be reminded of possible sources of such support and their entitlement to a carer's assessment by the local authority.

24.54 For children and young people, subject to the normal considerations of patient confidentiality, the plan should similarly be discussed with the people who have parental responsibility for them.

24.55 Treatment plans should be regularly reviewed and the results of reviews recorded in the patient's notes.

Treatment of incapacitated patients – interface between parts 4 and 4A of the Act and the MCA (section 28)

24.56 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 MMCA applies to patients subject to the 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 58 treatment (medication after an initial three month period, except ECT related medication)	The MCA may not be used to give anyone treatment to which section 58 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 regulated by part 4 of the Act for detained patients	The MCA may not be used to give detained patients any other medical treatment for mental disorder. Treatment regulated by part 4 of the Act at the time of the proposed treatment must be given in accordance with Part 4 of the Act instead
Treatment for CTO patients who have not been recalled to hospital (Part 4A patients)	The MCA may not generally be used to give these CTO patients any medical treatment for mental disorder, but attorneys, deputies and the Court of Protection may consent to such treatment on behalf of these CTO patients
Advance decisions to refuse treatment (as defined in the MCA)	Where the 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: <ul style="list-style-type: none"> • treatment to which section 58A applies cannot be given contrary to a valid and applicable advance decision • and treatment cannot be given to CTO patients who have not been recalled to hospital (Part 4A patients) contrary to a valid and applicable advance decision.
Patients who have attorneys or court-appointed deputies under the MCA with authority to take decisions on their behalf about their medical treatment	Attorneys and deputies (acting within the scope of their authority under the MCA) may not: <ul style="list-style-type: none"> • consent to treatment to which section 57 applies on behalf of any patient; • consent to treatment to which section 58A applies – but note that (except in emergencies) they may refuse it on a patient’s behalf • consent to or refuse any other treatment on behalf of detained patients

But note that attorneys and deputies may:

- consent to treatment on behalf of CTO patients who have not been recalled to hospital (Part 4A patients), even if treatment is to be given forcibly
- except in emergencies, refuse treatment on behalf of those patients.

24.57 See Chapter 13 for guidance on the relationship between detention under the Act and the deprivation of liberty safeguards under the MCA. See Chapter 30 for the interface between the powers of guardians under the Act and the MCA.

Court of Protection and other courts

24.58 The Court of Protection, as well as other courts may, in certain circumstances, have the power to order that a treatment must not be given. Should such an order be made, legal advice should be sought on the legal authority for continuing or starting any such treatment.

Summary of when medical treatment for mental disorder may be given under the Act

Type of patient (and relevant part of the Act)	When treatment can be given	Notes
Detained patients (part 4)	<p>If sections 57, 58 or 58A apply, treatment may be given only in accordance with those sections.</p> <p>Otherwise, treatment may be given:</p> <ul style="list-style-type: none"> • with the patient's consent; and • without the patient's consent under section 63, if the treatment is by or under the direction of the approved clinician in charge. 	<p>Neurosurgery for mental disorder and other treatments to which section 57 applies cannot be given without the patient's consent and must always be approved by a SOAD.</p> <p>ECT and other treatments to which section 58A applies cannot be given to a patient who has capacity to consent but refuses to do so. They can only be given to patients who lack capacity (or who are under 18) if approved by a SOAD.</p> <p>Medication to which section 58 apply can be given without the patient's consent, but only with the approval of a SOAD.</p> <p>Sections 57, 58 and 58A do not apply in emergencies, where treatment is defined in section 62 as immediately necessary (see paragraphs 25.37 – 25.42).</p>

<p>CTO patients who have not been recalled to hospital (part 4A patients)</p>	<p>If section 57 applies, treatment can be given only with the patient's consent and if the other rules in section 57 are followed.</p> <p>Otherwise, if the patient has capacity to consent to or refuse treatment, treatment may be given only with the patient's consent.</p> <p>Or, if the patient lacks capacity to consent, treatment may be given:</p> <ul style="list-style-type: none"> • with the consent of an attorney, deputy or the Court of Protection • without anyone's consent, provided that <ul style="list-style-type: none"> (i) the treatment is given by or under the direction of the approved clinician in charge of the patient's case, (ii) it is not inconsistent with a valid and applicable advance decision, or a decision of an attorney, deputy or Court of Protection, and either (iii) no force needs to be used, or (iv) force does need to be used but the patient does not object, or • in an emergency only, if the treatment is <ul style="list-style-type: none"> (i) immediately necessary and (ii) if force is to be used, the treatment is needed to protect the patient from harm and any force used is proportionate to the risk of harm. 	<p>Unless it is an emergency, if treatment is one to which section 58 or 58A would apply if the person was liable to be detained, the treatment has to either be: approved by a SOAD on a part 4A certificate; or certified by the approved clinician in charge of the patient's treatment on a part 4A consent certificate, if the patient has capacity (or competence, for patients under 16) to consent to the treatment and has done so.</p>
<p>Other patients</p>	<p>Treatment is not regulated by the Act, except that:</p> <ul style="list-style-type: none"> • where section 57 applies, patients can be given treatment only if they consent • and the other rules in section 57 are followed, and • patients under 18 cannot be given ECT or other treatments to which section 58A applies, unless they consent and the treatment is approved by a SOAD. <p>(Sections 57 and 58A do not apply in emergencies.)</p>	

Promoting good physical health

- 24.59 Commissioners and providers should ensure that patients with a mental disorder receive physical healthcare that is equivalent to that received by people without a mental disorder. The physical needs of patients should be assessed routinely alongside their psychological needs and usually as part of care and treatment planning. All reasonable steps should be taken to ensure that long term physical health conditions are not undiagnosed or untreated, and that patients receive regular oral health and sensory assessments and, as required, referral.
- 24.60 Patients detained under the Act are at particular risk of comorbidities. Staff should be aware their responsibilities to ensure all patients receive adequate physical health care, for example, the routine screening for and provision of interventions for high risk health conditions such as heart disease and diabetes should be in place subject to the patient consent.
- 24.61 LHBs should ensure that they are compliant with current requirements on food, diet and nutrition.
- 24.62 Providers should ensure that all patients have sufficient opportunities to undertake sufficient physical and other meaningful activity to support their physical and mental health recovery.

Chapter 25

Treatments subject to special rules and procedures

- 25.1 This chapter gives guidance on the special rules and procedures in the Mental Health Act 1983 (the Act) for certain types of medical treatment for mental disorder and particularly medication and electroconvulsive therapy. Other less commonly used treatments are covered.
- 25.2 Some treatments require consent and a second opinion and others require consent or a second opinion. Guidance on these is given in this chapter.
- 25.3 It also provides guidance on the 'clinician in charge of treatment' and treatment under section 57 or 58 or 58A of the Act, specific guidance on the role of second opinions under the Act, and a summary of the circumstances in which certificates cease to authorise treatment.

Terms and roles defined in this Chapter

Terms

- A SOAD is a second opinion appointed doctor - this is a registered medical practitioner appointed by HIW to approve certain forms of treatment.
- A SOAD certificate is a certificate issued by a SOAD approving particular treatment for an individual patient.
- A 'Part 4A certificate' is a certificate issued by a SOAD, under Part 4A of the Act in respect of the treatment of a community treatment order (CTO) patient.
- A Part 4 patient is a detained patient or a CTO patient recalled to hospital.
- A 'Part 4A patient' is a patient on a community treatment order (CTO) who has not been recalled to hospital.
- The term 'detained patient' has the same meaning as given in Chapter 24.

Roles

Clinician in charge of the treatment

- 25.4 The clinician in charge of the treatment 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 CTO patients, the clinician in charge of treatment must be an approved clinician, as set out below.

Type of patient	When the clinician in charge of the treatment must be an approved clinician
Part 4 patients - Detained and CTO patients recalled to hospital	<p>When the treatment is being:</p> <ul style="list-style-type: none"> • given without the patient's consent • 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 SOAD) • continued with the consent of a CTO 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
Part 4A patients - A CTO patient who has not been recalled to hospital	<p>When the treatment is being:</p> <ul style="list-style-type: none"> • 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) • given to a patient who has capacity to consent and has done so on the basis of a part 4A consent certificate issued by the approved clinician in charge of the person's treatment

25.5 Hospital managers should keep a record of approved clinicians who are available to treat patients for whom the hospital managers are responsible. They should ensure that where the Act requires, approved clinicians are the clinicians in charge of treatment.

Second Opinion Appointed Doctors

25.6 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 for the condition in question.

25.7 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.

Treatments requiring consent and a second opinion – section 57

Summary

Section 57:

- 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 subject to the Act.
- These treatments can only be given if the patient consents and three independent people appointed by the HIW have certified that the patient understands the treatment and has consented to it.

- 25.8 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 SOAD and two other people appointed by HIW certify the patient is capable of understanding the nature, purpose and likely effects of the treatment in question and has the capacity to consent to it;³⁴ and
 - the SOAD also certifies it is appropriate for the treatment to be given to the patient.
- 25.9 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 HIW the procedures which will be followed to implement the requirements of section 57.
- 25.10 Before asking HIW to begin the process necessary for a certificate authorising the treatment to be given, the referring professionals should:
- ensure options for psychological treatments have been fully considered
 - satisfy themselves the patient is capable of giving valid consent and is willing to consent
 - advise the patient of their right to independent mental health advocacy (IMHA)
 - advise the patient and (if the patient agrees) their nearest relative and other 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.

Medication for mental disorder requiring consent or a second opinion – section 58

Summary

Section 58:

- Is concerned with the administration of medication once three months have elapsed since the commencement of treatment.
- These treatments can only be given if the patient consents or a SOAD appointed by HIW certifies treatment may be given.
- These provisions apply to all detained patients.

- 25.11 Section 58 applies only to detained patients who cannot be given medication to which this section applies unless:
- an approved clinician in charge of the treatment, or a SOAD, certifies that the patient has the capacity to consent and properly does so
 - a SOAD certifies that the treatment is appropriate and either the patient does not have the capacity to consent; or the patient has the capacity to consent but has refused to do so.
- 25.12 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'.

³⁴ 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).

- 25.13 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.
- 25.14 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.
- 25.15 A fresh three month period will only begin if there is a break in the patient's detention.
- 25.16 The three month period is not broken in the following circumstance:
- the patient has been granted leave of absence
 - the patient is absent without leave
 - the patient has been transferred to another hospital whilst continuing to be detained
 - the authority to detain the patient being renewed under s20
 - there has been a change of medication
 - the medication not being administered continuously
 - the patient has been made subject to a community treatment order or has had their community treatment order revoked; or
 - the section under which the patient is detained being changed.
- 25.17 Detention should never be allowed to expire as a means of enabling a new three-month period to start.
- 25.18 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 the patient's valid consent is sought before any medication is administered. The patient's consent or refusal should be recorded in the patient's 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

- 25.19 A system should be in place for reminding clinicians in charge of treatment of detained patients at least four weeks before the expiry of the three month period. These systems should be capable of dealing with the possibility a patient may become a CTO patient, and may also have their CTO revoked, during the three-month period. A patient's move between detention and a CTO does not change the date on which the three-month period ends.
- 25.20 Before the three-month period ends, the approved clinician should personally seek the patient's consent to the administration of medication. The patient should be provided with adequate information regarding the proposed medication, the side effects and possible alternatives. The relevant good practice guidelines should also be followed to assist in determining the most appropriate medication, e.g. NICE. 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.

- 25.21 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' and those prescribed for side effects, either by name or by the classes described in the British National Formulary (BNF). Often both will be listed. 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.
- 25.22 A copy of the current certificates should be kept in the patient's notes and with the patient's Medication Admission Record so as to ensure that the patient is given only medication to which he or she has consented or has been certified as appropriate.

Electroconvulsive therapy (ECT) - section 58A

Summary

Section 58A:

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

- 25.23 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 to treatment may not be given treatment under section 58A unless they 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).
- 25.24 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.
- 25.25 If a mentally capable patient consents to the ECT, the consent must be certified by either the approved clinician in charge of the patient's treatment or a SOAD.
- 25.26 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.

- 25.27 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 current certificate should be kept in the patient's notes and with the patient's Medication Admission Record, so as to clearly show the legal basis for the medication and ECT being given. Records should be made of the discussion with the patient and of the relevant information to support the certificate being made.
- 25.28 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.
- 25.29 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

- 25.30 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.
- 25.31 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.
- 25.32 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 notes.

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

- 25.33 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).
- 25.34 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.

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

25.36 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. 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.

25.37 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.

25.38 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.

Part 4A treatments

Community Treatment Order (CTO) patients not recalled to hospital

25.39 Provisions with respect to the treatment of Part 4A patients are given in Chapter 24.

25.40 There are specific rules regarding the certification of certain treatment given to part 4A patients: these apply to 'section 58A type treatment' – ECT and other types of treatment to which section 58A applies.

25.41 In these circumstances, 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.

CTO patients recalled to hospital – exceptions to the need for certificates under section 58 or 58A

- 25.42 In general, CTO 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 CTO 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 Part 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.
- 25.43 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).
- 25.44 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 to properly make such a judgement.
- 25.45 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.

Arranging and preparing for a SOAD visit

Requesting a SOAD visit

- 25.46 If a SOAD certificate is required, the clinician in charge of the treatment is responsible for ensuring that a request for a second opinion is made.
- 25.47 If the patients is capable of understanding the nature, purpose and likely effects of the treatment and consents to the treatment a SOAD certificate is not required. If the above conditions are not met, a SOAD is required.

Preparing for the visit

- 25.48 SOADs will visit detained patients in hospital, however for CTO patients, hospital managers should ensure 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. Adequate facilities must be made available for the visit
- 25.49 Attending for examination by a SOAD is a condition of all CTOs. If a CTO patient fails to attend when asked to do so, they may be recalled to hospital for the examination, if necessary.
- 25.50 The hospital managers, in consultation with the clinician in charge of the treatment, should ensure 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 – who is expected to have discussed the treatment plan with consultees and for this discussion to have been recorded
 - the patient's responsible clinician (if that person is different from the person in charge of the treatment)
 - the statutory consultees
 - an interpreter if required
 - 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 attorney 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.
- 25.51 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.
- 25.52 During the visit the SOAD will want to satisfy themselves that the patient's detention or CTO 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.
- 25.53 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

- 25.54 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.
- 25.55 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

- 25.56 SOADs are required to consult two people ('statutory consultees') before issuing certificates approving treatment. Where section 57, 58 or 58A applies, one of the statutory consultees must be a nurse; the other must not be either a nurse or a medical doctor. Both 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.
- 25.57 Where a SOAD is considering giving a part 4A certificate, at least one of the statutory consultees must not be a medical doctor (and need not be a nurse), and neither may be the clinician in charge of the proposed treatment or the responsible clinician (if the patient has one).
- 25.58 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 or others that are professionally registered and involved in the patients care.
- 25.59 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.
- 25.60 The SOAD should ensure that the person that they consult with is aware that they are acting as a Statutory Consultee.
- 25.61 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' family, carers and relevant others where applicable, the implications of imposing treatment on a patient who does not want it and the reasons why the patient is refusing treatment.

25.62 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

25.63 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.

25.64 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.

25.65 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.

25.66 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.

25.67 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.

25.68 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.

- 25.69 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.
- 25.70 Copies of the 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.
- 25.71 Every attempt should be made by the clinician in charge of the treatment and the SOAD to reach agreement. A generally sound care and treatment plan need not be rejected as a whole because of a minor disagreement about one aspect of it.
- 25.72 If SOADs are unable to agree with the clinician in charge of the treatment, they should inform the clinician personally as soon as possible.
- 25.73 Neither the SOAD nor the approved clinician should allow a disagreement 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.
- 25.74 The opinion given by the SOAD is the SOAD's personal responsibility. There can be no appeal to HIW against the opinion.

Status of certificates under Part 4 and Part 4A

- 25.75 A certificate issued by an approved clinician or by a SOAD is not an instruction to administer treatment.
- 25.76 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.
- 25.77 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.
- 25.78 Under sections 61 and 64H, HIW 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 HIW 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.
- 25.79 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

- 25.80 All treatments 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.
- 25.81 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 the Welsh Ministers/HiW 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. Copies of reports should be given to patients.

Action where treatment is continued pending a new certificate

- 25.82 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 HiW and to cases where the treatment of CTO 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.
- 25.83 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.

Other circumstances when certificates cease to be effective

- 25.84 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	<p>The clinician concerned permanently stops being the approved clinician in charge of the treatment.</p> <p>The patient no longer consents to the treatment.</p> <p>The patient no longer has capacity to consent to the treatment.</p> <p>The patient has stopped (even if only temporarily) being either a detained patient or an CTO patient who is not recalled to hospital.</p>
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> <p>The SOAD specified a time limit on the approval of treatment, and the time limit has expired.</p>
SOAD certificate under section 58 or 58A	<p>The patient has stopped (even if only temporarily) being either a detained patient or a CTO patient who is not recalled to hospital 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> <p>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.</p>
Part 4A certificate	<p>The certificate was given on the basis that the patient lacked capacity to consent to or refuse the treatment, but the patient now has that capacity and consents to the treatment.</p> <p>The SOAD specified a time limit on the approval of a course of treatment, and the time limit has expired.</p>
Part 4 consent certificate	<p>There is a permanent change in the approved clinician in charge of the patient's treatment.</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>

- 25.85 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.
- 25.86 The use of a certificate issued to authorise treatment in respect of a detained patient and who has since been discharged onto a CTO and then recalled to hospital, should be considered carefully even though the certificate remains technically valid. A new certificate should be obtained as necessary.
- 25.87 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 26

Safe and therapeutic responses to challenging behaviour

- 26.1 The principles set out in this chapter should apply to all patients under the care of mental health services. It provides guidance on the provision of the safe, supportive and therapeutic management of patients whose behaviour presents a risk to themselves or others.
- 26.2 This chapter has used and referenced NICE Guidance as a major source of advice for services and practitioners who work with people with challenging behaviour and may be helpful in formulating local policy.

General matters

- 26.3 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 others, which might include hyperactivity, absconding, self-harming, sexual disinhibition, sexually inappropriate behaviour towards others, aggressive and threatening behaviour towards others and physical violence.
- 26.4 When managing such behaviour, staff should support patients in a therapeutic manner, and in ways that ensure their safety and optimise their privacy and dignity.
- 26.5 On admission to hospital, staff should discuss with patients whenever possible any immediate and potential risks they may present to themselves or others. Where such risks are identified staff and patients should seek to agree how these risks can be minimised and the care and treatment plans should include the interventions needed. A structured formal risk assessment should be used to develop a positive risk management plan. For guidance on care and treatment planning see Chapter 34.
- 26.6 Interventions to manage the risks associated with challenging behaviour should always be carried out in a way that minimises patient distress and discomfort, promotes dignity and never in a way that intentionally subjects patients to physical pain. Interventions may however, be perceived as punitive, patients should be as involved as much as practicable in managing their own behaviour and be given a rationale for the use of the interventions if agreement cannot be reached.
- 26.7 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 and agreed with the patient as far as possible. Interventions may include prevention, observation, restraint and/or seclusion.

Prevention

- 26.8 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 and treatment planning and systematic risk management. Preventative approaches may include de-escalation, which is a pro active approach to the reducing the potential for conflict where this begins to emerge.
- 26.9 Effective preventive management of challenging behaviour 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
 - undiagnosed/unrecognised physical health care needs and or pain.
- 26.10 Although individual care and treatment planning is fundamental to the appropriate management of behaviours that challenge, problems may also be minimised by using 'positive principles'.
- 26.11 These principles can be supported by general measures which 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
 - ensuring 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 and treatment 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 patients' complaints are dealt with quickly and properly.

Observation

- 26.12 Effective patient observation is central to the successful prevention of untoward patient-related incidents. Observation should be seen as an integral aspect of patient engagement and not simply as a task to be carried out on prescription.
- 26.13 A locally agreed policy on observation and positive engagement should, amongst other matters, ensure:
- patients' experience of observation will be taken into account particularly with respect to ensuring privacy and dignity is maintained as far as possible
 - that the most appropriate staff undertake observations, they are trained in best practice³⁵ and have a clear understanding of the need to review and amend observation levels
 - the need for multidisciplinary review when observation continues for 1 week or more.
- 26.14 The use of observation to manage challenging behaviour should generally only be used after other less intrusive interventions have been attempted. Patients can experience observation as provocative, and may have feelings of isolation; dehumanisation and/or any paranoid experiences can be exacerbated.
- 26.15 The least intrusive level of observation necessary should be used balancing the patient's safety, dignity and privacy with the need to maintain the safety of those around them.
- 26.16 The reasons for the observation, its aims, how long it is likely to last and what needs to be achieved for it to be stopped should be discussed with the patient. If the patient agrees, the aims and level of observation should generally be shared with the patient's family, carer and relevant others.
- 26.17 Decisions about observation levels should be recorded in the patient's notes and clearly specify the reasons for the observation. When deciding on levels of observation account should be taken of:
- the patient's current mental state
 - any prescribed and non prescribed medications and their effects
 - the current assessment of risk
 - the views of the patient as far as possible.
- 26.18 Staff undertaking observation should:
- take an active role in engaging positively with the patient
 - be appropriately briefed about the patient's history, background, specific risk factors and particular needs
 - be familiar with the ward, the ward policy for emergency procedures and potential risks in the environment
 - be approachable, listen to the patient and be able to convey to the patient they are valued.

³⁵ <https://www.nice.org.uk/guidance/ng10>

26.19 The responsible clinician should be informed as soon as possible if observation above the general level is carried out.

Restraint

26.20 Managing aggressive behaviour by physical restraint should be carried out only as a last resort, in an emergency and, if the intervention were not used, it is considered it is likely harm would occur. Decisions about all forms of restraint should be recorded in the patient's notes and clearly specify the reasons for the restraint.

26.21 If a patient is not subject to compulsory treatment, but care and treatment planning and risk assessment indicates restraint in any form may be necessary during care, this should be taken as an indicator of the need to consider an assessment for formal detention.

26.22 If a patient is deprived of their liberty in a hospital by a DoLS authorisation and restraint is necessary, this may also indicate consideration should be given to whether the patient can and should be detained under the Act.

26.23 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
- locking doors to wards.

26.24 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.

26.25 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.

26.26 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
- staff's duty to protect all those under their care.

- 26.27 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.
- 26.28 When physical restraint is being used, any relevant Welsh Government and other national guidance, including NICE guidelines, should be adhered to.
- 26.29 A locally agreed policy on restraint should, amongst other matters, ensure:
- clear guidelines for staff to maintain the physical wellbeing of a patient, including position and the monitoring of vital signs
 - the patient's experience of restraint is taken into account and all efforts made to maintain their privacy and dignity.
- 26.30 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.
- 26.31 Mechanical restraint should only be used in high secure settings. In Wales there are no high secure settings but it may be necessary to use mechanical restraint to transfer a patient to a high secure environment. Appropriate risk management plans should be in place if such restraint is essential.
- 26.32 If the circumstances described in the above paragraph apply then mechanical restraint should only be used as a last resort and for the purpose of managing extreme violence directed at other people or limiting self-injurious behaviour of extremely high frequency or intensity.

Use of medication

- 26.33 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, risk assessment and as part of an agreed care and treatment plan.
- 26.34 Local protocols should be in place covering all aspects of rapid tranquillisation. 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 Government and other national guidance, including NICE guidelines.

Such policies should be kept under regular review and should include:

- the patient's preferences or advance statements and decisions are taken into consideration whenever possible
- the patient's physical condition and history
- post rapid tranquilisation care.

26.35 Agitation, distress and/or aggression in elderly or other patients may require appropriate medication but only after all suitable distraction and other techniques to reduce such behaviour have been exhausted.

26.36 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

26.37 Seclusion is the supervised confinement of a patient in a room, which may be locked. Services that use seclusion should have a designated seclusion room that:

- provides privacy from other patients, but enable staff to observe and communicate with the patient at all times
- be safe and secure, and not contain anything which could cause harm to the patient or others
- be quiet, but not soundproofed, and with some means of calling for attention.
- is well insulated and ventilated, with temperature controls outside the room
- has access to toilet and washing facilities
- has furniture, windows and doors that can withstand damage.

26.38 At all times, the use of seclusion should be based on patient need, used as a last resort and employed for the shortest possible time. Seclusion should never be used as a punishment or threat, a routine part of a treatment programme or because of a shortage of staff. 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.

26.39 If any member of the multidisciplinary team disputes the need for seclusion, the matter should be referred immediately to a senior manager. If it appears necessary to seclude an informal patient, then this should always be taken as an indicator of the need to consider an assessment for formal detention.

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

26.41 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.

26.42 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.

- 26.43 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.
- 26.44 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.
- 26.45 There maybe 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.
- 26.46 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.
- 26.47 Following any period of seclusion hospital managers should:
- conduct an immediate post-incident debrief
 - monitor and respond to ongoing risks, and contribute to formal external post incident reviews
 - ensure the board receives regular reports from each ward about violent incidents, the use of restrictive interventions, patients' experience of those interventions and the learning gained.

Locked doors

- 26.48 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.
- 26.49 Service providers are responsible for ensuring 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.
- 26.50 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.
- 26.51 The professional in charge of a clinical area 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.
- 26.52 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
- when handing over to the relieving shift, the practitioner in charge should discuss in detail the reasons for the action taken.

26.53 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.

26.54 If doors are locked consideration must be given to whether such patients are being deprived of their liberty and, if so, whether authorisation needs to be sought under the DoLS. Alternatively, assessment for formal detention under the Act should be considered or the person moved to a safer environment.

Supporting clinical staff

26.55 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. This includes ensuring 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 any Welsh Government policy.

26.56 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.

Working with older patients

26.57 When working with older patients who exhibit behaviours that challenge staff should always ensure such interventions are delivered in accordance with best practice guidance relevant to the patient's age.

26.58 Hospital managers should ensure staff are trained using a training programme designed specifically for those working with frail older people.

26.59 Staff who might undertake restrictive interventions should be trained:

- in the use of these interventions in these age groups
- to adapt the manual restraint techniques for adults adjusting them age, frailty and the increased risk of fractures.

Working with children and young people

- 26.60 When working with children and young people who exhibit behaviours that challenge staff should always ensure such interventions are delivered in accordance with best practice guidance relevant to the patient's age.
- 26.61 Hospital managers should ensure staff are trained using a training programme designed specifically for those working with children and young people. Training programmes should include the use of psychosocial methods to avoid or minimise restrictive interventions whenever possible.
- 26.62 Staff who might undertake restrictive interventions should be trained:
- in the use of these interventions in these age groups
 - to adapt the manual restraint techniques for adults adjusting them according to the child or young person's height, weight and physical strength
 - in the use of resuscitation equipment recommendation in children and young people.
- 26.63 CAMHS should have a clear and consistently enforced policy about managing antisocial behaviour and ensure staff are trained in psychosocial and behavioural techniques for managing the behaviour.
- 26.64 The management of challenging behaviour in children and young people should take account of:
- the child or young person's views in making decisions about their care whenever possible.
 - the child or young person's level of physical, intellectual, emotional and psychological maturity
 - any history of aggression or aggression trigger factors, including experience of abuse or trauma and previous response to management of violence or aggression
 - any cognitive, language, communication and cultural factors that may increase the risk of violence or aggression in a child or young person.
- 26.65 Children and young people should be offered support and age-appropriate interventions in line with any Welsh Government and NICE guidelines.

Chapter 27

Leave of absence

27.1 This chapter gives guidance on who has the power to grant leave of absence, short and long-term leave, escorted leave, leave to reside in other hospitals, and recall from leave. It also draws attention to differences when considering leave of absence, including short-term leave for restricted patients.

General matters

27.2 In general, while a patient is detained in a hospital they can only leave hospital lawfully by being granted leave of absence in accordance with section 17 of the Mental Health Act 1983 (the Act).

27.3 In the case of restricted patients this requires the approval of the Secretary of State for Justice. A responsible clinician may also not grant leave of absence to patients detained under sections 35, 36 and 38 of the Act.

27.4 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). However, patients may be asked by staff to inform them when they want to leave the ward. In the case of children and young people safeguarding needs and the opinion of the person with parental responsibility should be taken into account.

Granting leave

27.5 Only the patient's responsible clinician can grant leave of absence to a patient detained under the Act. Responsible clinicians cannot delegate the decision to grant leave of absence to anyone else. In the absence of the usual responsible clinician (e.g. if they are on leave), permission can be granted only by the approved clinician who is, for the time being, acting as the patient's responsible clinician.

27.6 Responsible clinicians may grant leave for specific occasions or for specific or indefinite periods of time. They may make leave subject to any conditions which they consider necessary in the interests of the patient or for the protection of other people. These however should always be the least restrictive possible with due consideration given to the guiding principles in Chapter 1.

27.7 When considering and planning leave of absence, responsible clinicians should:

- take account of the patient's wishes, and those of carers, friends and others who may be involved in any planned leave of absence
- consider the benefits and any risks to the patient's health and safety of granting or refusing leave
- consider the benefits of granting leave to assist the patient's recovery and or the maintenance of their independence
- balance these benefits against any risks the leave may pose for the protection of other people (either generally or particular people)

- consider any conditions which should be attached to the leave, e.g. requiring the patient not to visit particular places or persons, and be aware of any child protection and child welfare issues in granting leave
- consider what support the patient would require during their leave of absence and the resources needed
- ensure any community services providing support for the patient during the leave are involved in the planning of the leave, and that they know the leave dates and times and any conditions placed on the patient during their leave
- ensure the patient is aware of plans put in place for their support, including what they should do if they think they need to return to hospital early
- should consider the patient's current risk and put in place any necessary safeguards, and liaise with any relevant agencies, e.g. the sex offender management unit (SOMU); and
- in the case of mentally disordered offender patients consider whether there are any issues relating to victims that impact on whether leave should be granted and the conditions to which it should be subject (see Chapter 40).

27.8 When considering whether to grant leave of absence for more than seven consecutive days, or extending leave so that the total period is more than seven consecutive days, responsible clinicians should also consider whether the patient should go onto a community treatment order (CTO) instead and, if required, consult any local agencies concerned with public protection. This does not apply to restricted patients, or, in practice, to patients detained for assessment under section 2 of the Act as they are not eligible to be placed on a CTO.

27.9 The option of using a CTO does not mean the responsible clinician cannot use longer-term leave if that is the more suitable option, but the responsible clinician will need to be able to show both options have been considered. Decisions should be explained to the patient and fully documented in the patient's notes.

27.10 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.

27.11 Hospital managers should take all reasonable steps to ensure the resources to support section 17 leave are available wherever practicable. This may be of particular importance in rural areas where public transport is not readily available.

Short-term leave

27.12 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. The parameters within which this discretion may be exercised should be clearly set out by the responsible clinician. It is important the terms of the leave prescribed by the responsible clinician cannot be interpreted differently by the staff managing the leave of absence.

- 27.13 Responsible clinicians should regularly review any short term leave they authorise on this basis and amend as necessary.

Longer periods of leave

- 27.14 The patient should be fully involved in the decision to grant leave and responsible clinicians should be satisfied patients are likely to be able to manage outside the hospital.
- 27.15 Subject to the patient's consent, there should be consultation with any appropriate relatives and friends and others (especially where the patient is to stay with them), including, if appropriate, independent advocacy and community services. Consideration should be given to whether or not it is safe and appropriate to grant leave if patients do not consent to carers or other people who would normally be involved in their care being consulted.
- 27.16 As with short-term leave, responsible clinicians should specify any circumstances in which the leave should not go ahead, for example if the patient's health has considerably deteriorated since it was authorised.

Recording leave

- 27.17 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 including a time-limit or review date. All expired section 17 leave authorisation forms should be clearly marked as no longer valid.
- 27.18 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.
- 27.19 In case a patient fails to return from leave, an up-to-date description of the patient should be available in their notes. A photograph of the patient (with their consent) should also be included in their notes. If the patient lacks capacity to decide whether to consent, a photograph should be taken in accordance with the Mental Capacity Act 2005 (MCA).
- 27.20 The outcome of leave – whether or not it went well, benefits achieved, particular problems encountered or concerns raised should also be recorded in patients' notes to inform future decision-making. Patients should be encouraged to contribute by giving their own views on their leave; some hospitals provide leave records specifically for this purpose.

Care and treatment while on leave

- 27.21 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 and if needed this should be provided.

27.22 A patient granted leave under section 17 remains 'liable to be detained' and 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. However the refusal of treatment may not on its own be sufficient grounds for recall and such a decision should take into consideration the guiding principles in Chapter 1 including the least restrictive care and treatment option and maximisation of independence.

Escorted leave

27.23 A responsible clinician may direct their patient remains 'in custody' while on leave of absence, either in the patient's own interests or for the protection of other people. Patients may be kept in the custody of any officer on the staff of the hospital or any person authorised in writing by the hospital managers. Such an arrangement is often useful, for example to enable patients to participate in escorted trips or to have compassionate home leave.

27.24 Escorted leave to Northern Ireland is permitted under the Mental Health Act 1983 – patients may be held in lawful custody by a constable or a person authorised in writing by the managers of the hospital. In Scotland, the Isle of Man or any of the Channel Islands escorted leave can only be granted if the local legislation allows such patients to be kept in custody while in that jurisdiction. If this is contemplated for a restricted patient advice should be sought from the Mental Health Casework Section of the Ministry of Justice.

Accompanied leave

27.25 While it may often be appropriate to authorise leave subject to the condition a patient is accompanied by a friend or relative, responsible clinicians should only specify that the patient is to be in the legal 'custody' of a friend or relative if it is appropriate for that person to be legally responsible and that the person understands and accepts the responsibilities of being the patient's legal custodian. In the case of children and young people it may be appropriate for the person with parental responsibility to be the legal custodian.

Leave to another hospital

27.26 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 (sometimes referred to as 'trial leave'). This can be a useful stage in the patient's recovery. Responsible clinicians may therefore require patients, as a condition of leave, to reside at another hospital in England and Wales, and they may then be kept in the custody of staff of that hospital. Before authorising leave on this basis, responsible clinicians should consider whether it would be more appropriate to transfer the patient to the other hospital instead (see Chapter 37).

27.27 Where a patient is granted leave of absence to another hospital, the responsible clinician at the first hospital should remain in overall charge of the patient's case. If it is thought a clinician at the other hospital should become the responsible clinician, the patient should be transferred to that hospital. An approved clinician in charge of any particular aspect of the patient's treatment may be from either hospital (see Chapter 36).

- 27.28 Section 17 leave may also 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.
- 27.29 The responsible clinician must ensure the staff in the second hospital understand the restrictions which the patient is under because of their detention under the Act. Those staff should 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.

Renewal of authority to detain

- 27.30 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 a CTO instead.

Recall from leave to hospital

- 27.31 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 the patient again becomes an inpatient.
- 27.32 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. For an unrestricted patient, the responsible clinician would have to be satisfied it is necessary in the patient’s interests or for the safety of others for the patient to be recalled.
- 27.33 The responsible clinician must arrange for a notice in writing revoking the leave to be served on the patient or on the person who is for the time being in charge of the patient. Hospitals should always know the address of patients who are on leave of absence and of anyone with responsibility for them whilst on leave. The reasons for recall should be fully explained to the patient, and if appropriate their family or carers and a record of the explanation included in the patient’s notes.
- 27.34 It is essential carers (especially where the patient is residing with them while on leave) and professionals who support the patient while on leave should know who to contact if they feel consideration should be given to return of the patient before their leave is due to end.

Restricted patients

- 27.35 Where the courts or the Secretary of State have decided that restricted patients are to be detained in a particular unit of a hospital, those patients will require the Secretary of State's permission to have leave of absence, to go to any other part of that hospital, as well as outside the hospital.
- 27.36 The responsible clinician should notify the Ministry of Justice if they need to suspend the leave of any restricted patients. Consideration will then be given whether to revoke or rescind the leave or allow the leave to continue.
- 27.37 For routine medical appointments or treatment, the Secretary of State's permission will be required. It is accepted however that there will be times of acute medical emergency where the patient requires emergency treatment. There may also be acute situations which, while not life threatening still require urgent treatment, e.g. fracture. In these situations, the responsible clinician may use their discretion, having due regard to the emergency or urgency being presented and the management of any risks, to have the patient taken to hospital. The Secretary of State should be informed as soon as possible that the patient has been taken to hospital, what risk management arrangements are in place, be kept informed of developments and notified when the patient has been returned to the secure hospital.
- 27.38 Further information and guidance on further types of short-term section 17 leave such as compassionate or holiday can be found on the Ministry of Justice website.

Chapter 28

Absence without leave

28.1 This chapter gives guidance on the powers under section 18 of the Mental Health Act 1983 (the Act) to return a patient who is absent without leave and on the policies, which should be in place, outlining actions necessary in such situations.

General matters

28.2 All instances of absence without leave should be recorded in the patient's case notes, and reported through local incident reporting mechanisms. Incidents should be reviewed so that lessons about ways of identifying patients most at risk of going missing can be learnt.

28.3 Patients are considered to be absent without leave in various circumstances, for example when they:

- have left the hospital in which they are detained without leave being agreed by their responsible clinician (under section 17 of the Act)
- have failed to return to the hospital at the time required to do so under the conditions of leave under section 17
- are absent without permission from a place where they are required to reside as a condition of leave under section 17
- have failed to return to the hospital if their leave under section 17 has been revoked
- are patients on a CTO who have failed to attend hospital when recalled
- are CTO patients who have absconded from hospital after being recalled there
- are conditionally discharged restricted patients whom the Secretary of State for Justice has recalled to hospital and
- are guardianship patients who are absent without permission from the place where they are required to live by their guardian.

Detained patients

28.4 Detained patients who are absent without leave may be taken into custody and returned by an Approved Mental Health Professional (AMHP), any member of the hospital staff, any police officer, or anyone authorised in writing by the hospital managers.

28.5 A patient who has been required to reside in another hospital as a condition of leave of absence can also be taken into custody by any member of that hospital's staff or by any person authorised by that hospital's managers.

28.6 Responsibility for the safe return of patients rests with the detaining hospital. If the absconding patient is initially taken to another hospital, that hospital may, with the written authorisation of the managers of the detaining hospital, detain the patient while arrangements are made for their return. A copy of a written authorisation can be taken as evidence they have the necessary authority without waiting for the original.

Guardianship patients

- 28.7 Guardianship patients who are absent without leave from the place they are required to live may be taken into custody by any member of the staff of a local authority, any person authorised in writing by the local authority or the private guardian (if there is one), or a police officer.

Patients on a CTO

- 28.8 Patients who are on a CTO who are absent without leave may be taken into custody and returned to the hospital to which they were recalled by an AMHP, a police officer, a member of staff of the hospital to which they have been recalled, or anyone authorised in writing by managers of that hospital or by the responsible clinician.

Other situations in which patients are in legal custody

- 28.9 In addition, there are various situations in which patients are considered to be in legal custody under the Act. These include:
- the detention of patients in places of safety under section 135 or 136 (see Chapter 16)
 - the transport of patients to hospital (or elsewhere) under the Act, including patients being returned to hospital when they have gone absent without leave (see Chapter 17); and
 - where patients' leave of absence is conditional on their being kept in custody by an escort (see Chapter 27).
- 28.10 If patients who are in legal custody abscond, they may also be taken into custody and returned to the place they ought to be, in accordance with the Act.

Local policies

- 28.11 Hospital managers should ensure there is a clear written policy about the action to be taken when a detained patient, or a patient on a CTO, goes missing. All relevant staff should be familiar with this policy. Hospital managers should agree their policy with other agencies – such as the police and ambulance services – as necessary. Patients should be given the opportunity to comment and inform the development of the policy
- 28.12 Policies in relation to detained and CTO patients should include guidance about:
- the immediate action to be taken by any member of staff who becomes aware a patient has gone missing, including a requirement they immediately inform the professional in charge of the patient's ward (where applicable), who should in turn ensure the patient's responsible clinician is informed
 - the circumstances when there should be a search of a hospital and its grounds
 - the circumstances in which other local agencies with an interest, including the local authority, should be notified
 - the circumstances and processes for when and how the police should be informed, and the information they should be given (this should be in line with local arrangements agreed with the police)
 - 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)

- when and how an application should be made for a warrant under section 135(2) of the Act to allow the police to enter premises in order to remove a patient who is missing, (see Chapter 16); and
 - how (and by whom) patients are to be returned to the place where they ought to be, and who is responsible for organising any necessary transport (see Chapter 17).
- 28.13 Local authorities should have equivalent policies for the action to be taken when they (or a private guardian) become aware a guardianship patient is absent without leave from the place where they are required to live.
- 28.14 The police should be asked to assist in returning a patient to hospital only if absolutely necessary. If the patient's location is known, the role of the police should, wherever possible, only be to assist a suitably qualified and experienced mental health professional in returning the patient to hospital.
- 28.15 However the police should always be informed immediately if the patient missing is:
- considered to be particularly vulnerable
 - a child or young person
 - considered to be dangerous; and/or
 - subject to restrictions under part 3 of the Act (restricted patients).
- 28.16 There may also be other cases where, although the help of the police is not needed, a patient's history makes it desirable to inform the police they are 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 them into custody. Where the police have been informed about a missing patient, they should be told immediately if the patient is found or returns.
- 28.17 Although every case should be considered on its merits, patient confidentiality will not usually be a barrier to providing basic information about a patient's absence to people – such as those the patient normally lives with or is likely to contact – who may be able to help with finding the patient.
- 28.18 Where a patient is missing for more than a few hours, their nearest relative should normally be informed.
- 28.19 Where patients (other than restricted patients) have been absent without leave for more than 28 days, section 21B of the Act requires such an examination to take place within a week of the patient's return and the provision of a report that the criteria for continued detention or being subject to a CTO or guardianship are still met. Otherwise, the patient's detention, CTO or guardianship will end automatically.

Chapter 29

Community treatment orders

- 29.1 This chapter provides guidance on the purpose of a community treatment order (CTO) including the process for assessing the suitability of the use of a CTO and on the duties of the practitioners and agencies involved in the management of patients subject to a CTO.
- 29.2 Guidance on the treatment of patients under a CTO and the operation of Part 4A of the Mental Health Act 1983 (the Act) is given in Chapter 25 and guidance on the extension and discharge of a CTO is given in Chapter 32.

Purpose of a CTO

- 29.3 The purpose of a CTO 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. A CTO is intended to help the patient to maintain stable mental health outside hospital and to promote their recovery.
- 29.4 It provides a framework for the management of patient care in the community, with conditions as required and gives the responsible clinician the power to recall the patient to hospital for treatment if necessary.
- 29.5 In considering the appropriateness of a CTO, practitioners should pay particular attention to the guiding principles in Chapter 1.

Making a community treatment order

- 29.6 Only patients who are detained in hospital for treatment under section 3 of the Act, or are unrestricted Part 3 patients, can be considered for a CTO. Patients can only be placed onto a CTO 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 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.

- 29.7 The decision as to whether a CTO is the right option for any patient is taken by the responsible clinician and requires the agreement of an approved mental health professional (AMHP). The AMHP must state in writing that they agree with the opinion of the responsible clinician and that it is appropriate to make the order.
- 29.8 In determining whether the criterion for making a CTO is met, the responsible clinician shall, in particular, consider, having regard to the patient's history of mental disorder and any other relevant factors, what risk there would be of a deterioration of the patient's condition if they were not detained in a hospital.
- 29.9 The risk that the patient's condition will deteriorate is a significant consideration, but does not necessarily mean the patient should be discharged onto a CTO rather than discharged. The responsible clinician must be satisfied the risk of harm arising from the patient's disorder is sufficiently serious to justify having the power to recall the patient to hospital for treatment.
- 29.10 CTOs should only be used when there is reasonable evidence to suggest there will be benefits to the individual. Such evidence may include:
- a clear link between non concordance with medication and relapse which is likely to require treatment in hospital
 - clear evidence there is a positive response to medication
 - evidence the CTO will promote recovery; and
 - evidence recall may be necessary (rather than informal admission or reassessment under the Act).
- 29.11 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.
- 29.12 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; a CTO or discharge from detention would be the right option for the patient at that particular time.

Role of the AMHP

- 29.13 The AMHP should 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.
- 29.14 If the AMHP does not agree a CTO should be made, or agree the suggested conditions, the CTO cannot proceed. It would not be appropriate for the responsible clinician to approach another AMHP in the absence of any change in circumstances.
- 29.15 In all cases the AMHP must reach an independent professional view and record this.

29.16 If the responsible clinician and AMHP agree the patient should be discharged onto a CTO 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 a CTO 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.

Consultation

29.17 Patients do not have to formally consent to a CTO, but, in practice patients should 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. An IMHA may support the patient during the consultation.

29.18 The responsible clinician may also want to consult with relevant others including:

- 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.

29.19 Consultation 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

29.20 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.

29.21 The responsible clinician may, with the AMHP's agreement, and following discussions with the patient, set other conditions which are necessary and appropriate to achieve one or more of the following objectives:

- ensuring that the patient receives medical treatment
- preventing risk of harm to the patient's health or safety
- protecting other people.

29.22 Conditions should be the least restrictive 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 the patient can readily understand what is expected.

- 29.23 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.
- 29.24 The reasons for any condition should be explained to the patient and others, as appropriate, and recorded in the patient's notes.

Information

- 29.25 Following the decision to discharge a patient onto a CTO, the responsible clinician should inform the patient, verbally and in writing, of the decision, 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.
- 29.26 The patient's GP should be informed the patient is to be made subject to a CTO, as well as others who are directly involved in the patient's care and treatment plans, including members of the voluntary sector.
- 29.27 There is a duty on hospital managers to take steps to ensure patients understand what a CTO 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 4.

Varying and suspending the CTO conditions

- 29.28 The responsible clinician has the power to vary or suspend any of the conditions of the CTO. Any proposed changes to the conditions should be discussed with the patient and anyone else affected by the potential changes such as their family and carers. As when the conditions were first set, the patient's views about the changes should be sought and considered before a change is made; and the responsible clinician should discuss with the patient whether they will be able to keep to any new or varied conditions.
- 29.29 The patient and their nearest relative should be informed of any changes to the conditions. Any help the patient needs to comply with them should be made available. Families and/or carers should also be supported to help the patient
- 29.30 Responsible clinicians do not have to obtain an AMHP's agreement before making any changes, but in general they should not vary or suspend conditions which had recently been agreed without discussion with that AMHP.
- 29.31 Any condition no longer required must be removed.
- 29.32 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 the medication needs to be given fortnightly, the responsible clinician can vary the conditions to reflect this change.

- 29.33 Any variation in the conditions must be recorded on the relevant statutory form, which should be sent to the hospital managers.
- 29.34 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.

Supporting and monitoring a patient on a CTO

- 29.35 The CTO should form a part of the patient's care and treatment plan and review and will form a fundamental part of the care and treatment planning process.
- 29.36 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 treatment plan.
- 29.37 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 the care co-ordinator (and others where appropriate), the reasons for this and what the next steps should be.
- 29.38 If the patient refuses crucial treatment, an urgent review of the situation will be needed. If suitable alternative treatment is available which would allow a CTO 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 treatment plan, and if necessary the conditions of the CTO, should be varied accordingly. A patient on a CTO must always give consent to treatment but if they lack capacity to consent then treatment for their mental disorder must be in accordance with Part 4A.
- 29.39 The patient's compliance with the conditions will be a key indicator of how a CTO 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.

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

- 29.40 Particular attention should be paid to carers and relatives when they raise a concern 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.
- 29.41 Carers and relatives are, typically, in much more frequent contact with the patient than professionals. Their concerns may prompt a review of how a CTO is working, whether more support in the community should be put in place or such is the level of

risk, consideration should be given to 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.

Recalling a patient subject to a CTO

- 29.42 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 the patient receives treatment quickly - increasing the likelihood the patient's condition can be stabilised and 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.
- 29.43 The responsible clinician may recall a patient on a CTO 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.
- 29.44 A patient may also be recalled to hospital if they fail to comply with either of the mandatory conditions which must be included in all CTOs i.e. failing to make 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.
- 29.45 The patient should always be given the opportunity to comply with the condition before recall is considered unless there is an immediate risk of harm to their health or safety or to others. 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.
- 29.46 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.
- 29.47 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 recall is necessary.
- 29.48 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.
- 29.49 Recall to hospital for treatment should not become a regular or normal event for any patient on a CTO. In circumstances where recall is being used frequently, the responsible clinician should consider reviewing the patient's treatment and consider whether the use of a CTO remains appropriate.

29.50 The patient may be recalled to hospital even if they are in the hospital informally when the decision to recall is made.

Procedure for recall to hospital

29.51 The responsible clinician has responsibility for co-ordinating the recall process, unless it has been agreed locally someone else will do this. It will be important to ensure the practical impact of recalling the patient on the patient's domestic circumstances is considered and managed.

29.52 Wherever possible the responsible clinician should give the patient (or arrange for the patient to be given) verbal reasons for the recall before it happens, taking into account any risks arising from giving notice of the recall. The family and carers involved in providing support to the patient should also be informed.

29.53 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. 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.

29.54 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 a CTO) 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.

29.55 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.

29.56 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. First class post must be used. If the notice is sent by first class post, it will be considered to be served on the second business day after it is delivered

29.57 Where the need for recall is urgent, as will usually be the case, a notice may be served by delivering it by hand to the patient. 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 hand 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 business day) beginning immediately after midnight following delivery.

- 29.58 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.
- 29.59 The patient should be taken to hospital in the least restrictive way possible and in line with the locally agreed transport of patients' policy (see Chapter 17). If the responsible clinician thinks it appropriate, the patient might be accompanied by a family member, carer or friend.
- 29.60 The responsible clinician should ensure 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

- 29.61 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.
- 29.62 The patient may be detained in hospital for a maximum of 72 hours after recall to allow the responsible clinician to determine what should happen next. During this period the patient remains a CTO patient, even if they stay in hospital for one or more nights.
- 29.63 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 if the CTO has not been revoked. On leaving hospital the patient will remain on a CTO as before, but a review of the conditions may be considered necessary.
- 29.64 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.
- 29.65 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.
- 29.66 The responsible clinician and the clinical team will need to consider the reasons why it was necessary to exercise the recall power and whether a CTO 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 and treatment plan (or both).

Revoking the CTO

- 29.67 Before the CTO can be revoked, the responsible clinician and an AMHP must agree the patient requires medical treatment as an inpatient and meets the criteria for detention as set out in section 3(2) of the Act.
- 29.68 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.
- 29.69 If the AMHP does not agree 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 a CTO. 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.
- 29.70 If the responsible clinician and the AMHP agree 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 is then detained again under the powers of the Act exactly as before going onto a CTO. A new detention period begins for the purposes of subsequent review and applications to the Mental Health Review Tribunal for Wales (MHRT for Wales).
- 29.71 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 12).

Review of patient's CTOs

- 29.72 In addition to the statutory requirements in the Act for review of CTOs, the patient's progress on their CTO should be discussed as part of all reviews of the care and treatment plan (see Chapter 34).
- 29.73 Reviews should cover whether the CTO is meeting the patient's treatment needs and, if not, what action is necessary to address this. A patient who no longer satisfies all the criteria for being on a CTO must be discharged without delay (see Chapter 32).

The hospital managers (of the responsible hospital)

- 29.74 Following recall of the CTO, the hospital managers are responsible for ensuring no patient is detained 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 the patient's length of stay following the time of detention after recall, as recorded on the form, is carefully monitored.
- 29.75 The hospital managers should also ensure there are clear guidelines and procedures in place to cover any necessary transfers of responsibility between responsible clinicians in the community and in hospital and the procedure to be followed when a patient is receiving inpatient services from a private provider and a community treatment order is appropriate.

29.76 The hospital managers have a duty to ensure a patient whose CTO is revoked is referred to the MHRT for Wales without delay.

Local health boards and local authorities

29.77 The local health board and local authorities are jointly responsible for ensuring the provision of statutory after-care services in line with the requirements of section 117 of the Act. Patients subject to a CTO cannot be discharged from section 117.

Chapter 30

Guardianship

30.1 This chapter provides guidance on the purpose of guardianship, assessing a patient for guardianship, the responsibilities of local authorities and the components of effective guardianship.

Purpose of guardianship

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

30.3 Guardianship must not be used to impose restrictions which amount to a deprivation of liberty. Guardianship does not give anyone the right to treat the patient without their permission or to consent to treatment on their behalf.

30.4 While the reception of a patient into guardianship does not affect the continued authority of an attorney or deputy appointed under the Mental Capacity Act 2005 (MCA), such attorneys and deputies will not be able to take decisions about where a guardianship patient is to reside³⁶, or take any other decisions which conflict with decisions made by the guardian.

30.5 A guardian may be a local authority or someone else approved by a local authority (a 'private guardian'). Guardians have three specific powers:

- the exclusive right to decide where a patient should live
- require the patient to attend for treatment, work, training or education at specific times and places (but they cannot use force to take the patient there)
- demand a doctor, approved mental health professional (AMHP) or another relevant person has access to the patient at the place where the patient lives.

30.6 Guardianship can provide an authoritative framework for working with a patient, with a minimum of constraint, to achieve as independent a life as possible within the community. Where it is used, it should be part of the patient's overall care and treatment plan.

Assessment for guardianship

30.7 As with applications for detention in hospital, AMHPs and doctors making recommendations should consider whether the objectives of the proposed application could be achieved in another less restrictive, way and in light of the guiding principles contained in Chapter 1. An application for guardianship may be made, in relation to a person who is aged 16 or over and who is not a ward of court, on the grounds that:

- the patient is suffering from mental disorder of a nature or degree which warrants their reception into guardianship
- it is necessary, in the interests of the welfare of the patient or for the protection of other persons.

³⁶ C v Blackburn and Darwen Borough Council [2011] EWHC 2231 (COP).

- 30.8 Where patients lack capacity to make important decisions about their welfare, one alternative to guardianship will be to rely on the MCA. While this is a factor to be taken into account, it will not by itself determine whether guardianship is necessary or unnecessary. AMHPs and doctors need to consider all the circumstances of the particular case.
- 30.9 Subject to the grounds for guardianship being satisfied, situations when guardianship might be considered include cases where:
- it appears necessary to use the guardian's power to require a patient to live in a particular place
 - 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)
 - 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 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).
- 30.10 In cases which raise unusual issues, or where guardianship is being considered in the interests of the patient's welfare other than for the protection of other persons and there are finely balanced arguments about where the patient should live, it may be preferable instead to seek a best interests decision from the Court of Protection under the MCA if the patient lacks mental capacity to decide residence.
- 30.11 If the relevant criteria are met, guardianship may also be considered for a patient who is to be discharged from detention under the Act. However, if it is thought the patient needs to remain liable to be recalled to hospital (and the patient is eligible), a community treatment order (CTO) may be appropriate (see Chapter 29).

Responsibilities of local authorities

- 30.12 Each local authority should establish a policy setting out the arrangements for:
- receiving, scrutinising and accepting or refusing applications for guardianship. Such arrangements should ensure applications are properly but quickly dealt with
 - monitoring the progress of each patient's guardianship, including steps to be taken to fulfil the authority's statutory obligations in relation to private guardians and to arrange visits to the patient at a minimum of every 3 months. The patient's care and treatment plan should detail who will undertake these visits on behalf of the local authority
 - that the need to continue guardianship is reviewed in the last two months of each period of guardianship in accordance with the Act ensuring the suitability of any proposed private guardian, and that they are able to understand and carry out their duties under the Act including the appointment of a nominated medical attendant
 - ensuring patients under guardianship and their nearest relative receive, both verbally and in writing, information in accordance with regulations under the Act
 - ensuring the patient is aware of the independent mental health advocacy (IMHA) service

- ensuring the patient is aware of the right to apply to the Mental Health Review Tribunal for Wales and that a named officer of the local authority will help them make such an application if assistance is necessary
 - maintaining detailed records relating to guardianship patients in line with good practice for record keeping and be available for monitoring by CSSIW and HIW as required
 - discharging patients from guardianship as soon as it is no longer required.
- 30.13 Patients may be discharged from guardianship at any time by the local authority, the responsible clinician authorised by the local authority, or (in most cases) the patient's nearest relative. The local authority must consider discharge when they receive a report from the patient's nominated medical attendant or responsible clinician renewing their guardianship under section 20 of the Act.
- 30.14 The local authorities should establish a panel of not less than 3 members of the local authority or members of a committee or sub-committee of the local authority to make discharge decisions. This should be the case whether the decision following receipt of a report under section 20 of the Act or otherwise.

Components of effective guardianship - care and treatment planning

- 30.15 An application for guardianship should be accompanied by a care and treatment plan (CTP) established in accordance with section 8 of the Mental Health (Wales) Measure 2010 and regulations made pursuant to it.
- 30.16 The plan should identify the services needed by the patient and who will provide them. It should also indicate which of the powers guardians have under the Act are necessary to achieve the plan. If none of the powers are required, guardianship should not be used.
- 30.17 The CTP should consider how the patient's recovery can be promoted and how his or her independence could be maintained, however key elements are likely to be:
- suitable accommodation to help meet the patient's needs
 - access to day care, education and training facilities, as appropriate
 - effective co-operation and communication between all persons concerned in implementing the care and treatment plan
 - if there is to be a private guardian support from the local authority for the guardian.
- 30.18 A private guardian should be prepared to advocate on behalf of the patient in relation to those agencies whose services are needed to carry out the care and treatment plan. A private guardian should display 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.
- 30.19 Regulations require private guardians to appoint a doctor as the patient's nominated medical attendant. It is the nominated medical attendant who must examine the patient during the last two months of each period of guardianship and decide whether to make a report extending the patient's guardianship. (Where the patient's guardian is the local authority itself, this is done by the responsible clinician authorised by the local authority).

30.20 It is for private guardians themselves to decide whom to appoint as the nominated medical attendant, but they should first consult the local authority. The nominated medical attendant may be the patient's GP, if the GP agrees.

Power to require a patient to live in a particular place

30.21 Guardians have the power to decide where patients should live. The power to require patients to reside in a particular place may not be used to require them to live in a situation in which they are deprived of liberty. Guardianship will not be appropriate for a person who has the capacity to decide where to live and will not reside in the place they are required to live by their guardian, unless they were to be deprived of their liberty under the Act.

30.22 If the person lacks the capacity to decide where to live, they may be deprived of their liberty if this is authorised separately by either (a) a DoL authorisation in respect of a hospital or care home placement if they are 18 or over; or (b) by a DoL order made by the Court of Protection under the MCA in respect of other community settings if they are 16 or over. If it is appropriate for deprivation of liberty to be authorised under the MCA, the local authority should consider whether guardianship remains appropriate, bearing in mind the need to apply the least restrictive option.

30.23 If patients leave the place they are required to live without the guardian's permission, they can be taken into legal custody and brought back there (see Chapter 28). This power can also be used to take patients for the first time to the place they are required to live, if patients do not (or, in practice, cannot) go there by themselves.

30.24 Patients should always be consulted first about where they are to be required to live, unless their mental state makes that impossible. Guardians should not use this power to make a patient move without warning.

30.25 The authority to convey the person to back to the place they are required by their guardian to live is contained in section 18(3).

Guardianship and hospital care

30.26 A patient subject to guardianship may be admitted to hospital informally in the same way as any other patient. Guardianship will remain in force if the patient is admitted to hospital under section 2 or 4 but not if a patient is detained for treatment as a result of an application under section 3.

30.27 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 local authority or person approved by such authority or to be transferred to hospital. (See section 19 of the Act and the regulations).

30.28 Guardianship does not prevent the deprivation of a person's liberty being authorised under the MCA, if the person needs to be detained in a hospital in their best interests in order to receive care and treatment. A DoL authorisation or DoL order can be sought so long as:

- it would not be inconsistent with the guardian's decision about where the patient should live; and

- the person does not object to being kept in hospital for treatment for mental disorder or to receiving that treatment.

30.29 Guardianship should not be used to require a patient to reside in a hospital except where it is necessary for a very short time in order to provide shelter while accommodation in the community is being arranged.

Patients who resist the authority of the guardian

30.30 If a patient consistently resists exercise by the guardian of any of their powers, there should be a full review of their care and treatment and the continued appropriateness of the guardianship order.

Guardianship orders under section 37

30.31 Guardianship may be used as an alternative to hospital orders by courts where the criteria set out in the Act are met. The court must be satisfied the local authority or named person is willing to act as guardian. In considering the appropriateness of the patient being received into guardianship, the local authority should be guided by the same principles that apply under Part 2 of the Act to applications for guardianship. 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; however they may apply to the Mental Health Review Tribunal for Wales.

Chapter 31

Leave of absence, a Community Treatment Order or guardianship?

31.1 An unrestricted patient may be subject to the powers of the Mental Health Act 1983 (the Act) while living in the community by one of three ways: leave of absence, a community treatment order (CTO) or guardianship. This chapter provides guidance on deciding between these three options.

Deciding between leave of absence, a CTO and guardianship

31.2 Leave of absence (section 17) allows a patient detained under the Act to be temporarily absent from hospital where further in-patient treatment as a detained patient is still thought to be necessary.

31.3 Leave of absence may be granted to a patient on specified occasions or for a specified period. Longer-term leave (more than seven consecutive days) can also be granted. This can be useful where the clinical team wish to see how the patient manages outside hospital before making the decision to discharge.

31.4 In cases of longer-term leave the responsible clinician must first consider whether the patient should be discharged onto a CTO instead. Any decision to authorise section 17 leave for more than seven days should be fully documented, including why a CTO or discharge is not appropriate.

31.5 A CTO (section 17A) is used where it is necessary for the patient's health or safety or for the protection of others to continue to receive treatment after their discharge from hospital. A key feature of the CTO framework is that it is suitable only where there is no reason to think the patient will need further treatment as a detained in-patient for the time being, but where the responsible clinician needs to be able to recall the patient to hospital if necessary (see Chapter 29).

31.6 Guardianship (section 7 of the Act) is social care-led and is primarily focused on patients with welfare needs. Its purpose is to enable patients to receive care in the community where it cannot be provided without the use of compulsory powers (see Chapter 30).

31.7 Some factors to consider are:

Leave of absence or CTO

Factors suggesting longer-term leave	Factors suggesting a CTO
Discharge from hospital is for a specific purpose or a fixed period.	Confidence the patient is ready for discharge from hospital on an indefinite basis.
The patient's discharge from hospital is specifically on a 'trial' basis.	Good reasons to expect the patient will not need to be detained for the treatment they need to be given.

<p>The patient is likely to need further in-patient treatment without their consent.</p> <p>There is a serious risk of arrangements in the community breaking down or being unsatisfactory – more so than for a CTO.</p>	<p>The patient appears prepared to consent or comply with the treatment they need – but risks as below mean recall may be necessary.</p> <p>The risk of arrangements in the community breaking down, or of the patient needing to be recalled to hospital for treatment, is sufficiently serious to justify a CTO, but not to the extent it is very likely to happen.</p>
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CTO or guardianship

Factors suggesting guardianship	Factors suggesting a CTO
<p>The focus is on the patient's general welfare, rather than specifically on medical treatment.</p> <p>There is little risk of the patient needing to be admitted compulsorily and quickly to hospital.</p> <p>There is a need for an enforceable power to require the patient to reside at a particular place.</p>	<p>The main focus is on ensuring the patient continues to receive necessary medical treatment for mental disorder, without having to be detained again.</p> <p>Compulsory recall to hospital for treatment may well be necessary, and a speedy recall is likely to be important.</p>

Deprivation of liberty while on a CTO, leave of absence or subject to guardianship

- 31.8 Patients who are on a CTO or on leave, and who lack capacity to decide whether or not to consent to the arrangements required for their care or treatment, may occasionally need to be detained for further care or treatment for their mental disorder in circumstances in which recall to hospital for this purpose is not considered necessary. They might also need to be admitted to a care home or hospital because of physical health problems.
- 31.9 If they are detained in a care home or other environment, a Deprivation of Liberty Safeguards authorisation (DoL authorisation) or Court of Protection order under the Mental Capacity Act 2005 (MCA) must be obtained. Deprivation of liberty under the MCA can exist alongside guardianship, a CTO or leave of absence, provided that there is no conflict with the conditions of the CTO or leave set by the patient's responsible clinician.
- 31.10 If they will be detained in a hospital for further treatment for mental disorder (whether or not they will also receive treatment for physical health problems), they should be recalled to be treated under the Act. The MCA cannot be used to authorise the deprivation of their liberty.
- 31.11 For guidance on the use of a DoL authorisation or Court of Protection order in relation to a patient who is subject to guardianship (see Chapter 30).

Chapter 32

Renewals, extensions and discharge: detentions and community treatment orders

32.1 This chapter provides guidance on how the procedures in the Mental Health Act 1983 (the Act) for renewing detention and extending a CTO should be applied. It provides guidance on the role and responsibilities of the responsible clinician and the role of the patient's nearest relative. Guidance is given on a nearest relative's power of discharge and an illustrative standard letter for nearest relatives to use to discharge a patient is provided.

Detention: renewal, discharge or CTO

32.2 Before a patients' detention expires, responsible clinicians must decide whether patients' current period of detention should be renewed. Responsible clinicians must examine the patient and decide within the two months leading up to the expiry of the patient's detention whether the criteria for renewing detention under section 20 of the Act are met or whether discharge is appropriate.

32.3 The responsible clinician should discuss their decision with the patient and must consult one or more other people who have been professionally concerned with the patient's medical treatment. The responsible clinician should also consult the wider multi-disciplinary team (MDT). Where appropriate, this should include the nearest relative, the independent mental health advocate (IMHA) and/or other representative, family and carers, the local authority and local health board responsible for the patient's after-care ; and any other key service providers.

32.4 Where responsible clinicians are satisfied the criteria for renewing the patient's detention are met, they must submit a report to that effect to the hospital managers.

Second professional

32.5 Before responsible clinicians can submit that report, they are required to obtain the written agreement of another professional ('the second professional') that the criteria are met. Before examining patients to decide whether to make a renewal report, responsible clinicians should identify and record who the second professional is to be. This second professional must be professionally concerned with the patient's treatment and must not belong to the same profession as the responsible clinician.

32.6 Hospital managers should have a local policy on the selection of the second professional. 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:

- 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; and
- the two professionals are able to reach their own decisions independently of one another.

- 32.7 The second professionals should:
- have sufficient experience and expertise to decide whether the patient's continued detention is necessary and lawful
 - have been actively involved in the planning, management or delivery of the patient's care and treatment; and
 - have had sufficient recent contact with the patient to be able to make an informed judgement about the patient's case.
- 32.8 Second professionals should satisfy themselves, in line with the local policies, they have sufficient information on which to make the decision or whether they need to meet separately with the patient. Responsible clinicians should ensure the second professional is given enough notice to be able to interview or examine the patient if appropriate.

Not holding a review before detention expires

- 32.9 If authority for detention is not renewed and the patient continues to be kept in circumstances which amount to a deprivation of liberty this will be a breach of the patient's Article 5 ECHR right. The responsible clinician should therefore notify the hospital managers immediately and the hospital managers should report the breach to HIW as a serious incident.
- 32.10 The patient must be informed and either be immediately discharged or there must be lawful authority to continue to detain the patient, for example, in exercise of the holding powers in the Act. If necessary a new application for admission or assessment should then be made. The hospital managers should ensure a review is undertaken within one month to determine why this has happened and what actions have been taken to resolve this and to ensure it would not happen again in the future.

Community treatment orders

- 32.11 Only responsible clinicians may extend the period of the CTO. To do so, responsible clinicians must examine their patient and decide, during the two months leading up to the day on which the patient's CTO is due to expire, whether the criteria for extending the CTO under section 20A of the Act are met. They must also consult an approved mental health professional (AMHP) and one other person who has been professionally concerned with the patient's medical treatment.
- 32.12 When deciding whether to extend the period of a CTO the responsible clinician, second professional and AMHP should all consider carefully whether or not the criteria for extending the CTO are met and, if so, whether an extension is appropriate.
- 32.13 Where responsible clinicians are satisfied that the criteria for extending the patient's CTO are met, they must submit a report to that effect to the managers of the responsible hospital, clearly stating their reasons.
- 32.14 Before responsible clinicians can submit that report they must obtain the written agreement of an AMHP. Responsible clinicians should ensure the AMHP is given enough notice to be able to interview the patient if appropriate.
- 32.15 This does not have to be the same AMHP who originally agreed the patient should become a CTO patient. It may (but need not) be an AMHP who is already involved in the patient's care and treatment. It can be an AMHP acting on behalf of any willing

local authority. If no other local authority is willing, responsibility for ensuring that an AMHP considers the case should lie with the local authority which is responsible under section 117 for the patient's after-care.

The responsible clinician's power of discharge

32.16 Section 23 of the Act allows responsible clinicians to discharge part 2 patients and unrestricted part 3 patients and all CTO patients by giving a discharge order in writing. As responsible clinicians have the power to discharge patients, they must keep under review the appropriateness of using that power. If, at any time, responsible clinicians conclude that the criteria which would justify renewing a patient's detention or extending the patient's CTO are not met, they should exercise their power of discharge. They should not wait until the patient's detention or CTO is due to expire.

The nearest relative's power of discharge

32.17 Patients detained for assessment or treatment under part 2 of the Act may also be discharged by their nearest relatives. The hospital managers should ensure the nearest relative is aware of this power and how to use it.

32.18 Before giving a discharge order, nearest relatives must give the hospital managers at least 72 hours' notice in writing of their intention to discharge the patient.

32.19 During that period, the patient's responsible clinician can block the discharge by issuing a 'barring report' stating that, if discharged, the patient is likely to act in a manner dangerous to themselves or others. This question focuses on the probability of dangerous acts, such as causing serious physical injury or lasting psychological harm, not merely on the patient's general need for safety and others' general need for protection.

32.20 The nearest relative's notice and discharge order must both be given in writing, but do not have to be in any specific form. In practice, hospital managers should treat a discharge order given without prior notice as being both notice of intention to discharge the patient after 72 hours and the actual order to do so. Hospital managers should have systems in place to ensure notices and discharge orders served on the hospital are received and considered without delay by hospital managers or their authorised officers.

32.21 Hospital managers should offer nearest relatives any help they require, such as providing them with a standard letter to complete. An example is given in Annex 1

Discharge by the hospital managers and the Tribunal

32.22 Patients may also be discharged by the hospital managers or by the Tribunal (see Chapter 38 and Chapter 12 respectively).

Chapter 33

After-care

33.1 This chapter provides guidance on the duty of local health boards and local authorities to provide after-care for certain patients under section 117 of the Mental Health Act 1983 (the Act). It should be read in conjunction with Chapter 34 on care and treatment planning.

Entitlement to and meaning of mental health after-care

33.2 Section 117 of the Act requires local health boards (LHBs) and local authorities, in co-operation with other relevant non-statutory agencies, to provide, or arrange for the provision of, after-care to patients detained in hospital for treatment under section 3, 37, 45A, 47 or 48 of the Act who then cease to be detained and leave hospital. This includes patients granted leave of absence under section 17 and patients who are to be subject to community treatment orders (CTOs). It applies to people of all ages, including children and young people.

33.3 The duty to provide after-care services continues as long as the patient is in need of such services. In the case of a patient on a CTO, after-care must be provided for the entire period they are on the CTO, but this does not mean the patient's need for after-care will necessarily cease as soon as they are no longer on a CTO.

33.4 After-care services mean services which have the purpose of meeting a need arising from, or related to, the patient's mental disorder and reducing the risk of a deterioration of the patient's mental condition (and, accordingly, reducing the risk of the patient requiring admission to hospital again for treatment for mental disorder).

33.5 After-care services may encompass healthcare, social care and employment services, supported accommodation and services to meet the person's wider social, cultural and spiritual needs, as long as these services meet a need that arises directly from, or is related to the particular patient's mental disorder, and help to reduce the risk of deterioration in the patient's mental condition. In line with the guiding principles set out in Chapter 1 the services should be the least restrictive necessary.

33.6 Local authorities and LHBs have a joint responsibility to provide or commission mental health after-care services. Local authorities and LHBs should maintain a record of people for whom they provide or commission after-care and what after-care services are provided.

33.7 Where eligible patients have remained in hospital informally after ceasing to be detained under the Act, they are still entitled to after-care under section 117 once they leave hospital. This also applies when patients are released from prison, having spent part of their sentence detained in hospital under a relevant section of the Act.

After-care planning

- 33.8 Although the duty to provide after-care begins when the patient leaves hospital, the planning of after-care should start whilst the patient is in hospital. LHBs and local authorities should take reasonable steps, in consultation with the patient's care co-ordinator and other members of the multidisciplinary team, to identify appropriate after-care services for patients in good time for their eventual discharge from hospital or release from prison.
- 33.9 It is the local authority in which the person was ordinarily resident prior to detention under the Act that will be the local authority that is responsible for the provision of aftercare services³⁷. Disputes about ordinary residence will be determined by the appropriate Ministers. The relevant LHB in Wales will also be determined by where the person was ordinarily resident immediately before being detained.
- 33.10 When considering relevant patients' cases, the Mental Health Review Tribunal for Wales (the Tribunal) and hospital managers will expect to be provided with information from the professionals concerned on the after-care arrangements which would be made if the patient were to be discharged. Discussion of after-care arrangements involving local authorities, other relevant agencies and families or carers (where appropriate) should take place in advance of the Tribunal.
- 33.11 Before deciding to discharge or grant more than short-term leave of absence to a patient or to place a patient onto a CTO, the responsible clinician should ensure the patient's needs for after-care have been fully assessed, and planned in consultation with the patient (and their carers, where appropriate) and included in their care and treatment plan.
- 33.12 The care and treatment plan, as well as addressing all the relevant areas of life, may also be the means to record aftercare arrangements under section 117.

Direct payments

- 33.13 A local authority may make direct payments³⁸ to pay for after-care services under section 117 of the Act. A person who is eligible for after-care services can request a direct payment from their local authority. Where the patient is a child or if a person lacks capacity to either request or receive direct payments, a willing and appropriate 'suitable' person can make the request and if appropriate who will then receive and manage the direct payment on their behalf.
- 33.14 The Community Care, Services for Carers and Children's Services (Direct Payments) (Wales) Regulations 2011 prescribes the persons who may act as a 'suitable person'. The local authority must be satisfied making a direct payments to the recipient or to a 'suitable person' is an appropriate way to discharge their section 117 duty and that the 'suitable person' will act in the best interest of the recipient when arranging their after care.

³⁷ <http://gov.wales/topics/health/publications/health/guidance/aftercare/?lang=en>

³⁸ A direct payment is a monetary amount paid directly to the service user or their representative to pay for their own care and support.

- 33.15 If a local authority is providing or arranging accommodation as part of a patient's after-care, there is nothing to prevent the patient and/or friends or relatives making top-up payments to enable the patient to live in their preferred accommodation. Residential accommodation is not included within the scope of a direct payment.
- 33.16 In determining whether a direct payment should be made, a local authority is required to have regard to whether the payment is appropriate for a person with that person's condition, the impact of that condition on the person's life and whether a direct payment represents value for money. A payment can also, in certain circumstances, be made to a nominee.

Ending section 117 after-care services

- 33.17 The duty to provide after-care services exists until both the LHB and the local authority are satisfied the patient no longer requires them. This joint agreement to discharge the patient from section 117 aftercare should be recorded in the patients record and all relevant agencies and individuals should be notified.
- 33.18 The circumstances in which it is appropriate to end section 117 after-care will vary from person to person and according to the nature of the services being provided.
- 33.19 Fully involving the patient and their family, carer and/or advocate in the decision-making process will play an important part in the successful ending of after-care.
- 33.20 After-care services under section 117 should not be withdrawn solely on the basis of any of the following:
- the patient has been discharged from the care of specialist mental health services
 - an arbitrary period has passed since the care was first provided
 - the patient is deprived of their liberty under the Mental Capacity Act
 - the patient has returned to hospital informally or under section 2, or
 - the patient is no longer on a CTO or section 17 leave.
- 33.21 Even when the provision of after-care has been successful (in that the patient has settled well in the community), the patient may still continue to need after-care services, e.g. to prevent a relapse or further deterioration in their condition. After-care services may be reinstated if it becomes obvious they have been withdrawn prematurely, e.g. where a patient's mental condition begins to deteriorate immediately after services are withdrawn.
- 33.22 Patients are under no obligation to accept the after-care services they are offered. An unwillingness to accept services does not mean patients have no need to receive those services and such a refusal would not be sufficient grounds to discharge section 117 responsibilities.

Chapter 34

Care and Treatment Planning

- 34.1 This chapter provides guidance on care and treatment planning for patients detained under the Mental Health Act 1983 (the Act) and relevant informal patients. It includes those patients subject to a Community Treatment Order (CTO), received into Guardianship as well as those receiving services provided under section 117.
- 34.2 Part 2 of the Mental Health (Wales) Measure 2010 (the Measure) and the Mental Health (Care Co-ordination and Care and Treatment Planning) (Wales) Regulations 2011 (the Regulations) place duties on care co-ordinators in relation to the preparation, content, consultation and review of care and treatment plans.
- 34.3 The Code of Practice to Parts 2 and 3 of the Mental Health (Wales) Measure 2010 provides guidance to local authorities, Local Health Boards (“LHBs”), and care coordinators and any other persons in relation to their functions under Parts 2 and 3 of the Measure. These Parts make provision in relation to care and treatment planning and care coordination for users of secondary mental health services, and in relation to the provision of assessments for former users of secondary mental health services.

Involvement, engagement and consultation

- 34.4 The Regulations prescribe those persons and bodies who the care co-ordinator should take all practicable steps to consult. The Measure requires the care coordinator to collaborate with the patient and the patient’s mental health service providers to agree care and treatment outcomes and prepare the care and treatment plan. Appropriate engagement is important if a patient’s rights are to be respected and they are to participate in the co-production of their care and treatment plan.
- 34.5 Encouragement for involvement in care and treatment planning should be clear and unambiguous. Technical language and jargon should be avoided in the planning process and encouragement for involvement and engagement should be in the patient’s preferred language. The plan may be completed in the Welsh or the English language, or partly in Welsh and partly in English.
- 34.6 For children, it will normally be necessary to ensure the involvement; engagement and consultation of appropriate family members (see Chapter 19).
- 34.7 If a patient does not wish to be involved at a particular point in time, this should not be seen as a definitive or permanent statement; involvement and engagement in care and treatment planning may fluctuate and so the patient’s preferred level of inclusion should be subject to regular and ongoing review.
- 34.8 Where a patient does not wish to, or refuses to, engage with the care and treatment plan this should be clearly recorded, including the reasons why and rationale for continuing the care and treatment without agreement. If it appears the patient does not have the capacity to agree to any aspect of their care and treatment, a proportionate though formal assessment of their capacity should be recorded

- 34.9 The IMHA may provide help and support to a patient in relation to care and treatment. Where an IMHA is involved, the care coordinator and members of the care and treatment team should respect the independence of the IMHA and seek to work openly and collaboratively to achieve the best treatment plan and actions for the patient.
- 34.10 An appropriate assessment of risk should form part of the development of the care and treatment plan. This should include an assessment of the person's own safety, vulnerability and the safety of others and is usually ongoing. Organisations must ensure that staff undertaking the role of care coordinator or who are involved in the delivery of care and treatment plans are competent and receive training in the role which will include the assessment and management of risk.

Inpatient Care

- 34.11 The Code of Practice to Parts 2 and 3 of the Measure provides detailed guidance on care and treatment planning.
- 34.12 When a patient is admitted to hospital, and has a care coordinator, the in-patient team should contact the care coordinator to obtain the patients' care and treatment plan. The care and treatment plan should be reviewed and amended to reflect any significant change in circumstances or identified outcomes, with the patients' input. If this is not possible, any wishes expressed by the patients in advance should be considered (see Chapter 9). In all but exceptional circumstances, this should be undertaken within 72 hours.
- 34.13 A person admitted under the Act who is not previously known to secondary mental health services will require a period of assessment before concluding that continued secondary mental health inpatient services are required. If continued inpatient services are required then the care and treatment planning process should commence.

Matters to be considered within the care and treatment plan

- 34.14 The process of agreeing outcomes requires involvement and engagement with the patient, mental health service providers, and other appropriate consultees.
- 34.15 The care and treatment plan should include a clear description of the outcomes agreed with the patient (where possible), and the patient's mental health service providers. Outcomes to be achieved will be drawn from one or more of the following areas as set out in section 18 of the Measure:–
- a) finance and money;
 - b) accommodation;
 - c) personal care and physical wellbeing;
 - d) education and training;
 - e) work and occupation;
 - f) parenting or caring relationships;
 - g) social, cultural or spiritual;
 - h) medical and other forms of treatment including psychological interventions.

- 34.16 Whilst there is no requirement for a care and treatment plan to record outcomes against each of these potential areas for intervention, it is likely that, outcomes would arise in more than one of these areas. It is also the case that care coordinators are not limited to recording outcomes only in relation to these 8 areas. Outcomes in additional areas may be recorded where identified, such as sensory or communication needs.
- 34.17 In addition to the requirements of the Code of Practice to Parts 2 and 3 of the Measure the following guidance in relation to the eight areas of life may be of particular relevance for those subject to the Act.

Finance and Money

- 34.18 The financial implications of being admitted to hospital should be explored if needed. This discussion may involve families and carers if appropriate. Access to an assessment for entitlement to benefits and, where appropriate, support to access receipt of benefits, may also form part of the care and treatment plan arrangements.

Accommodation

- 34.19 For a patient admitted to hospital under the Act the assessment process should identify if there are any needs or outcomes associated with accommodation. This may include identifying if there are any risks of losing accommodation during the admission.
- 34.20 The security of a patient's accommodation in their absence is of particular relevance especially if there is an extended period of admission under the Act. The care co-ordinator should ensure that there has been consideration of, and where appropriate action to ensure, the security of the person's accommodation in their absence.
- 34.21 If necessary, a patient should be supported to find suitable accommodation prior to discharge. Support should be proportionate to the level of need and ability, for example a patient may only need advice on contacting a housing support officer or hospital discharge scheme, or a patient may need an assessment for supported accommodation or support to attend a meeting.
- 34.22 Any accommodation provided for a patient subject to the Act should be the most suitable and least restrictive according to the level of need and risk identified through the assessment process. An individual's capacity to agree to any accommodation option that involves any degree of restriction should always be recorded.

Personal Care and Physical Wellbeing

- 34.23 An assessment of a patient's ability to address their personal care and physical wellbeing, which may include personal safety, and an assessment of how any physical or medical conditions may interact with a person's mental health or prescribed treatment, must be included within the holistic assessment.
- 34.24 Every patient (unless they object) detained under the Act or admitted to hospital informally should have a physical health examination on admission to hospital and if needed this should be repeated at regular intervals during the period of hospital stay.

- 34.25 The care and treatment planning arrangements should take account of any outcomes that a patient may want to achieve that maintains personal care or physical wellbeing, this may include promotion and maintaining of good health by, for example, healthy eating, promotion of smoking cessation, or attending regular physical health checks when discharged.
- 34.26 The care and treatment plan may include offering education and information on health promotion and personal safety.

Education and Training

- 34.27 Education and training can play a significant part in a patient's recovery. For some, education and training can involve the learning or regaining of skills that may have been lost, while for others education and training will involve continued learning appropriate to age and situation.
- 34.28 For a child or young person who is detained in hospital, the care and treatment plan should identify the arrangements for their continuing education.
- 34.29 Additionally and separately, education and training may include how to manage symptoms, prescribed treatments such as self-administration, or how to recognise relapse indicators. The multi disciplinary team should provide opportunities that educate and help a patient understand the cause and management of their mental health problem including the education and training in independent self-management skills.

Work and Occupation

- 34.30 The role of occupational and vocational therapy may be an important aspect to the patient's care and treatment. The care and treatment plan may be informed by the outcome of occupational therapy assessments that have been undertaken and outcomes planned according to the skills, abilities and aspirations that a patient may have identified.
- 34.31 Detention under the Act should not unnecessarily restrict a patient's access to structured opportunities to develop skills that increase independence or enhance prospects for seeking or maintaining employment. The care and treatment plan should include details of any arrangements that support this.

Parenting or Caring Relationships

- 34.32 Detention under the Act may cause distress for a patient and their family. Where appropriate, the care and treatment plan should identify how contact with a patient's family (including any children) and friends can be regularly maintained in hospital ensuring that there is appropriate balance of privacy, dignity and safety.
- 34.33 The assessment process should identify if the patient has any parenting or caring responsibilities and any relevant arrangements made. The care and treatment plan may also consider what information, support or education a patient may need to maintain or manage a parenting or caring relationship following discharge from hospital.

- 34.34 For children admitted under the Act, particular attention will need to be paid to the role of the patient's parents and or carers and their own role within the family (see Chapter 19).

Social, Cultural or Spiritual

- 34.35 Outcomes related to a patient's social, cultural or spiritual identity may play a significant part of personal recovery. It may be difficult to maintain this identity during an admission to hospital.
- 34.36 As needed, the care and treatment plan should consider how a patient's cultural and spiritual identity is maintained which may include arrangements for the patient to attend religious or faith establishments, or if this is not possible, to receive faith visits in hospital.
- 34.37 Establishing social networks can support a patient's recovery. This may be achieved by providing opportunities within the ward environment for peer support or providing the patient with information about local community support groups and agencies. Leave arrangements should consider opportunities to access local support networks to help prepare for discharge from hospital.

Medical and other forms of treatment including psychological interventions

- 34.38 The treatment a patient is prescribed must be clearly identified within the care and treatment plan. It is recognised that there may be frequent alterations to treatment, for example the prescribed dose or frequency of medication, this amount of detail may not be appropriate to include in the care and treatment plan, but should be recorded and provided as information to the patient in writing if requested.
- 34.40 However, it is important that the care and treatment plan describes what medication is being prescribed and what it is intending to achieve. The care and treatment plan may also include the details for monitoring and reducing any side effects of medication, which may include the frequency of physical observations or tests.
- 34.41 Multidisciplinary treatment care and support interventions are a critical part of the treatment provided in hospital. These should be recorded within the care and treatment plan. The provision of and access to psychological interventions should also be considered within the care and treatment plan arrangements. This may include interventions that can be provided by suitably qualified and experienced staff within the ward environment or information regarding different psychological therapies and how these may be accessed.

Relapse prevention/Crisis Plan

- 34.42 The care and treatment plan should include the indicators of the patient becoming unwell, and the actions to be taken in response. The purpose of this section of the care and treatment plan is to detail the arrangements that may help to prevent deterioration in a patient's mental health and to record the actions and support that others can offer to prevent a crisis.

- 34.43 This section of the care plan should include how to contact relevant services. The crisis plan should also indicate the interventions that are most likely to help reduce a crisis, such as an emergency appointment with a professional, or treatments that have worked well in the past.
- 34.44 A relapse prevention plan should be developed for all patient's prior to discharge from hospital, and access to support in a developing crisis situation should be included as part of any section 117 or other after care arrangements.

Reviews

- 34.45 The Measure provides for the formal review of the care and treatment plan. The guidance for reviewing the care and treatment plan laid out in the Code of Practice for parts 2 and 3 of the Measure applies equally to patients receiving secondary mental health services under the Act. This involves the relevant amendments to the care and treatment plan as needed. It is not sufficient to state the plan has been reviewed.
- 34.46 In addition to that guidance, a review of the care and treatment plan should generally be undertaken:
- Within 72 hours of application of the Act and admission to hospital (where a CTP existed prior to application)
 - Prior to any subsequent application of the Act
 - Prior to any Mental Health Review Tribunal or Managers Hearing
 - Prior to any renewal of detention under the Act
 - Within 72 hours of recall to hospital
 - Prior to authorisation of section 17 leave
 - Prior to discharge form hospital.
- 34.47 Reviews will include discussions between the care coordinator, multi-disciplinary team, other care providers, the patient and their family or other relevant persons. At reviews, the patient will have the opportunity to receive the support of an IMHA.
- 34.48 Where the review considers a leave of absence from hospital under section 17 of the Act, the views of the family or carers should, where relevant, be taken into account.

Chapter 35

Receipt and scrutiny of documents

35.1 This chapter provides guidance on the receipt and scrutiny of documents under the Mental Health Act 1983 (the Act).

Statutory forms

35.2 Regulations require specific statutory forms are to be used for certain applications, recommendations, decisions, reports and records under the Act. The forms are set out in the Mental Health (Hospital, Guardianship, Community Treatment and Consent to Treatment) (Wales) Regulations 2008 (the regulations).

35.3 If no hard copies of the statutory forms are available, photocopies of the original blank forms can be completed instead, as can computer-generated versions. However, the wording of the forms must correspond to the current statutory versions of the forms set out in the regulations.

35.4 Those completing forms must ensure they are legible. It is not possible to scrutinise documents that cannot be read and may therefore not constitute legal authority for a patient's detention.

Applications for detention in hospital and supporting medical recommendations

35.5 Regulations say applications for detention under the Act must be delivered to a person who is authorised by the hospital managers to receive them.

35.6 There is a difference between receiving admission documents and scrutinising them. Receipt involves physically receiving documents; checking they appear to amount to an application that has been duly made and recording receipt.

35.7 Scrutiny involves more detailed checking (both administrative and medical) for any omissions or errors and, where permitted, taking action to have the documents rectified after they have already been acted on if this is permissible.

35.8 Hospital managers should formally delegate their duties to receive and scrutinise admission documents to a limited number of officers, who may include clinical staff on wards. Someone with the authority to receive admission documents should be available at all times at which patients may be admitted to the hospital. A manager of appropriate seniority should take overall responsibility on behalf of the hospital managers for the proper receipt and scrutiny of documents.

35.9 Hospitals should have a checklist for the guidance of people delegated to receive documents ('receiving officers'), to help them detect those errors which fundamentally invalidate an application and which cannot be corrected at a later stage in the procedure and those errors that can be rectified under section 15 of the Act within 14 days of receipt. Receiving officers should have access to a manager for advice if they have concerns about the validity of an application, including outside office hours.

- 35.10 When a patient is being admitted on the application of an approved mental health professional (AMHP), the receiving officer should go through the documents and check their accuracy with the AMHP.
- 35.11 Where the receiving officer is not authorised by the hospital managers to agree to the rectification of a defective admission document, the documents should be scrutinised by a person who is authorised to do so. This scrutiny should happen at the same time as the documents are received or as soon as possible afterwards (and certainly no later than the next working day).
- 35.12 Documents should be scrutinised for accuracy and completeness and to check they do not reveal any failure to comply with the procedural requirements of the Act in respect of applications for detention. Medical recommendations should also be scrutinised by someone with appropriate clinical expertise to check the reasons given appear sufficient to support the conclusions stated in them. Advice should be sought from a senior colleague if there is any doubt as to the sufficiency of the medical recommendations.
- 35.13 If admission documents reveal a defect which fundamentally invalidates the application and which cannot, therefore, be rectified under section 15 of the Act, the patient can no longer be detained on the basis of the application. Authority for the patient's detention can be obtained only through a new application (or, in the interim, by the use of the holding powers under section 5 if the patient has already been admitted to the hospital). Unless that authority is to be sought, the hospital managers should use their power under section 25 to discharge the patient. The patient should be informed both verbally and in writing, and in an accessible format for the patient.

Guardianship applications and supporting medical recommendations

- 35.14 Local authorities should prepare a checklist for the guidance of those delegated to receive guardianship applications on their behalf. That checklist should identify those errors which can be rectified under section 8(4) of the Act and those which cannot. As in the case of applications for detention in hospital, the written recommendations of both medical practitioners which are required under section 7(3) of the Act should be scrutinised by someone with the appropriate clinical expertise.
- 35.15 Where a guardianship application is made, the person receiving the documents on behalf of the local authority should check them for inaccuracies and defects with the AMHP or nearest relative making the application.

Community treatment order documentation

- 35.16 There are no provisions in the Act for community treatment orders (CTOs) and related documents to be rectified once made. Hospital managers should ensure arrangements are in place to provide advice about how the relevant forms should be completed and check documents have been properly completed. Significant errors or inadequacies may render patients' CTOs invalid, and errors in recall notices or revocations may invalidate hospital managers' authority to detain.

35.17 Hospital managers should ensure that, if needed, responsible clinicians have access to and the opportunity (where practicable) to have them checked in advance by someone else familiar with what the Act requires.

Audit

35.18 Hospital managers are responsible for ensuring patients are lawfully detained or on a CTO. Local authorities are responsible for ensuring that guardianship is lawful.

35.19 Hospital managers and local authorities should ensure the people they authorise to receive and scrutinise statutory documents on their behalf are competent to perform these duties, understand the requirements of the Act and receive suitable training.

35.20 Hospital managers and local authorities should also ensure arrangements are in place to audit the effectiveness of receipt and scrutiny of documents on a regular basis.

Chapter 36

Allocating or changing a Responsible Clinician

- 36.1 This chapter deals with the identification of Responsible Clinicians for patients being assessed and treated under the Mental Health Act 1983 (the Act), including a change of Responsible Clinician.

Allocating a Responsible Clinician

- 36.2 Every patient must have an allocated Responsible Clinician (RC). The RC is the approved clinician who will have overall responsibility for the patient's care and treatment.
- 36.3 Hospital managers should have local protocols in place for allocating RCs to patients. The protocols should ensure:
- the patient's RC is the available approved clinician with the most appropriate expertise to meet the patient's main assessment and treatment needs
 - a patient's RC can be easily determined
 - cover arrangements are in place when the RC is not available (e.g. during non-working hours, annual leave etc.); and
 - there is a system for keeping the appropriateness of the RC under review.
- 36.4 To ensure the most appropriate available approved clinician is allocated as the patient's RC, hospital managers should keep a register of approved clinicians.
- 36.5 The selection of the appropriate RC should be based on the individual needs of the patient concerned. For example, where psychological therapies are central to the patient's treatment, it may be appropriate for a professional with particular expertise in this area to act as the RC.
- 36.6 Wherever possible, the clinician responsible for the care and treatment of children and young people should be a child and adolescent mental health services (CAMHS) specialist (see Chapter 19). If this is not possible clinical staff should have access to a CAMHS specialist for advice and consultation.
- 36.7 Wherever possible, the clinician responsible for the care and treatment of a person with learning disabilities or autistic spectrum disorder (ASD) should be a specialist in that field (see Chapter 20). If this is not possible clinical staff should have access to a learning disability and ASD specialist for advice and consultation.
- 36.8 If the patient's main treatment needs are not immediately clear, the allocation of a RC may be made on a temporary basis until such time as it become clear who is appropriate to be allocated to the patient.

Change of Responsible Clinician

- 36.9 It may be appropriate for the patient's RC to change during a period of care and treatment, if such a change enables the needs of the patient to be met more effectively. In considering such a change it is also important to take account of the need for continuity and continuing engagement with, and knowledge of, the patient. If the patient requests a change their reasons should be established to inform an appropriate response.
- 36.10 Where a patient's treatment and rehabilitation requires movement between different hospitals or to the community, the prospective RC needs to be identified in good time to enable movement to take place. The existing RC remains responsible until these responsibilities are transferred. If movement to another hospital is indicated, RCs should take the lead in identifying their successors, and hospital managers should respond promptly to requests to assist in this process.
- 36.11 There may be circumstances where the RC is qualified with respect to the patient's main assessment and treatment needs but is not appropriately qualified to be in charge of a subsidiary treatment needed by the patient (e.g. medication which the RC is not qualified to prescribe). In such situations, the RC will maintain their overarching responsibility for the patient's case, but another appropriately qualified professional can take responsibility for a specific treatment or intervention.
- 36.12 Where the person in charge of a particular treatment is not the patient's RC, the person in charge of the treatment should ensure the RC is kept informed about the treatment and that treatment decisions are discussed with the RC in the context of the patient's overall case. Guidance should be available locally on the procedures to follow, including when to seek a second opinion, if there are unresolved differences of opinion.

Chapter 37

Duties of hospital managers

- 37.1 This chapter gives guidance on the responsibilities of hospital managers under the Mental Health Act 1983 (the Act), and on their specific powers and duties not addressed in other chapters. It provides guidance on the identification of hospital managers, the exercise of their functions and on their specific powers and duties including:
- admission
 - transfer between hospitals and into guardianship
 - transfer and assignment of responsibility for community treatment order (CTO) patients
 - provision of information for patients and relatives
 - patients' correspondence
 - duties in respect of victims of crime; and
 - the referral of cases to Mental Health Review Tribunal for Wales (MHRT for Wales).
- 37.2 It also provides guidance on the Welsh Minister's power to refer cases to the Mental Health Review Tribunal for Wales and hospital accommodation for children and young people.

Identification of hospital managers

- 37.3 In Wales NHS hospitals are managed by local health boards. For these hospitals (including acute/non-mental health hospitals), the local health boards (LHBs) themselves are defined as the 'hospital managers' for the purposes of the Act. In an independent hospital the person or persons in whose name the hospital is registered are the hospital managers.
- 37.4 Hospital managers have the authority to detain patients under the Act. They have responsibility for ensuring the requirements of the Act are followed. In particular, they must ensure patients are detained and treated only as the Act allows and that patients are fully informed of, and are supported in, exercising their statutory rights. Hospital managers have equivalent responsibilities towards CTO patients.
- 37.5 In practice, most of the decisions of the hospital managers are undertaken by individuals (or groups of individuals) on their behalf by means of the formal delegation of specified powers and duties.
- 37.6 In particular, decisions about discharge from detention and CTOs are taken by panels of people (managers' panels) specifically selected for the role. They are directly accountable to the Board in the execution of their delegated functions. In this chapter, unless otherwise stated, 'hospital managers' includes anyone authorised to take decisions on their behalf. Separate guidance is given in Chapter 37 about the function of managers panels.

Exercise of hospital managers' functions

- 37.7 Apart from exercising hospital managers' power of discharge, hospital managers (meaning the organisation, or individual, in charge of the hospital) may arrange for their functions to be carried out, day-to-day, by particular people on their behalf. In some cases, regulations say they must do so.
- 37.8 The arrangements for authorising people to exercise delegated functions should be set out in a scheme of delegation. Unless the Act or the regulations say otherwise, organisations may delegate their functions under the Act to any one and in any way their constitution allows or in the case of LHBs in line with NHS legislation.
- 37.9 Organisations (or individuals) in charge of hospitals retain responsibility for the performance of all hospital managers' functions exercised on their behalf and must ensure the people acting on their behalf are competent to do so.
- 37.10 The organisation (or individual) concerned should put in place appropriate governance arrangements to monitor and review the exercise of functions under the Act on its behalf. Many organisations establish a Mental Health Act steering or scrutiny group specifically for this purpose.

Specific powers and duties of hospital managers:

Admission

- 37.11 It is the hospital managers' responsibility to ensure the authority for detaining patients is valid and a copy of the report made by the approved mental health professional (AMHP) should be available to them. Hospital managers should have a clear system in place for notifying local authorities when the patient is a child or young person. For guidance on the receipt, scrutiny and rectification of documents related to detentions under the Act (see Chapter 35).
- 37.12 Where a patient is admitted under the Act on the basis of an application by their nearest relative, the hospital managers must request the relevant local authority to provide them with the social circumstances report as required by section 14.

Information for patients and carers

- 37.13 Sections 132, 132A and 133 of the Act and the Mental Health (Hospital, Guardianship, Community Treatment and Consent to Treatment) (Wales) Regulations 2008 (the regulations) require hospital managers to arrange for detained patients, CTO patients and (where relevant) their nearest relatives, to be given information about the way the Act works and about their rights including their rights of appeal for discharge. The provisions do not apply to a community patient who has been recalled to hospital unless the patient's community treatment order is revoked and the patient becomes a detained patient. There is also no requirement to give information to patients who are detained in places other than a hospital. However in line with the guiding principles patients should be kept fully informed about their care and treatment For further guidance on the exercise of these duties (see Chapter 4).

Information about independent mental health advocates (IMHAs)

- 37.14 Hospital managers are required to take such steps as are practicable to ensure patients who are receiving treatment in hospital for their mental disorder and those subject to guardianship, CTO or who are conditionally discharged understand help is available from an IMHA and how to obtain that help (see Chapter 6).
- 37.15 If a patient lacks capacity to decide whether or not to obtain help from an IMHA, the hospital manager should ask an IMHA to attend the patient so that the IMHA can explain to the patient what they can offer. Hospital managers should ensure procedures are in place to allow the patient's nearest relative, responsible clinician or AMHP to ask an IMHA to attend.

Transfer between hospitals

- 37.16 Section 19 of the Act and the regulations allows hospital managers to authorise the transfer of most detained patients from one hospital to another. Decisions on transfers may be delegated to a person who could, but need not be the patient's responsible clinician. For restricted patients, the consent of the Secretary of State for Justice is also required (see Chapter 22).
- 37.17 A hospital manager does not have the power to insist another hospital accepts a detained patient, nor to insist a proposed new placement is funded by another agency. People authorising transfers on the hospital managers' behalf should ensure there are good reasons for the transfer and that the needs and interests of the patient are central to decision making. Transfers are potentially an interference with a patient's right to respect for privacy and family life under Article 8 of the European Convention on Human Rights (ECHR) and care should be taken to act compatibly with the ECHR and in the case of children the UNCRC when deciding whether to authorise a transfer.
- 37.18 Wherever practicable, patients should be involved in the process leading to any decision to transfer them to another hospital. It is important to explain the reasons for a proposed transfer to the patient and, where appropriate, their nearest relative and carers. The reasons should be recorded. Only in exceptional circumstances should patients be transferred to another hospital without prior notification.
- 37.19 The factors to be considered when deciding whether to transfer a patient includes:
- what effect a transfer is likely to have on the course of the patient's disorder or their recovery
 - whether the transfer would give the patient greater access to carers, or have the opposite effect, and
 - whether a transfer would enable the patient to be in a more culturally suitable or compatible environment, or whether it would have the opposite effect.
- 37.20 Detained patients may themselves want a transfer to another hospital for example, to be nearer their family or friends. Or they may have a reasonable wish to be treated by a different clinical team, which could only be achieved by a transfer. The professionals involved in a patient's care should always be prepared to discuss the possibility of a transfer with them.

- 37.21 Requests for transfer made by, or on behalf of, patients should be recorded and given careful consideration. Every effort should be made to meet the patient's wishes. If this cannot be achieved, the patient or the person who made the request on the patient's behalf should be given a written statement of the decision and the reasons for it.
- 37.22 It is not a statutory requirement to have a nearest relative's consent to transfer. However unless the patient objects, the patient's nearest relative should be consulted before a patient is transferred to another hospital, and, in accordance with the regulations, they must be notified of the transfer as soon as practicable after the decision is made.
- 37.23 In the case of transfers to high security psychiatric hospitals, unless the circumstances are urgent, or there is a clinical reason precluding notification, or there would be risks to the health or safety of the patient or others, or there is some other significant reason to make it inadvisable, the relevant hospital managers should give the patient and/or their representative sufficient information about the proposed transfer.
- 37.24 They should also inform them that if they disagree with the factual or clinical triggers for the transfer they can make submissions in writing which will be considered by the high security psychiatric hospital's admissions panel. As a minimum this will include providing the documents listed below or where the documents are not provided a summary of their content:
- the letter of reference from the hospital which wishes to transfer the patient to the high security hospital
 - the assessment by the clinician from the high security hospital; and any other accompanying reports and/or documents the hospital managers think should be shared.
- 37.25 If the assessing doctor is invited to attend the deliberations of the admissions panel, the hospital should consider whether the patient and/or their representative should be invited to attend or be represented at those deliberations.
- 37.26 When a patient is transferred, the documents authorising detention, including the authority for transfer, any original AMHP reports, risk reports, Tribunal information, the care and treatment plan and other relevant information should be sent to the hospital to which the patient is transferred. The transferring hospital should retain copies of these documents.

Transfers into guardianship

- 37.27 The regulations allow hospital managers to authorise the transfer of most detained patients into guardianship with the agreement of the relevant local authority. This procedure avoids the need to discharge the patient from detention and making a separate guardianship application. There should be good reasons for any transfer into guardianship and the needs and interests of the patient must be central to decision making.

Transfer and assignment of responsibility for CTO patients

37.28 The managers of a hospital to which a CTO patient has been recalled may authorise the patient's transfer to another hospital during the 72-hour maximum period of recall. With the agreement of the hospital to which the patient is being transferred, the hospital managers may also reassign responsibility for CTO patients so that a different hospital will become the patient's responsible hospital.

Duties in respect of victims of crime

37.29 The Domestic Violence, Crime and Victims Act (DVCVA) 2004 places a number of duties on hospital managers in relation to certain unrestricted Part 3 patients who have committed sexual or violent crimes together with guidance on the exercise of these. The duties include ensuring the following information is communicated to victims:

- when authority to detain the patient expires
- when the patient is discharged, including allowing the victim to make representations about discharge conditions and whether a CTO is to be made
- what conditions of discharge relate to the victim, and when these cease
- the victim's entitlement to make representations on the need for a CTO, (and forwarding these to people responsible for making decisions on discharge) and allowing representation concerning the conditions attached to the CTO
- any conditions on the CTO relating to the victim or their family, and any variation of the conditions; and
- when the CTO ceases.

37.30 These duties complement similar arrangements for restricted Part 3 patients, managed by the probation service.

Patients' correspondence

37.31 Section 134 of the Act describes hospital manager's duties in respect of detained patients' correspondence.

Duty to refer cases to Mental Health Review Tribunal for Wales (the Tribunal)

37.32 Hospital managers must refer a patient's case to the Tribunal in the circumstances set out in section 68 of the Act, summarised below:

Hospital managers must refer the following patients	When
<p>Patients who are detained under part 2 of the Act, and patients who were detained under part 2 but are now CTO patients; or</p> <p>If the patient is still a section 2 patient, pending the outcome of an application to the county court for a change in their nearest relative.</p>	<p>Six months have passed since they were first detained, unless:</p> <ul style="list-style-type: none"> • the patient applied to the Tribunal themselves after they became a section 3 patient • the patient's nearest relative applied to the Tribunal after the responsible clinician barred the nearest relative's order to discharge a section 3 patient • the patient's displaced nearest relative has applied to the Tribunal after the displacement order is made • the patient's case was referred to the Tribunal by the Welsh Ministers after the patient became a section 3 patient.
<p>Patients who are detained under part 2 of the Act, or were detained under part 2 but are now CTO patients</p>	<p>Three years have passed since their case was last considered by the Tribunal (one year if they are under 18)</p>
<p>People who were CTO patients but whose CTOs have been revoked</p>	<p>As soon as practicable after the responsible clinician revokes the CTO</p>
<p>Patient was transferred from guardianship to a hospital including Part 3 patients</p>	<p>Six months have passed, unless the patient has already applied to the Tribunal after being transferred from guardianship to a hospital</p>
<p>Patients detained under hospital orders, hospital directions or transfer directions under part 3 of the Act without being subject to special restrictions (collectively, unrestricted part 3 patients), or who were detained under part 3 of the Act but are now CTO patients</p>	<p>Three years have passed without their case being considered by the Tribunal (one year if they are under 18)</p>
<p>Note: for these purposes:</p> <ul style="list-style-type: none"> • detention under part 2 of the Act does not include any time spent detained under the 'holding powers' in section 5 (see Chapter 18); and • applications to the Tribunal do not count if they are withdrawn before they are determined. 	

- 37.33 Hospitals will be able to comply properly with these duties only if they maintain full and accurate records about:
- the detention and discharge of the patients for whom they are responsible
 - applications made by those patients to the Tribunal, and
 - applications and references to the Tribunal made by other people in respect of those patients.
- 37.34 Hospital managers should ensure they have systems in place to alert them or the person to whom the function is delegated in good time to the need to make a referral. Persons exercising this function should be familiar with the relevant requirements of the Tribunal itself and the procedural rules by which it operates.
- 37.35 When hospital managers are required to refer the case of a patient to the Tribunal, whose CTO is revoked, this must be done as soon as possible after the revocation.
- 37.36 Where a tribunal hearing has been arranged, the hospital managers should inform the relevant LHB and local authority 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.
- 37.37 Hospital managers should periodically audit compliance and the timeliness of referrals to the Tribunal.

References to the Tribunal by the Welsh Ministers

- 37.38 The Welsh Ministers may, at any time, refer the cases of detained patients and CTO patients to the Tribunal. Anyone may request a reference and the Welsh Ministers will consider all such requests on their merits.
- 37.39 Hospital managers should consider asking the Welsh Ministers to make a reference in respect of patients whose rights under article 5(4) of the ECHR might otherwise be at risk of being violated because they are unable, for whatever reason, to have their case considered by the Tribunal in a timely manner following their initial detention or at reasonable intervals thereafter.
- 37.40 The hospital managers should normally seek such a reference in any case where:
- a patient's detention under section 2 has been extended under section 29 of the Act pending the outcome of an application to the county court for the displacement of their nearest relative
 - the patient lacks the capacity to request a reference
 - the patient's case has never been considered by the Tribunal or a significant period has passed since it was last considered.

Hospital accommodation for children and young people

- 37.41 Section 131A of the Act puts a duty on hospital managers to ensure any children or young people aged under 18 receiving in-patient care for mental disorder in their hospitals are accommodated in an environment which is suitable for their age in line with their needs). The duty applies to children and young people admitted informally to hospitals, as well as those detained under the Act.

Chapter 38

Hospital managers' discharge power

38.1 Section 23 of the Mental Health Act 1983 (the Act gives hospital managers the power to discharge most detained patients and all patients subject to a community treatment order (CTO). They may not discharge patients who are held under the section 5 holding powers or in a place of safety under sections 135 or 136 or those remanded to hospital under 35 or 36 or subject to an interim hospital order under section 38 or restricted patients without the consent of the Secretary of State for Justice. This chapter provides guidance on the use and application of these powers.

The power of discharge

- 38.2 The hospital managers must either consider appeals for the discharge of patients for which they are responsible themselves or, arrange for their power to be delegated to a 'managers' panel'.
- 38.3 A hospital managers' panel may consist of 3 or more people who are non-executive directors of the local health board that is responsible for the hospital or members of a committee which is authorised for the purpose. Members of managers' panels must not be employees of the local health board concerned. Hospital managers' panels in independent hospitals should not include people who are on the staff of the hospital or who have a financial interest in it.
- 38.4 In all cases, the board (or its equivalent) of the organisation should ensure that the people appointed to a 'managers' panel' understand their role and the Act and that they receive adequate and appropriate training to ensure they:
- understand the Act and other relevant legislation
 - understand the associated Codes of Practice, and particularly the need to consider the views of the patients both past and present, those of their nearest relatives and others if appropriate
 - understand risk assessment and risk management reports; and
 - are able to reach sound judgements and properly record their decisions.
- 38.5 In order to fulfil their role, managers' panels should ensure that they understand equality issues in relation to age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex and sexual orientation and have an understanding of the needs of particular groups including those listed below:
- patients from minority cultural or ethnic backgrounds
 - patients with physical and/or sensory impairments
 - patients with learning disabilities and/or autistic spectrum disorders; and
 - patients who lack mental capacity to make specific decision regarding their care and treatment.
- 38.6 Relevant arrangements should be made to ensure that panel members can communicate effectively with patients and make suitable arrangements to ensure that patients can be understood.

38.7 Appointments to managers' panels should be made for a fixed period and reappointment (where permitted) should not be automatic and should be reviewed.

Reviewing detention or a Community Treatment Order

38.8 Hospital managers should ensure all relevant patients, nearest relatives and, carers, are aware that patients have the right to seek discharge by the hospital managers. They also need to understand the distinction between this right and the right to apply for to the Mental Health Review Tribunal for Wales.

38.9 Hospital managers:

- may undertake a review of whether or not a patient should be discharged at any time at their discretion
- must undertake a review if the patient's responsible clinician submits a report to them under section 20 of the Act, renewing detention or under section 20A, extending a CTO
- should consider holding a review when they receive a request from a patient. Such a request may be supported by a carer, their independent mental health advocate (IMHA) (see Chapter 6), independent mental capacity advocate (IMCA), by their attorney or deputy (see Chapter 7); and
- should consider holding a review when the responsible clinician makes a report to them under section 25 barring an order by the nearest relative to discharge a patient.

38.10 In the last two cases, when deciding whether to consider the case, hospital managers should take into account whether the Tribunal has recently considered the patient's case or is due to do so in the near future. The decision reached should be recorded in writing. If the decision is not to consider the case the reasons why not should be documented.

38.11 The Act does not define the procedure for reviewing a patient's detention or a CTO. However, the exercise of this power is subject to the general law and to public law duties that arise from it. Hospital managers' conduct of reviews must satisfy the fundamental legal requirements of fairness, reasonableness and lawfulness.

Managers' panels should therefore:

- adopt and apply a procedure which is fair and reasonable
- not make irrational decisions – that is, decisions which no managers' panel, properly directing itself as to the law and on the available information, could have made; or
- not act unlawfully – that is, contrary to the provisions of the Act and any other legislation including the Mental Capacity Act 2005. The Human Rights Act 1998 (HRA) and the Equality Act 2010.

38.12 Hospital managers should have mechanisms in place that seek to involve patients, nearest relatives and carers in the hearing process. This should include:

- involvement at the hearing itself
- offering the patient information and advice on the review process
- supporting them to fully participate and ensuring that, wherever practicable, hearings are scheduled in consultation with the patient so that any representative of the patient and others supporting them may attend; and
- be given reasonable notice of when a hearing will take place.

Criteria to be applied

- 38.13 The Act does not define the specific criteria to be used by hospital managers when considering discharge. The essential consideration is whether the grounds for continued detention or continued CTO under the Act are satisfied. To promote equality of decision making, managers' panels should consider the questions set out below in the order stated.

For patients detained for assessment under sections 2 of the Act:

- Is the patient still suffering from mental disorder?
- If so, is the disorder of a nature or degree that warrants the continued detention of the patient in hospital?
- Ought the detention to continue in the interests of the patient's health or safety or for the protection of other people?

For other detained patients:

- Is the patient still suffering from mental disorder?
- If so, is the disorder of a nature or degree that makes treatment in a hospital appropriate?
- Is continued detention for medical treatment necessary for the patient's health or safety or for the protection of other people?
- Is appropriate medical treatment available for the patient?
- Consideration should also be given to whether the Mental Capacity Act 2005 can be used to treat the patient safely and effectively.

For patients on a CTO:

- Is the patient still suffering from mental disorder?
- If so, is the disorder of a nature or degree that makes it appropriate for the patient to receive medical treatment?
- If so, is it necessary in the interests of the patient's health or safety or the protection of other persons that the patient should receive such treatment?
- Is it still necessary for the responsible clinician to be able to exercise the power to recall the patient to hospital, if that is needed?
- Is appropriate medical treatment available for the patient?

- 38.14 If three or more members of the panel who between them make up a majority are satisfied the answer to any of the questions set out above is 'no', the patient should be discharged.

- 38.15 Where the answer to all the relevant questions above is 'yes', but the responsible clinician has made a report under section 25 barring a nearest relative's attempt to discharge the patient, the panel should also consider the following question: Would the patient, if discharged, be likely to act in a manner that is dangerous to other persons or to themselves? This question provides a more stringent test for continuing the detention or the CTO.
- 38.16 If three or more members of the panel being a majority disagree with the responsible clinician and decide that the answer to this question is 'no', the panel should usually discharge the patient.
- 38.17 Managers' panels should always consider whether there are other reasons why the patient should be discharged despite the answers to the questions set out above; regard should be had to the principle of least restrictive option and maximising independence.

Conduct of reviews where continued compulsion is contested

- 38.18 In order to reach considered judgment about the need for continuing the patient's detention or CTO sufficient information about the patient's past history of care and treatment, and details of any future plans will be required. It should include the patient's care and treatment plan and other supporting reports and assessments.
- 38.19 It is essential that panels are fully informed about any history of violence or self-harm and that a recent risk assessment and/or risk management plan should be provided.
- 38.20 Up-to-date written reports from the patient's responsible clinician and from other key individuals directly involved in the patient's care as appropriate, such as the patient's care co-ordinator, named nurse, social worker, occupational therapist or clinical psychologist should be provided in advance of the hearing. Generally these should be similar in format and content to those that would be submitted to the Tribunal (see Chapter 12).
- 38.21 The patient should be provided with copies of the reports as soon as they are available, unless disclosing the information would be likely to cause serious harm to the physical or mental health of the patient or any other individual. Any decision to withhold a report (in whole or part) should be recorded, with reasons.
- 38.22 Patient's legal or other representatives such as their attorney or deputy, their IMHA, and, where appropriate, and the patients consents, the nearest relative and carer should also receive copies of these reports.
- 38.23 Nearest relatives should normally be informed when manager's panels consider cases. Where the patient objects to the notification of their nearest relative, such notification may be withheld subject to the normal considerations about involving nearest relatives
- 38.24 Where relevant, panels should also have a copy of any order made by the responsible clinician under section 25 barring a patient's discharge by their nearest relative.

- 38.25 The process and manner of a hearing is for managers' panels themselves to decide, whilst they may be conducted with a level of informality this needs to be balanced with the rigour demanded by the importance of the task.
- 38.26 It is for hospital managers themselves to decide where hearings should take place, but that decision should take into account what is in the best interests of the patient and the suitability of the environment for the purpose. For CTO patients, and patients currently on leave of absence from hospital, the hospital itself may not be the most convenient or acceptable place for the patient. Hospital managers should be prepared to consider whether there are more appropriate locations it would be feasible to use.
- 38.27 The patient and the other people addressing the panel should, if the patient wishes, be able to hear each other's statements to the panel and to put questions to each other. This should be facilitated unless the panel believes that it would be likely to cause serious harm to the physical or mental health of the patient or any other individual. Patients should usually be offered the opportunity of speaking to the panel alone, unless it is considered inappropriate for them to do so, on the grounds of safety or the patient's welfare.
- 38.28 Panels should be prepared to consider the views of the patient's relatives and carers, and other people who know the patient well, either at the patient's request or where such people offer their views on their own initiative. Carers and any other relevant people may be invited to put their views to the managers' panel in person or in writing. If the patient objects to this, a suitable member of the professional care team should be asked to include the person's views in their report.
- 38.29 Where there is difference of opinion among the professionals about whether the patient continues to meet the grounds for continued detention or CTO, managers' panels should weigh up the evidence in order to reach an independent judgement. The guiding principles should inform their deliberations. In some cases, it might be necessary to consider adjourning to seek further medical or other professional advice.
- 38.30 Prior to the managers' panel the responsible clinician, and the multi-disciplinary team, should have considered the services and other arrangements that might be provided should the patient be discharged and whether such arrangements would enable discharge or termination of the CTO (see Chapter 33).
- 38.31 The presence or absence of adequate community care arrangements, including a deprivation of liberty authorisation or Court of Protection order may be critical in deciding whether continued detention is necessary. If managers' panels believe they have not been provided with sufficient information about arrangements that could be made to enable the patient be discharged, or that such steps could have been taken but have not, they should consider adjourning and request further information or to allow arrangements for service provision to be taken.
- 38.32 If panels conclude that the patient ought to be discharged, but practical steps to put after-care in place (see Chapter 33), or obtain a Deprivation of Liberty authorisation or a Court of Protection order, need to be taken first, they may adjourn the panel for a brief period to enable that to happen before formally discharging the patient. Professionals should work together to minimise the time it takes to do this.

Uncontested renewals

- 38.33 Where a patient's detention is renewed or their CTO extended, the hospital managers must always consider the grounds for continuance even if the patient has indicated that they do not wish to challenge the renewal or extension.
- 38.34 Hospital managers and managers' panels should apply as much rigour to considering uncontested cases as to contested ones and follow the same procedures. If hospital managers decide to adopt a different procedure such as a paper based review in an uncontested case this should be documented with the reasons for this recorded. In deciding whether or not to review the case on the papers, hospital managers should consider if previous reviews during the current period of compulsory powers have been 'paper reviews'.
- 38.35 Where a panel has reason to suspect that the patient may, in fact, want to contest or there are prima facie grounds to think that the statutory grounds to renew detention or extend the CTO are not met the panel should hold a full review. The fact that patients have not said they object to the renewal or extension should not in and of itself be taken as evidence that they agree with it, or that it is the correct decision.

Decisions

- 38.36 Hospital managers have a common law duty to give reasons for their decisions. The decisions of managers' panels, and the reasons for them should be fully recorded at the end of each review. The decision should be communicated as soon as practicable, both verbally and in writing, to the patient and any representatives, the nearest relative and, carers (subject to the normal rules of confidentiality) and to the professionals concerned. Formal records of the decision and copies of the paper relating to the review should be kept in the patient's notes.
- 38.37 If the patient is not to be discharged, at least one member of the panel should offer to see the patient (or their representative) where practicable to explain in person the reasons for the decision. The patient should normally be accompanied by a member of staff who has knowledge of the patient.

Not holding a review before detention expires

- 38.38 The hospital managers should have processes in place to ensure that the responsible clinician or the hospital manager holds a review before the period of detention or CTO expires. If this does not occur, this should be considered a very serious matter that should be reviewed and any such occurrences closely monitored. The reasons for the review not having taken place and the actions put in place to stop this happening again should be fully documented.

Chapter 39

Conflicts of Interest

- 39.1 Conflicts of interest may arise which prevent an AMHP from making the application for a patient's detention or guardianship, and a doctor from making a recommendation supporting the application

Conflicts of Interest Regulations

- 39.2 The Mental Health (Conflicts of Interest) (Wales) Regulations 2008 ('the regulations') set out the circumstances in which there is a potential conflict of interest such that an AMHP cannot make an application mentioned in section 11(1) of the Act, or a registered medical practitioner cannot make a medical recommendation for the purposes of an application mentioned in section 12(1) for a person to be admitted under the Act. .
- 39.3 The potential conflict of interest may arise for a number of reasons. Those reasons are the existence of a professional, financial, business or personal relationship between that person and another assessor, or between that person and either the patient or, where the application is to be made by the patient's nearest relative, the nearest relative.

Financial conflict

- 39.4 The regulations state that where the application is for the admission of the patient to a registered establishment (i.e. an independent hospital), neither of the medical recommendations may be given by a registered medical practitioner who is on the staff of that hospital or who receives or has an interest in the receipt of any payments made on account of the maintenance of the patient.
- 39.5 This is not the case for doctors who work in NHS hospitals. The regulations state that where the application is for the admission of the patient to a hospital which is not a registered establishment (i.e. an independent hospital), one (but not more than one) of the medical recommendations may be given by a registered medical practitioner who is on the staff of that hospital or who receives or has an interest in the receipt of any payments made on account of the maintenance of the patient.
- 39.6 There will be a conflict of interest for financial reasons if the assessor stands to make a financial gain dependent upon whether or not the assessor decides to make an application or give a medical recommendation. However, any fee paid to a practitioner in respect of an examination of a patient pursuant to section 12 of the Act or the provision of any recommendation as a result of such examination, will not be a financial gain for the purposes of the regulations.

Business conflict

- 39.7 When considering a patient, an assessor will have a potential conflict of interest if that assessor is closely involved in the same business venture as another assessor, the patient or the patient's nearest relative including being a partner, a director, other office-holder or major shareholder of that venture. Where the patient's nearest relative is making an application, an assessor will have a potential conflict of interest if he or she is closely involved in the same business venture as the nearest relative including being a partner, director, other office holder or major shareholder of that venture.

Professional conflict

- 39.8 The regulations state that when considering a patient, an assessor will have a potential conflict of interest for professional reasons if:
- the assessor works under the direction of, or is employed by, one of the other assessors considering the patient;
 - the assessor is a member of a team organised to work together for clinical purposes on a routine basis of which the other two assessors are also members.
- 39.9 Where the patient's nearest relative is making an application, an assessor will have a potential conflict of interest if:
- the assessor works under the direction of, or is employed by, that patient's nearest relative
 - the assessor employs the patient's nearest relative or the nearest relative works under his or her direction;
 - the assessor is a member of a team organised to work together for clinical purposes on a routine basis of which the nearest relative is also a member.
- 39.10 When considering a patient, an assessor will have a potential conflict of interest if:
- the assessor works under the direction of, or is employed by, the patient;
 - employs the patient or the patient works under his or her direction;
 - the assessor is a member of a team organised to work together for clinical purposes on a routine basis of which the patient is also a member.

Personal Conflict

- 39.11 An assessor will have a potential conflict of interest in considering a patient, if he or she is related to another assessor, the patient or the patient's nearest relative (if the nearest relative is making the application), the assessor should withdraw from the application process.
- 39.12 The regulations set out the nature of the personal relationships pertinent to a personal conflict. 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.

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

Emergency Provision

39.14 The regulations do not prevent an AMHP making an application or a registered medical practitioner giving a medical recommendation if there would otherwise be delay involving serious risk to the health or safety of the patient or others.

Other potential conflicts

39.15 There may be circumstances not covered by the regulations where the assessor feels there is (or could be seen to be) a potential conflict of interest. Assessors should work on the principle that in any situation where they believe the objectivity or independence of their decision in the application process is (or could be seen to be) undermined, then they should not become involved or should withdraw. This could include a therapeutic or pastoral relationship between any of the assessors or the assessors and the patient.

39.16 The regulations do not cover potential conflicts of interest relating to a community treatment order (CTO). The responsible clinician, who is responsible for making the decision as to whether to place a patient on a CTO, or any decision to revoke a CTO, should not have any financial interest in the outcome of the decision and should not be a relative of the patient. Responsible clinicians should not be regarded as having a financial interest in a hospital solely because they work there.

39.17 These regulations do not cover potential conflicts of interest relating to renewal of detention or guardianship. However, the persons involved in making the decision as to whether to renew the detention (the responsible clinician and other professionals consulted by the responsible clinician) or the guardianship (the appropriate practitioner) should not have any financial interest in the outcome of the decision.

39.18 The Act requires an AMHP to take an independent decision about whether or not 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 local channels. Local arrangements should be in place to deal with such situations.

Chapter 40

Information for victims

40.1 This chapter provides guidance about the rights of victims of serious violent and sexual offences committed by certain person detained under Part 3 of the Mental Health Act 1983 (the Act) (Part 3 patients). It includes the information to be provided and the obligations placed on the Secretaries of State for Justice and Health as well as professionals with regard to victims.

The Victim Contact Scheme (VCS)

40.2 Under the Domestic Violence, Crime and Victims Act 2004 (DVCVA), victims of specific serious violent and sexual offences committed by certain Part 3 patients have the right to information from the National Probation Service under the Victim Contact Scheme (VCS). Under the Victim Contact Scheme, these victims ('statutory victims') have a right to be informed of key developments in the patient's care and treatment and to make representations about the conditions they believe should be in place on discharge from hospital.

40.3 The Code of Practice for Victims of Crime ('the Victims' Code') sets out the information, support and services, victims of relevant crimes can expect to receive from criminal justice agencies in England and Wales. The Victims' Code also summarises the information victims are entitled to under the Victim Contact Scheme, as set out in the DVCVA.

The National Probation Service Victim Contact Scheme

Specified Offences

40.4 For the purpose of this chapter, 'relevant offences', or 'specified offences', are those set out in section 45(2) of the DVCVA:

- murder or an offence specified in Schedule 15 to the Criminal Justice Act 2003
- an offence in respect of which the patient is subject to the notification requirements of part 2 of the Sexual Offences Act 2003; or
- an offence against a child within the meaning of part 2 of the Criminal Justice and Court Services Act 2000.

40.5 For relevant offences committed on or after 1 July 2005, the police or joint police and Crown Prosecution Service Witness Care Unit should send details of statutory victims to the appropriate National Probation Service Victim Liaison Unit (VLU).

40.6 The VLU should offer victims the opportunity to engage with the Victim Contact Scheme if the patient is:

- convicted of a specified sexual or violent offence and made the subject of a hospital order with a restriction order (section 37 and section 41 of the Act)
- found unfit to plead in respect of a specified sexual or violent offence, but has committed and been charged with the offence

- found not guilty by reason of insanity under the Criminal Procedure (Insanity) Act 1964 in respect of a specified sexual or violent offence, and made subject to a hospital order with special restrictions (section 37 and section 41 of the Act)
- convicted of a specified sexual or violent offence and then made the subject of a hospital direction and limitation direction (section 45A and section 45B of the Act); or
- sentenced to 12 months imprisonment or more for a specified sexual or violent offence, and transferred to hospital under a transfer direction and restriction direction (section 47 and section 49 of the Act).

The National Probation Service Victim Contact Scheme (restricted patients)

- 40.7 Under the Victim Contact Scheme, victims must, as a minimum, be:
- offered the opportunity to engage with the Victim Contact Scheme by the Victim Liaison Unit
 - assigned a Victim Liaison Officer (for restricted patients and prisoners transferred under section 47 who are subject to restriction directions made under section 49 who have not passed their licence expiry date)
 - offered the right to make representations to whoever is responsible for making the decision on the patient's discharge, either the Secretary of State for Justice or the Tribunal, about the patient's discharge conditions, for example about geographic exclusion zones or 'no contact' conditions
 - informed of discharge conditions which relate to them; and
 - informed about any other key information about the patient's progress, which it is appropriate to share in all the circumstances of the case.
- 40.8 Victims can choose to opt in or out of the Victim Contact Scheme at any time. If a victim was not identified at the time of sentencing or did not take up contact when it was offered, they may contact or be referred to the Victim Liaison Unit at any time during the patient's treatment and rehabilitation.
- 40.9 From 22 April 2014 victims of restricted Part 3 patients, who have opted in to the Victim Contact Scheme, will be told if permission for community leave, whether escorted or unescorted, is granted by the Mental Health Casework Section (MHCS) of the Ministry of Justice, unless there are exceptional reasons why they should not be told.
- 40.10 Information about restricted patients will be provided by the Victim Liaison Officer to the victim whereas information about unrestricted patients will come directly to the victim from hospital managers or clinicians once any relevant licence period has expired.

Mental health casework section requirements

Victims of Part 3 restricted patients

- 40.11 The Mental health casework section will, through the Victim Liaison Officer, contact victims who are in the Victim Contact Scheme. Information will be shared on certain key stages of the patient's care and treatment, including:
- when the patient is transferred to hospital and becomes a restricted patient

- if a relevant prisoner is transferred to hospital under section 47 of the Act
- when the Secretary of State for Justice is considering a proposal for discharge, and there is a request for representations from the victim
- if the Secretary of State for Justice decides to discharge the patient
- the conditions of discharge relating to the victim or their family
- any variation of conditions of discharge relating to the victim or their family
- if the restricted patient is recalled for further treatment under the Act
- if the part 3 patient is absolutely discharged, resulting in the cessation of conditions and the removal of the Part 3 patient's liability to be recalled to hospital
- when the patient's restrictions are lifted or expire
- if a patient previously found unfit to plead is remitted back to court to continue legal proceedings
- if a patient is to be remitted to prison
- if the Mental Health Casework Section has approved or rescinded escorted or unescorted leave.

40.12 The Mental Health Casework Section (MHCS) may pass on additional information, for example about a hospital transfer, to the Victim Liaison Officer or directly to the victim, if the victim is in direct contact with MHCS. Similarly the Victim Liaison Officer may provide victims with more information only if appropriate in all the circumstances of the case, and whilst being mindful of patient confidentiality including in respect of confidential medical information.

40.13 When considering requests for community leave or transfer, MHCS will take into account victim concerns. MHCS also expects, where the responsible clinician knows of VLO involvement, he or she will contact them to ensure victim concerns are addressed in any application. This can include ensuring patients are not allowed leave or to be placed in a hospital in the vicinity of the victim.

Duties of hospitals in respect of unrestricted patients

Victims of unrestricted part 3 patients

40.14 The Mental Health Act 2007 included amendments to the DVCVA and provided that victims of Part 3 unrestricted patients should have the same level of information as restricted patients in terms of consideration for discharge and the victim's right to make representations with regard to discharge conditions and to be informed of these conditions.

40.15 The Victim Liaison Unit should offer victims of Part 3 unrestricted patients the opportunity to engage with the Victim Contact Scheme. Victims who want to engage with the Victim Contact Scheme will have their details passed to the hospital. The hospital manager or responsible clinician then becomes responsible for providing information to the victim.

40.16 Where a previously restricted Part 3 patient is no longer subject to those same restrictions, for example, a person transferred from prison without a restriction order as the custodial part of their sentence was about to end (i.e. they are a 'notional section 37 patient'), they will be treated as an unrestricted patient when they reach their sentence end date.

- 40.17 At this time, if there is a victim identified in the Victim Contact Scheme, the Victim Liaison Unit will send the victim's details to the hospital. The hospital manager or responsible clinician then becomes responsible for providing information to the victim. The Victim Liaison Officer should continue to provide updates to the victim until the end of the licence period, even if the patient remains in hospital and, in particular if they are released on licence.
- 40.18 Hospital managers must ensure the statutory minimum of information is communicated to victims. Statutory information consists of:
- whether the patient is to be discharged
 - whether a community treatment order (CTO) is to be made, including allowing the victim to make representations about the conditions attached to the CTO
 - what conditions of the CTO relate to the victim
 - when the CTO ceases
 - when authority to detain the patient expires
 - when the Part 3 patient is discharged, including allowing the victim to make representations about discharge conditions, and
 - what conditions of discharge relate to the victim, and when these cease.
- 40.19 The decision about whether to pass more information to victims than the statutory minimum will be for the relevant hospital manager to decide. The information that can be provided to a victim will be limited if it relates to medical treatment, as this information will be confidential medical information. The usual rules under the Data Protection Act 2004 and guidance in the Code on confidentiality apply (see Chapter 10).

Non statutory victims

- 40.20 Where victims of part 3 restricted patients do not fall within the scope of the DVCVA for statutory contact under the VCS (i.e. non-statutory victims), it is good practice for the National Probation Service (NPS) to consider providing VCS services to any victim of a restricted patient who requests information. Examples include:
- where the conviction occurred prior to the DVCVA, but the victim has now made contact
 - the victim of a non-qualifying offence or sentence length (for prisoners transferred under sections 47 who are subject to restriction directions made under section 49) where the victim has expressed concerns about their safety; or
 - to the victims of co-defendants convicted in connection with the same incident.
- 40.21 Once the discretion has been exercised to offer such a non-statutory victim contact under the VCS, they should be offered the same service as statutory victims. This means, once the NPS has decided to offer the VCS to these non-statutory victims, they should be assigned a victim liaison officer (VLO), provided with the opportunity to make representations about discharge conditions, and provided with information which the NPS considers to be appropriate in all the circumstances of the case, in the same way as statutory victims.

40.22 Each provider organisation should have a nominated individual who is responsible for understanding the Victims Code, VCS and promoting the rights of victims. Details of who this individual is should be available so victims, professionals and patients can identify them and obtain the required information and, if required, raise any concerns or complaints.

Additional support for victims who are family, carers or friends

40.23 Professionals should be particularly mindful some victims of Part 3 patients may also be the patient's family member, carer, friend, or their nearest relative, and may wish to maintain contact with the patient, including visiting them in hospital. The guidance in relation to enabling contact and visits should be applied equally to these individuals as to other family, friends and carers (see Chapter 11).

40.24 Professionals may need to balance the needs and rights of victims who are also family, friends or carers with their needs and rights as victims and/or to reduce the risk of any potential harm arising from contact with the patient. Such victims may require additional support in order for them to maintain contact, and keep them safe, especially if the victim is a child or young person, lacks capacity or has a learning disability or autistic spectrum disorder.

40.25 Hospital managers must ensure they fulfil the terms specified in the European directive on minimum standards on rights, support and protection of victims of crime in any of their interactions with victims of Part 3 patients³⁹.

40.26 There may be a family member, friend and carer who is a victim or for other reasons does not wish to maintain contact or visit, despite a Part 3 patient's wish for them to do so. The rights of the individual victim should be protected and maintained in this and, if appropriate, this should be explained to the patient (see for example paragraph xx on withholding patient correspondence).

³⁹ European directive 2012/29/EU establishes minimum standards on the rights, support and protection of victims of crime. Article 6 in particular aims to ensure victims are provided with certain information in regard to an offender's release or escape from detention.
http://ec.europa.eu/justice/criminal/files/victims/guidance_victims_rights_directive_en.pdf

Annex 1

Illustrative standard letter for nearest relatives to use to discharge a patient

To the managers of [insert name and address of hospital in which the patient is detained, or (for a patient on a community treatment order) the responsible hospital.]
Order for discharge under section 23 of the Mental Health Act 1983

My name is [give your name] and my address is [give your address]
[Complete A, B or C below]

A. To the best of my knowledge and belief, I am the nearest relative (within the meaning of the Mental Health Act 1983) of [name of patient].

or

B. I have been authorised to exercise the functions of the nearest relative of [name of patient] by the county court.

or

C. I have been authorised to exercise the functions of the nearest relative of [name of patient] by that person's nearest relative.

I give you notice of my intention to discharge the person named above, and I order their discharge from [say when you want the patient discharged from detention or a community treatment order] the time when:

- the notice is received by the hospital manager or an authorised person; or
- if the notice is sent by pre-paid post, the day service is deemed to have taken place [for first class post, service is deemed on the second business day following posting, and for second class post, service is deemed on the fourth business day following posting; or
- the notice is put into the internal mail system; and
- the time when you want the patient discharged.

2. SignedDate

[Please note: you must leave at least 72 hours between when the hospital managers get this letter and when you want the patient discharged.]

Key words and terms

To be added post consultation

To

Required policies and procedures

To be added post consultation

Index

To be added post consultation