Mental Health Act 1983

Consultation by the Welsh Assembly Government on the Mental Health Act Code of Practice for Wales

Published: 5th November 2007
Consultation will end: 28th January 2008
## Contents

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Explanatory Notes</td>
<td>1</td>
</tr>
<tr>
<td>Background</td>
<td>3</td>
</tr>
<tr>
<td>Development of the Code of Practice for Wales</td>
<td>5</td>
</tr>
<tr>
<td>Consultation questionnaire</td>
<td>9</td>
</tr>
<tr>
<td>How to respond</td>
<td>13</td>
</tr>
<tr>
<td>Annex A: About you</td>
<td>15</td>
</tr>
</tbody>
</table>
Explanatory Notes

i. This consultation relates to the Code of Practice for Wales to the Mental Health Act 1983.

ii. There are related concurrent consultation exercises taking place on:

- secondary legislation prepared under the Mental Health Act 1983; and
- the use of regulation-making powers under the Deprivation of Liberty Safeguards of the Mental Capacity Act 2005.

iii. Further information on these consultations can be found on the Welsh Assembly Government’s website at www.wales.gov.uk/consultation or by telephoning 029 2082 5164.
Background

Background to the Code of Practice

1.1 The Mental Health Act 1983 sets out the legal framework underpinning the detention and treatment of patients under compulsion. The Code of Practice provides guidance, including good practice, as to how the Act should be applied and principles which should inform decisions under the Act. The Code highlights, where relevant, the connections between the Act and other legislation, such as the Mental Capacity Act 2005.

1.2 The Act provides that practitioners mentioned in section 118(1) shall have regard to the Code. Failure to do so could give rise to legal challenge and a court, in reviewing any departures from the Code, will scrutinise the reasons for the divergence to ensure there is sufficient and convincing justification in such circumstances.

1.3 The Code is designed to guide practitioners in discharging their powers and duties under the Mental Health Act. As such it must be accessible, understandable and easy to use for patients, their carers, families, friends and others.

1.4 The Code reflects the changes to the 1983 Act made by the Mental Health Act 2007 and developments in best practice in mental health services since the publication of the previous version of the Code, in 1999.

1.5 The Welsh Ministers are required to prepare and publish a Code of Practice to the Mental Health Act 1983, by virtue of section 118 of the Act. In doing so they are required to consult such bodies as appear to them to be concerned. This consultation is part of that process.
Background to consultation

1.6 The draft Code accompanies this consultation. This consultation document briefly sets out the scope of the draft Code and describes how it has been developed.

1.7 This paper invites comments on the style and content of the Code from a wide range of stakeholders and other interested parties. It asks some specific questions about the Code, including the impact that the Code may have on different groups within society, given the Welsh Ministers’ duty to promote equality. As well comments to the specific questions within this consultation, all comments and suggestions on the Code are welcome.

1.8 Consultation begins on 5 November 2007, and will end on the 28 January 2008. The Assembly welcomes all comments, and will review them, before publishing a formal response. The Code will then be laid in the Assembly and subject to agreement, will then be published.
Development of the Code of Practice for Wales

Drafting of the Code

2.1 This consultation provides an opportunity for all who wish to comment on the style, format and content of the draft Code of Practice. Although this document introduces the formal consultation on the Code, there has been extensive informal engagement before now.

2.2 Following the introduction of the Mental Health Bill into Parliament in November 2006, officials in the Welsh Assembly Government began preparing draft chapters of the Code of Practice for Wales. Drafting has taken account of the changes to the Bill as it was considered by Parliament. The draft Code now reflects the Mental Health Act 1983 as amended by the Mental Health Act 2007.

2.3 The draft chapters were sent to members of the Welsh Assembly Government’s Mental Health Act Implementation Reference Group, for their comments and these comments, where appropriate, have been included. The Mental Health Act Implementation Reference Group is representative of the main mental health stakeholders in Wales.

2.4 The draft chapters have also been commented upon by those Government Departments, where policy responsibility has not been devolved to Welsh Ministers.

2.5 In addition, officials have hosted a number of workshops with specific expert groups. Workshops have been held with members of the police services (including the Police Confederation), Mental Health Advocacy providers, Mental Health Act Managers and Administrators and the Learning Disability Implementation Advisory Group.
2.6 There are references within the Code to statutory accompanying the Mental Health (Hospital, Guardianship, Community Treatment and Consent to Treatment) (Wales) Regulations 2008¹. These draft Regulations are the subject of a concurrent consultation, and as such the form reference has not been included in the Code. This is indicated by the use of ‘[x]’ in the text. Similar markers indicate other areas which are included for reference; the final version of the Code will correctly reflect the Regulations and other matters as appropriate.

Statement of principles

2.7 The 2007 Act amends section 118 of the 1983 Act; this now requires the Welsh Ministers to set out a statement of principles in the Code which should inform decisions under the Act. In preparing the statement of principles, Welsh Ministers are required to ensure that each of the following matters is addressed:-

- respect for patients’ past and present wishes and feelings;
- respect for diversity generally, including, in particular, diversity of religion, culture and sexual orientation (within the meaning of section 35 of the Equality Act 2006);
- minimising restrictions on liberty;
- involvement of patients in planning, developing and delivering care and treatment appropriate to them;
- avoidance of unlawful discrimination;
- effectiveness of treatment;
- views of carers and other interested parties;
- patient wellbeing and safety, and
- public safety

¹ It is intended that these Regulations will replace the Mental Health (Hospital, Guardianship and Consent to Treatment) Regulations 1983.
2.8 Welsh Ministers must also have regard to the desirability of ensuring:-

- the efficient use of resources; and
- the equitable distribution of services.

2.9 Chapter 1 of the Code of Practice for Wales incorporates the above requirements.

**Status of the Code**

2.10 The preparation and issue of a Code of Practice is a statutory requirement. Section 118 of the Act requires Welsh Ministers to publish a Code of Practice, to set out key principles and to keep the Code under review. The Code must reflect the provisions of the Act, and cannot endorse provisions which are not in accordance with the provisions of the Act. The Assembly also needs to ensure that the Code reflects its policies on mental health and other matters.

2.11 There are a number of situations which arise when dealing with people who are seriously mentally disordered, and practitioners often have to weigh up complex factors when deciding which course of action to pursue. A balance must be struck between the principle of safeguarding the liberty of the individual, and protecting the individual, and others, from the risk of harm. The Code must reflect these situations and enable professional practitioners to exercise their judgment in the particular circumstances of a case. This means that professionals will, when applying the Code need to balance conflicting factors in response to the circumstances of the case.

2.12 The draft Code reflects the current legal position in the Mental Health Act 1983, and other legislation. Departures from the Code could give rise to legal challenge and a court, in reviewing any departures from the Code, will scrutinise the reasons for the departure to ensure there is sufficiently convincing justification in the circumstances.
Consultation questionnaire

Consultation process

3.1 This consultation commences on 5 November 2007, and will run until 28 January 2008.

3.2 Following consultation, officials will compile a report on the comments received, and publish all comments received, unless authors have asked for them to be treated as confidential (subject to the issues set out in paragraph 4.7 below). The report will indicate the changes made to the Code as a result of comments received.

3.3 A revised version of the Code, including the comments made, will then be laid before the National Assembly for Wales in accordance with procedures as required under the Government of Wales Act 2006 and the 1983 Act.

3.4 The planned date for the coming into force of the Code of Practice for Wales is October 2008.


Consultation events

The Welsh Assembly Government is holding five consultation events in Wales to consider the Code of Practice for Wales and the secondary legislation prepared under the Mental Health Act and the Deprivation of Liberty Safeguards of the Mental Capacity Act.
3.7 These events are being held on:-

- 15 November 2007 at the Hilton Hotel, Newport (South Wales);
- 19 November 2007 at the Halliwell Centre, Carmarthen;
- 27 November 2007 at The Celtic Royal Hotel, Caernarfon;
- 5 December 2007 at The Angel Hotel, Cardiff; and
- 10 December 2007 at the Talardy Hotel, St Asaph.

For further information on how to attend any of these events please contact Sarah Richards on 029 2080 1470 or Sarah.Richards@wales.gsi.gov.uk.

3.8 The Welsh Assembly Government has given Mind Cymru and Learning Disability Wales grant funding to hold a number of events across Wales for service users and carers.

3.9 For further information on these events please contact Mind Cymru on 029 2039 5123 and Learning Disability Wales on 029 2068 1160.

**Consultation questions**

3.10 We would welcome all comments on the contents of the Code, and any suggestions for additional material. However we are asking specific questions about it as follows:-

a. **Do you have any comments on the structure, style and tone of the draft Code?**

b. **Do you have any comments about how the guiding principles in the draft Code are set out? Could they be improved?**
c. Do you feel that the Code adequately reflects Welsh Assembly Government policy in relation to mental health and other related services?

d. Has the Code adequately identified all the areas in which equality is a major issue? Do you have any suggestions about how it could address equality issues more effectively?

e. Are issues relating to the Welsh Language adequately covered? If not, what needs to be done to improve this aspect of the Code?

f. Are there any issues that the draft Code ought to cover, but doesn’t? If so, what is missing and how should it be addressed in the Code?

g. Will the Code, as drafted, optimally help professionals to fulfil their responsibilities and make decisions under the Mental Health Act? Are there any changes that you would recommend that would make it more useful to those using it?

h. Do you feel that the Code should include flowcharts of processes or examples? If so, how and where should these be used?

i. Is there material in the draft Code that could be cut down, left out or more appropriately and usefully be covered in other guidance?

j. Are there any issues relating to those responsible for commissioning mental health services or managing the provision of services that are not adequately covered?

3.11 If you wish to comment on the draft Code, it would be helpful to let us have your answers to any or all of these questions, as well as any more specific points you want to make about the draft.

3.12 Details on how to respond are given in section 4 of this document overleaf.
**How to respond**

4.1 Please send your response by 28 January 2008 to:-

Mental Health, Vulnerable Groups & Offenders Policy Branch  
Welsh Assembly Government  
Cathays Park  
Cardiff  
CF10 3NQ

Or by e-mail to MentalHealthPolicyMailbox@Wales.GSI.gov.uk

4.2 Please mark the subject of your letter/email ‘Consultation on the Code of Practice for Wales’. We would be grateful if all responses could include information about you in your response; a sample pro-forma is attached at Annex A of this document.

**Extra copies**

4.3 Further paper copies of this consultation can be obtained from this address and it is also available on line at [www.wales.gov.uk/consultation](http://www.wales.gov.uk/consultation).

**Publication of response**

4.4 A paper summarising the responses to this consultation will be published within three months of the closing date for the consultation.

**Representative groups**

4.5 Representative groups are asked to give a summary of the people and organisations they represent when they respond.
Confidentiality

4.6 Information provided in response to this consultation, including personal information, may be published or disclosed in accordance with the access to information regimes (these are primarily the Freedom of Information Act 2000 (FOIA), the Data Protection Act 1998 (DPA) and the Environmental Information Regulations 2004).

4.7 If you want the information that you provide to be treated as confidential, please be aware that under the FOIA there is a statutory Code of Practice with which public authorities must comply. This deals with, amongst other things, obligations of confidence. In view of this it would be helpful if you could explain to us why you regard the information you have provided as confidential. If we receive a request for disclosure we will take full account of your explanation, but we cannot give an assurance that confidentiality can be maintained in all circumstances. An automatic confidentiality disclaimer generated by your IT systems will not, of itself, be regarded as binding on the Welsh Assembly Government.

4.8 The Welsh Assembly Government will process your personal data in accordance with the DPA and in the majority of circumstances this will mean that your personal data will not be disclosed to third parties.
Annex A: About you

Please use this section to tell us about yourself

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<th>Full name</th>
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**Job title** or capacity in which you are responding to this consultation exercise (e.g. member of the public, etc)

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**Organisation/company name** (if applicable)

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**Postcode**

If you are a representative of a group, please tell us the name of the group and give a summary of the people or organisations that you represent:

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If you would like us to acknowledge receipt of your response please tick this box: [ ]

Address to which acknowledgement should be sent, if different from above

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MENTAL HEALTH ACT

CODE OF PRACTICE FOR WALES
Contents

Introduction 1
1. Guiding Principles 3
2. Examination and assessment prior to application for admission to hospital or guardianship 9
3. Conflicts of interest 23
4. Places of safety and police powers 27
5. Admission to hospital under Part 2 of the Act 35
6. Guardianship 39
7. Conveyance of patients 45
8. Holding powers 51
9. Receipt and scrutiny of documents 57
10. Duties of Hospital Managers 61
11. Treatment for mental disorder 69
12. Appropriate medical treatment 75
13. Medical treatment under the Act and second opinions 79
14. Psychological treatments 95
15. Supporting patients safely and therapeutically 99
16. Personal searches 109
17. Information for detained patients, those subject to supervised community treatment or guardianship, and Nearest Relatives 113
18. Visiting patients in hospital 121
19. The Nearest Relative 125
20. Involvement of carers 131
21. Independent Mental Health Advocacy 133
22. The Mental Health Review Tribunal 141
23. Advance statements of wishes and feelings 147
24. Leave of absence from hospital 151
25. Absence without leave 157
26. Supervised Community Treatment 161
27. The Hospital Manager’s power of discharge (Section 23) 171
28. After-Care 179
29. Assessment, admission and discharge under Part 3 of the Act 185
30. Children and young people under the age of 18 191
31. People with learning disabilities or autistic spectrum disorder 203
32. Victims 209
33. The Mental Capacity Act 2005 213
Bibliography 219
Introduction

i. The Code has been prepared and is issued under section 118 of the Mental Health Act 1983 (‘the Act’) by the Welsh Ministers after consulting such bodies as appeared to them to be concerned, and laid before the National Assembly for Wales.

ii. The Code takes account of those amendments and insertions to the Act as made by the Mental Health Act 2007.

iii. The Act sets out the legal framework and the Code of Practice provides the principles and guidance on how the framework should be applied in practice. The Code shows, where relevant, the connections between the Act and other legislation, such as the Mental Capacity Act 2005.

iv. The Welsh Ministers are required to keep the operation of the Code under review. The Mental Health Act Commission will be monitoring experiences of using the Code and will take this into account in drawing up its proposals for any further modification in due course. The Commission also publishes from time to time Practice Notes containing advice on particular points which have been drawn to its attention.

v. Finally, a note on the presentation used in this Code:-

- It is hoped that this Code will be helpful not only to those for whom the Act requires it to be written but also to patients, their families and friends and others who support them. It has been drafted as far as possible with this aim in mind.

- It is acknowledged that the term ‘service user’ is often used by people accessing services for care and treatment of their mental disorder. Similarly some people prefer the term ‘survivor’, ‘client’, ‘consumer’ and ‘recipient’. This Code uses the phrase ‘patient’ throughout in line with the term used throughout the Act.

- A child is a person under the age of 18 years; it is recognised that using the terms ‘young person’ or ‘adolescent’ appropriately apply to more physically and mentally mature children. This Code uses the terms ‘child’ and ‘children’ throughout. That term should be read as including all children and young people under the age of 18 unless otherwise stated.

- Throughout the Code the Mental Health Act 1983 (as amended by the Mental Health Act 2007 and other statutes) is referred to as “the Act”. Where there is reference to other statutes, the relevant Act is clearly indicated.

- There are a number of references throughout this Code to the Mental Capacity Act 2005. The Code assumes that its readers are familiar with the main provisions of that Act as it relates to the care and treatment of people with mental disorder who lack capacity to make particular decisions for themselves. Guidance on the Mental Capacity Act is given in that Act’s own Code of Practice.
1. **Guiding Principles**

The status of the Code of Practice

1.1 The Code has been prepared and is issued under section 118 of the Mental Health Act 1983 (‘the Act’). Whilst it is issued as guidance to those referred to paragraph 1.2 below, those people are required to have regard to the Code in carrying out their relevant functions under the Act. Departures from the Code could give rise to legal challenge and a court, in reviewing any departure from the Code will scrutinise the reasons for the departure to ensure there is sufficiently convincing justification in the circumstances. It is good practice to ensure any such reasons are appropriately evidenced.

1.2 The Code is provided as guidance to registered medical practitioners, managers and staff of hospitals, independent hospitals, mental nursing homes and care homes and Approved Mental Health Professionals (who have defined responsibilities under the Act) on how they should proceed when undertaking functions under the Act.

1.3 It is intended that the Code should be accessible to patients, carers, advocates and others who support them. The Code should also be beneficial to the Mental Health Review Tribunal, police and others involved in providing services to people who are, or may become, subject to compulsion under the Act.

1.4 The Code is available in both English and Welsh.

Background to the Guiding Principles

1.5 The Welsh Assembly Government Mental Health Strategy “Adult Mental Health Services for Wales” established four underpinning principles to guide everybody involved in planning, commissioning, managing, working in and using mental health services. The four principles are:

- Empowerment;
- Equity;
- Effectiveness; and
- Efficiency.

1.6 Whilst these principles were explicitly set out in the strategy for adults (which includes older adults), they are sufficiently broad in scope to provide overarching guidance to inform decision making under the Act across the age spectrum and client specialisms. The Strategy’s four principles are used to provide headings under which the statement of principles required under section 118(2A)-(2C) of the Act are set out. All of the chapters of this Code of Practice should be read within the context of these principles as set out from paragraphs 1.10 onwards.
1.7 The Child and Adolescent Mental Health Services (CAMHS) strategy "Everybody’s Business" establishes a set of principles to guide and underpin its implementation. These principles are referred to in the introduction to chapter 33 ‘Children and Young People under the age of 18. These additional principles should inform decision-making regarding children and young people.

1.8 In developing the principles due consideration has been given to the Strategy and National Service Framework for Older People in Wales.

1.9 The “Statement on Policy and Practice for Adults with a Learning Disability” includes principles to underpin the delivery of services to adults with a learning disability. These principles are referred to in the introduction to chapter 34 ‘Patients with Learning Disabilities or Autistic Spectrum Disorder’. These additional principles should inform decision-making regarding adults with a learning disability or autistic spectrum disorder.

**Guiding Principles**

**Empowerment**

1.10 Patient wellbeing and safety should be at the heart of decision-making. Where relevant this incorporates ensuring the wellbeing and safety of others. Patients and their carers and other interested parties should be actively engaged in the assessment of the risks posed to the patient’s own health and safety and the health and safety of others.

1.11 Patients should, wherever practicable, be involved with all relevant agencies in formulating a risk management plan and in its implementation.

1.12 Retaining the independence, wherever practicable, of the patient should be central to all interventions under the Act. Alternatives to avoid the use of compulsory powers should be explored prior to the making of an application for admission, and the least restrictive options should be considered. This should include creative approaches to service delivery in order to provide choice and alternative means of providing treatment and care. This should always be balanced with ensuring that patients receive treatment that is appropriate to their needs and is required to prevent them from harming themselves or other people.

1.13 Patients should be involved in the planning, development and delivery of their care and treatment. Professionals must be proactive in ensuring patients receive information in a timely manner and that the information is accessible and can be clearly understood by them. Independent advocacy has a significant role to play in empowering patients to be fully engaged in these processes, whether the individual is entitled to independent mental health advocacy as a qualifying patient under the Act, or is able to access other independent advocacy.

1.14 Where assessment under the Act is required, patients should be fully engaged in the process to the extent their capacity allows. Mental health professionals undertaking assessments should give due regard to patients’ present
and past wishes including any advance decisions. Those subject to compulsion under the Act should be encouraged to participate actively in their own care.

1.15 Decisions should be made in an open and transparent manner, subject to the need to manage information whose disclosure could cause harm to the patient or to other people.

1.16 Assessment, care and treatment under the Act should draw upon patients’ strengths, seeking their recovery and the re-establishment of their independence as soon as is safely practicable.

1.17 Those who perform functions under the Act should pay particular attention to ensuring the maintenance of the rights and dignity of patients, their carers and families whilst ensuring the safety of patients and that of other people. This should include careful consideration of the potentially stigmatising effect assessment and admission processes may have on patients, their carers and families, for example the way in which a patient is conveyed to hospital.

**Equity**

1.18 Practitioners should ensure that the services they provide are in line with the Welsh Assembly Government’s strategies for mental health and learning disability. This will ensure that mental health professionals have a range of options to offer patients and be able to provide care using the least restrictive option to meet patient’s needs and the need for their safety and public safety. This should include consideration of the ability to provide treatment subject to compulsion in non-hospital environments as a positive option.

1.19 Practitioners must pay due regard to the all legislation relating to equality and non-discrimination. They must respect diversity generally and give positive due regard to the needs of each patient including consideration of their:-

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

Assessment, care and treatment must be delivered in a manner, which avoids unlawful discrimination and ensures compliance with all applicable statutory requirements.
1.20 The views, needs and wishes of patients’ carers and families should be taken into account in the assessment and delivery of care and treatment. Particular consideration should be given as to the likely impact of clinical decisions on patients’ carers and other relevant people.

1.21 As a general principle, it is the responsibility of staff to ensure that effective communication takes place between themselves, patients and others. All those involved in the assessment, treatment and care of patients should ensure that everything possible is done to overcome any barriers to communication that may exist.

1.22 Welsh speakers should, where reasonably practicable or appropriate in the circumstances, be given the option of delivery of assessment and treatment and provision of relevant information through the medium of Welsh. Service providers, who have Welsh Language Schemes, must act in accordance with the provisions of their Schemes.

1.23 Where a person’s language is other than English or Welsh, assessment should be delivered using a trained interpreter, who will address issues of both language and cultural interpretation, which includes the use of British Sign Language.

**Effectiveness**

1.24 Any person made subject to compulsion under the Act should be provided with evidence based treatment and care, the purpose of which should be to alleviate, or prevent a worsening of, that person’s mental disorder, or any of its symptoms or manifestations. Treatment should be appropriate to patients’ needs taking account of their individual circumstances, and giving full consideration to any applicable advance decisions.

1.25 Decisions under the Act should be taken with a view to minimising the harm done by mental disorder, by ensuring the safety and wellbeing (mental and physical) of patients and protecting the public from harm.

1.26 Treatment and care environments should be safe (for the patient and the public), supportive and therapeutic delivering a range of interventions with a focus on patient recovery and positive clinical and personal outcomes. Care environments should be appropriate to a person’s age and their gender, and should maintain to the fullest possible extent a person’s dignity.

**Efficiency**

1.27 Care programmes should be delivered by practitioners from the appropriate range of statutory and non statutory agencies working in partnership to meet the needs of the patients and those of their carers. This is particularly important where patients have co-occurring problems such as physical ill health, or learning disability, or substance misuse together with a mental health problem.
1.28 Where elements of the care programme are being delivered by carers, mental health professionals should ensure that they work in partnership with those carers.

1.29 Where patients are in transition from one service to another, for example from adolescent to adult care or from adult to older adult services, practitioners should ensure that patients are receiving the most appropriate service to meet their needs and, where practicable, delivered in line with their expressed wishes.

1.30 Where patients are subject to compulsory admission, agencies should work together to plan a programme of care that as far as practicable takes account of the views and wishes of patients. Care plans should focus on seeking early discharge and the provision of aftercare, if necessary, at the earliest opportunity.
2. Examination and assessment prior to application for admission to hospital or guardianship

2.1 This chapter considers the roles and responsibilities of Approved Mental Health Professionals (AMHPs) and doctors when undertaking assessments and examinations to consider whether to make an application or provide a recommendation in support of such an application, under the Act. It also provides guidance on the approach to be taken during those assessments and examinations and the matters which should be considered.

General matters

2.2 Assessments of the needs of a person with mental health problems, where the assessment may lead to an application for admission to hospital or guardianship, must be carried out in light of the guiding principles set out in chapter 1.

2.3 An individual should only be compulsorily admitted if the statutory criteria are met and other relevant factors have been considered as set out in paragraphs 2.9 and 2.11 below. Doctors and AMHPs undertaking assessments need to apply professional judgment and reach decisions independently of each other but in a framework of co-operation and mutual support. Good working relationships require knowledge and understanding of the distinct role and responsibilities of each assessor (see below). It can assist the assessment process for the assessors to see the person. Chapter 3 of this Code gives guidance on potential conflicts of interest between assessors.

2.4 Given the importance of effective communication and co-operation it is essential that at least one of the doctors undertaking the medical assessment discusses the assessed needs of the patient with the applicant (whether AMHP or Nearest Relative) and it is recommended that both of them do this.

2.5 The Act requires that, where practicable, one of the recommending doctors should have previous acquaintance with the patient (section 12(2)). When planning an assessment, consideration should be given to whether the circumstances and known risks make it appropriate for the assessment to take place where there is one doctor who is not familiar with the patient. The identity of the most appropriate AMHP to assess the patient should also be considered, taking into account the AMHPs qualifications and experience.

2.6 Everyone involved in undertaking assessments should be alert to the need to provide support for colleagues, especially where there is a risk of a patient causing physical harm. Staff should be aware of circumstances where the police should be requested to provide assistance, and how to use that assistance to minimise the risk of violence.
2.7 The objective of the assessment is to determine whether the grounds for detention under the Act are met, taking into account appropriate alternative means of providing care and treatment. Assessment is also an important consideration of the means to address risk and provide care or treatment.

2.8 All those considering a patient's case for possible admission under the Act should ensure that they take all relevant factors into account (including those listed at 2.11) and they consider appropriate alternatives to compulsory admission.

**The factors to be taken into account at assessment**

2.9 An application for admission may not be made in respect of a patient except (in summary) for his or her own health, or for his or her own safety, or for the protection of other people.

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

### Applications under section 2

A person can only be detained for assessment and treatment under section 2 if the following grounds 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 medical treatment) for at least a limited period; and
- because of the person's mental disorder, his or her ability to make decisions about the provision of medical treatment is significantly impaired; and
- the person should be so detained in the interests of their own health or safety or with a view to the protection of other persons.
Applications under section 3

A person can only be detained for treatment under section 3 if the following grounds 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; and
- it is necessary for the health or safety of the person or for the protection of other persons that he or she should receive such treatment and it cannot be provided unless the person is detained under this section; and
- appropriate medical treatment is available for the person.

Applications for reception into Guardianship

A person can only be received into Guardianship if he or she is 16 years of age or over and if the following grounds apply:-

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

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

2.11 In judging whether compulsory admission is appropriate, those concerned should consider the statutory grounds and also take account of:-

- the patient’s past and present wishes and feelings, which includes the patient’s view of his or her own needs;
- the patient’s cultural background and social and family circumstances;
- the nature of the mental disorder and its likely course;
- other forms of potential care or treatment including, where relevant, consideration of whether the patient would be willing to accept medical treatment in hospital informally or as an out-patient and of whether guardianship would be appropriate (see chapter 6);
- the needs of the patient’s carers, family and others with whom the patient lives;
• the need for others to be protected from the patient; and
• the burden on those close to the patient of a decision to admit or not to admit under the Act.

2.12 Ordinarily only when all these factors have been considered should the applicant (in consultation with the other professionals who are considering whether to recommend admission) judge whether the grounds stipulated in sections 2, 3, 4 and 7 of the Act are satisfied, and take the decision accordingly. In certain circumstances, the urgency of the situation may curtail detailed consideration of all these factors.

What is meant by the “health or safety” of the patient?

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

2.14 Whilst consideration of a patient’s physical health as well as mental health is appropriate in considering whether admission is necessary, compulsory admission under the Act is never an option where the person needs treatment only for a physical disorder.

2.15 Those assessing the patient should consider:

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

What is meant by ‘protection of other persons’?

2.16 In considering the protection of other persons (see sections 2(2)(b) and 3(2)(c) of the Act) it is essential to assess separately both the occurrence, i.e. likelihood of the potential risks, and the nature of the potential risks, i.e. harm arising from the patient’s mental disorder, taking into account:-
• reliability of evidence, including any relevant details of the patient’s clinical history and past behaviours, including contact with other agencies and (where relevant) criminal convictions;

• the degree of risk and its nature. A risk of physical harm or serious persistent psychological harm to others is an indicator of the need for compulsory admission;

• the willingness and ability to cope with and manage the risk, by those with whom the patient lives, as well as those who provide care and support to the patient, and whether there are alternative options available for managing the risk; and

• the overall acceptability of risk, in terms of likelihood and harm to those involved in the care of the patient and others potentially at risk.

**Informal admission**

2.17 Compulsory admission powers should only be exercised if there are no effective alternative means of providing support or treatment available.

*Patients with capacity to consent to treatment for admission*

2.18 Informal admission to hospital is usually appropriate when a patient who has the capacity to do so consents to admission. However, there may be circumstances where compulsory admission is justified despite the patient’s stated willingness to be admitted voluntarily, especially if admission is felt to be necessary because of the danger the patient presents to him or herself or others. Compulsory admission should be considered where such a patient’s current medical state, together with reliable evidence of past experience, indicates a strong likelihood that he or she will have a change of mind about informal admission either prior to or after admission with a resulting risk to the patient’s health or safety or to the safety of other people.

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

2.19 This section should be read alongside the guidance on treatment for mental disorder in chapter 11 and the interface with the Mental Capacity Act 2005 (MCA) in chapter 33.

2.20 Where a patient aged 16 or over does not have the capacity to consent to admission and/or to the treatment that is expected to be required, AMHPs and doctors may consider that the patient can be safely and effectively treated by relying on the provisions of the MCA. However, where it is necessary to deprive a person of their liberty in order to treat them then the MCA cannot be relied upon unless the treatment has been authorised under that Act (via an authorisation under the Deprivation of Liberty Safeguards (DoLS)). Authorisation under DoLS can be obtained for persons of 18 or above who meet the relevant grounds.
2.21 Where a patient can be safely and effectively assessed or treated by relying on the provisions in the MCA, it should not be necessary to use sections 2, 3 or 7 of the Mental Health Act 1983. In particular, if a patient can be safely and effectively dealt with under the MCA.

2.22 Treatment under the MCA will usually be preferable to detention under the Act except in the following circumstances:-

- it is not possible safely or effectively to provide appropriate care or treatment in a way which does not amount to deprivation of the person’s liberty, and the person is ineligible for DoLS authorisation. For example where the person objects to being admitted to hospital for treatment for mental disorder;
- the person is assessed as needing a particular treatment for their mental disorder but has made a valid and applicable advance decision to refuse this treatment (refer to chapter 23);
- a degree of restraint needs to be used which is justified by the risk posed to other people but which, exceptionally, cannot be said to be proportionate to the risk to the patient personally (as required by sections 6, 11 or 20 of the MCA);
- necessary assessment or treatment cannot be safely or effectively delivered without a power to treat the patient compulsorily because a patient’s capacity to consent fluctuates and the patient is not expected to co-operate when he or she has capacity;
- there is a risk that either a patient or other person could potentially suffer harm, as a result of that patient having sufficient capacity to refuse some, if not all, of the elements of a care or treatment package (such as refusing to be admitted to hospital), as a result of which the patient will not receive the care or treatment which he or she requires; and
- the patient is being considered for detention under Part 3 of the Act in connection with criminal proceedings.

Individual professional responsibility – the Approved Mental Health Professional

Responsibilities for the assessment process

2.23 It is important to emphasise that an AMHP assessing a patient for possible admission under the Act has overall responsibility for co-ordinating the process of assessment and, where he or she decides to make an application, for implementing that decision. The AMHP must, at the start of the assessment, identify him or herself to the patient, members of the patient’s family, carers or friends present and the other professionals involved in the assessment. The AMHP should explain in clear terms his or her own role and the purpose of the visit, and ensure that the other professionals have explained their roles. AMHPs should carry with them documents identifying them as AMHPs and identifying which Local Social Services Authority
(LSSA) has approved them to undertake the role. Where an AMHP is approved by one LSSA but is acting on behalf of another LSSA this should also be identified.

2.24 Although acting on behalf of a LSSA by virtue of section 114(10), the AMHP should exercise his or her own professional judgment based on social and medical evidence when deciding whether to apply for a patient to be detained for assessment or treatment or be made subject to guardianship.

2.25 The AMHP should interview the patient in a suitable manner, taking account of the Guiding Principles in chapter 1 and the following points:-

- It is not desirable for a patient to be interviewed through a closed door or window except where there is serious risk to other people. This occasionally occurs when the patient is already in a hospital setting and seclusion is being used. In a community setting where direct access to the person is not possible but there is no immediate risk of physical danger to the patient or to others, powers in the Act to obtain access (section 135) should be used.

- Where the patient is subject to the effects of sedative medication or the short-term effects of drugs or alcohol, the AMHP should consult with the doctor(s) and, unless it is not possible because of the patient’s disturbed behaviour and the urgency of the case, either wait until, or arrange to return when, the effects have abated before interviewing the patient. If this is not realistic, or the risk indicates that it would not be appropriate to wait, the assessment will have to be based on the information the AMHP can obtain from all reliable sources. This should then be made clear in the AMHP’s report (see paragraph 2.62).

2.26 The patient should ordinarily be given the opportunity of speaking to the AMHP alone. If the patient wants or needs another person (for example a familiar person or an independent advocate) to be present during the assessment and any subsequent action that may be taken, then ordinarily the AMHP should assist in securing that other person’s attendance. It is recognised that the urgency of the case or some other reason may on some occasions make it inappropriate to do so. Patients may feel more safe or confident with a friend or other person they know well in attendance. Equally, an advocate can provide support to patients.

2.27 If the AMHP has reason to fear physical harm in carrying out the assessment then he or she should insist that another practitioner be present or take such steps as are necessary to secure his or her safety.

2.28 When an application for admission is to be made, the AMHP should plan how the patient is to be conveyed and should take steps to make the necessary arrangements (see chapter 7 and also the Guiding Principles set out in chapter 1).

Responsibilities regarding the ‘Nearest Relative’

2.29 The AMHP is required by the Act to attempt to identify the patient’s Nearest Relative as defined in section 26 of the Act.
2.30 The AMHP should confirm with the patient the identity of their Nearest Relative as soon as is practical. The AMHP should advise the patient of their right to apply for the displacement of their Nearest Relative in the event of certain circumstances arising (see chapter 19).

2.31 Where the patient appears to have no Nearest Relative, the AMHP should advise the patient of his or her right to apply to the county court for the appointment of a person to act as his or her Nearest Relative.

2.32 Consultation by the AMHP with the Nearest Relative about possible application for admission under section 3 or reception into guardianship is a statutory requirement unless it is not reasonably practicable or would involve unreasonable delay (section 11(4)). Circumstances in which the Nearest Relative need not be informed or consulted include those where the AMHP cannot obtain sufficient information to establish the identity or location of the Nearest Relative or where to do so would require an excessive amount of investigation.

2.33 In determining whether taking steps to inform a Nearest Relative of an intention to make an application for admission for assessment is practicable, the AMHP should consider the likely effect that informing the Nearest Relative would have on the patient’s health and wellbeing. The same goes for the requirement to consult with the Nearest Relative under section 11(4) in relation to proposed applications for admission for treatment.

2.34 Consulting and notifying the Nearest Relative is a significant patient safeguard, and declining to do so, on the grounds that it would not be reasonably practicable, should be limited to the circumstances outlined above at paragraph 2.33. However, consultation should not take place where it would lead to an infringement of the patient’s rights to respect for their privacy which could not be justified by the benefit of that involvement. The AMHP should consider not consulting where the patient strongly objects to the consultation and/or where the AMHP considers the potential impact of consultation on the patient to be detrimental. Detrimental impact will include where the patient is assessed as being likely to suffer emotional distress, deterioration in his or her mental health, physical harm or some form of financial or other exploitation.

2.35 If the Nearest Relative objects to an application being made for admission for treatment or reception into guardianship the application cannot proceed at that time. If, because of the urgency of the case, and the risks of not taking forward the application immediately, it is thought necessary to proceed with the application, the AMHP will then need to consider applying to the county court for the Nearest Relative’s ‘displacement’ (section 29) (see chapter 19). Consultation must not be avoided purely because it is thought that the Nearest Relative might object to the application or as a means to avoid taking action to displace the Nearest Relative.

2.36 If the AMHP has been unable to consult the Nearest Relative before making an application for admission for treatment for reasons other than that it not being reasonably practicable to do so, he or she should continue to attempt to inform the

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1 R (on the application of E) v Bristol City Council [2005] EWHC 74 (Admin)
Nearest Relative about the application and of their power of discharge (section 11(3)). If the AMHP has been unable to inform the Nearest Relative before the patient’s admission, he or she should notify the Hospital Managers as soon as this has been done.

2.37 The AMHP is required where practicable to inform the Nearest Relative of either their intention to make an application for admission for assessment or the application, and required to consult the Nearest Relative where admission for treatment is being considered (but see also above]). In addition to the requirement regarding the Nearest Relative in section 11 of the Act, the AMHP should where possible:-

- ascertain the Nearest Relative’s views about both the patient’s needs and the Nearest Relative’s own needs in relation to the patient; and
- inform the Nearest Relative of the reasons for considering an application for admission to hospital or guardianship under the Act and the effects of making such an application.

2.38 If a Nearest Relative would find it difficult to undertake his or her statutory functions, or is reluctant for any reason to do so, regulation 26 of the Mental Health (Hospital, Guardianship, Community Treatment and Consent to Treatment (Wales) Regulations 2008 provides that the Nearest Relative may delegate those functions to another person. AMHPs should make Nearest Relatives aware of this provision.

Consultation

2.39 The value of involving carers and family in the decision making process is well recognised because it provides a particular perspective of the patient’s circumstances and experiences. In so far as the urgency of the case allows, an AMHP who is the applicant for the admission of a patient to hospital or guardianship should consult with other relevant carers, friends or relatives and should take their views into account.

2.40 The AMHP should consult wherever possible with others who have been involved with the patient’s care in the statutory, voluntary or independent services.

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

- the patient;
- the patient’s Nearest Relative (whenever practicable);
- the doctor(s) involved in the assessment;
- the care co-ordinator if the patient is on Care Programme Approach;
- the patient’s GP, if he or she was not involved in the assessment; and
- any other relevant person involved in the persons care.
2.42 The doctor should:-

- decide whether the patient is suffering from mental disorder within the meaning of section 1 the Act and assess its seriousness and the need for further assessment and/or medical treatment in hospital or for reception into guardianship;
- consider the factors set out in paragraph 2.11 above, and discuss them with the applicant and the other doctor involved;
- specifically address the grounds for admission under the Act and, if satisfied that they are met, provide a recommendation setting out those aspects of the patient’s symptoms and behaviour on which that conclusion is based; and
- ensure that, where there is to be an application for admission, a hospital bed is made available.

**Medical examination**

2.43 In addition to following the guidance on assessment provided above, the doctor in carrying out a medical examination should:-

- carry out a direct personal examination of the patient’s mental state; and
- consider all available relevant clinical information including that in the possession of others, whether professionals or non-professionals.

2.44 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, a doctor should discuss the circumstances with the AMHP co-ordinating the assessment and consideration should be given to applying for a warrant allowing the police to exercise their lawful power of entry (section 135).

2.45 It may not always be practicable for the patient to be examined by both doctors at the same time, but they should discuss the patient’s case with each other.

2.46 It is recommended that both doctors discuss the patient’s case with the applicant. It is essential for at least one of them to do so (see paragraph 2.4).

**The second medical recommendation**

2.47 To help ensure that an assessment is as comprehensive as possible it is desirable that one of the medical recommendations should be provided by a doctor with previous acquaintance with the patient. Ideally, this should be a doctor who knows the patient in his or her professional capacity, but it is sufficient for the doctor to have had some previous knowledge of the patient’s case. This should be the case even when the section 12(2) ‘approved’ doctor (who is, for example, a hospital based consultant) already knows the patient. Where this is not possible (for example the
patient is not registered with a GP) it is desirable for the second medical recommendation to be provided by an ‘approved’ doctor (see paragraphs 2.64 and 2.65).

### A decision not to apply for admission

2.48 There is no obligation on an AMHP or Nearest Relative to make an application for admission just because the statutory criteria are met, such duty arising only if the AMHP/Nearest Relative is satisfied that such an application should be made. A decision not to apply for admission under the Act should be supported, where necessary, by an alternative framework of care and/or treatment. The decision should also be clearly recorded in the AMHP report of the assessment and the patient’s notes, explaining how the accompanying risk of harm is to be managed.

2.49 Most compulsory admissions to hospital require prompt action to be taken. However the AMHP, in possession of duly completed medical recommendations, has up to 14 days from having personally seen 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 secure alternative arrangements that mean detention is not required.

2.50 Where a decision not to apply for a patient’s compulsory admission is taken, the AMHP must decide how to implement those actions (if any) which his or her assessment indicates are necessary to meet the needs of the patient including, for example, referral to social workers or services within the social services department or a referral for health care. It is particularly important that any care co-ordinator or key worker concerned with the patient’s care be fully involved in the taking of such decisions.

2.51 Given the role of carers and family members in helping to support people with mental health problems it is crucial that services work collaboratively with patients and carers, subject always to the patient’s right to respect for his or her private life under Article 8(1) of the European Convention on Human Rights.

2.52 The professionals must ensure that where an application is not made, they, the patient and (with the patient’s consent except where section 13(4) applies see 2.55) the patient’s Nearest Relative and any other closely connected relatives, carers or friends have a clear understanding of any alternative arrangements that are put in place to support the person. Such arrangements and any plans for reviewing them must be recorded in writing as part of the overall care planning process and copies made available to all those who need them (subject to the patient’s right to confidentiality).

2.53 Where the AMHP has carried out an assessment at the request of the Nearest Relative under section 13(4), and it is decided not to make an application for admission, the reasons for not doing so must be given to the Nearest Relative in writing. Such a letter should contain, as far as possible, sufficient details to enable the Nearest Relative to understand the decision whilst at the same time preserving the patient’s right to confidentiality.
2.54 Sometimes there will be differences of opinion between professionals considering a patient’s case. There is nothing wrong with disagreements: handled properly these offer an opportunity to safeguard the interests of the patient and the protection of others by widening the discussion regarding the best way of addressing any risks of harm and of meeting the patient’s needs.

2.55 Doctors and AMHPs should be ready to consult colleagues (especially care co-ordinators and other community care staff involved with the patient’s care), while retaining the final responsibility for their own decisions. Where disagreements do occur, professionals should ensure that they discuss these with each other.

2.56 Where there is an unresolved dispute about an application for admission, it is essential that the professionals do not abandon the patient and the family. Rather, they should explore and agree alternative arrangements, if necessary on a temporary basis, and ensure that the patient, carer and family are kept informed. Any such plans should include provisions for managing identified risks and the arrangements for reviewing the plan. It should be recorded in writing, with copies made available to all those who need it (subject to the patient’s right to confidentiality).

2.57 The AMHP is usually the right applicant, bearing in mind his or her professional training, knowledge of the legislation and local resources, also bearing in mind the potential adverse effect that an application by the Nearest Relative might have on the latter’s relationship with the patient.

2.58 Where applicable, practitioners should inform the Nearest Relative of the availability of an AMHP to make an assessment of the need for the patient to be admitted under the Act, and for the AMHP to make the application. They may also advise the Nearest Relative of the safeguards set out in section 13(4), and also of his or her right to make an application under the Act.

2.59 Practitioners should never advise the Nearest Relative to make an application in order to avoid involving an AMHP in an assessment.

2.60 Section 13(1) and (4) place a duty on a LSSA to arrange for an AMHP to consider the case of a patient within their area where they have reason to believe that an application for admission to hospital or receipt into guardianship needs to be made with respect to that patient. Where the patient is detained under section 2, the LSSA that arranged for an AMHP to consider the patient’s case for admission under that section remains responsible for arranging for an AMHP to consider the patient’s case if the LSSA has reason to believe that an application for admission to hospital...
for treatment under section 3 is required. These duties do not prevent any other LSSA from arranging for an AMHP to consider a patient’s case if that is more appropriate. Where an application for receipt into Guardianship is believed to be necessary, it would be advantageous for the LSSA for the area where the person is to be placed to be involved in the assessment.

2.61 Given the responsibilities above, LSSAs should ensure that a 24-hour AMHP service is available to ensure that a Nearest Relative is not put in the position of having to make an application under the Act because it is not possible for an AMHP to attend for assessment.

2.62 Each LSSA should ensure that there is a means for the recording of decisions by AMHPs and their reasons not to consult with or notify Nearest Relatives when it is felt impracticable in the circumstances to do so. This information should be provided to the Hospital Managers.

**Section 13(4) of the Act**

2.63 LSSAs are required, if requested by a Nearest Relative of a patient residing in their area, to arrange for an AMHP to consider the patient’s case (section 13(4)) and:-

- should have explicit policies on how to respond to repeated requests for assessment where the condition of a patient has not changed significantly;
- should give guidance to AMHPs as to whether Nearest Relative requests can be accepted by way of GPs or other professions. Such requests should certainly be accepted provided the GP or other professional has been so authorised by the Nearest Relative.

**Emergencies out of hours, etc**

2.64 Arrangements should be made to ensure that information about assessments is passed to professional colleagues who are next on duty, for example where an application for admission is not immediately necessary but might be in the future. In such circumstances, the necessary arrangements could, for example, then be made for an AMHP to attend the next day. Making out of hours services aware of situations that are ongoing, such as when there is concern over an individual but no assessment has commenced or a person has absconded before an assessment could start or be completed, assists the out of hours services to respond accordingly.

**Agency responsibilities – the Local Health Board**

2.65 The Welsh Ministers have delegated to Local Health Boards the function of approving medical practitioners under section 12(2). Local Health Boards 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 which indicates how each approved doctor can be contacted and the hours that he or she is available; and

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

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

Joint agency responsibilities – Local Health Boards/Trusts/Local Social Service Authorities

2.67 Good practice requires that Local Health Boards, Trusts and LSSAs should co-operate in ensuring that regular meetings take place between professionals involved in mental health assessments in order to promote understanding, and to provide a forum for clarification of their respective roles and responsibilities.
3. Conflicts of interest

3.1 This chapter deals with circumstances in which conflicts of interest are deemed to arise, that might compromise the making of applications by AMHPs and the provision of medical recommendations by doctors in support of applications.

### Conflicts of interest

3.2 The Mental Health (Conflicts of Interests) (Wales) Regulations 2008 ("the Conflicts Regulations") set out circumstances in which a conflict of interest will arise for the purposes of section 12A of the Act. The regulations prevent an AMHP or a doctor (both of which are referred to as ‘assessors’ within the Regulations) from making an application for a patient's admission or guardianship, or recommendation in support of the same.

3.3 The potential conflict of interest may concern the assessors' relationships to each other, to the patient, to the Nearest Relative or to the hospital where the patient is to be admitted. It could concern a professional, financial, business or personal relationships.

3.4 When an assessor is subject to a potential conflict of interest, the regulations allow for them to make an application or recommendation in emergency situations if not to do so would cause a delay that might put the health or safety of the patient or others at serious risk. Hospital Managers should ensure that administrative systems are in place, including systems of record keeping, which ensure robust governance in such exceptional circumstances.

### Potential conflict of interest for professional reasons

3.5 The Conflicts Regulations identify that an assessor for a patient will have a potential conflict of interest where they are working in a direct line management relationship with another assessor and, as such, are prevented from working together in making applications or considering whether to make recommendations in support of applications.

3.6 There will be a conflict of interest if all three assessors (i.e. both doctors and the AMHP) come from the same team, and work together for clinical purposes on a routine basis. In these circumstances two, but not more than two, assessors may come from the same team, and an alternate third assessor must be sought.

3.7 In circumstances where the Nearest Relative is considering making an application for admission to hospital, the Conflicts Regulations provide that the registered medical practitioners who have been asked to consider making medical recommendations should not be under the immediate direction of, or in the employment of, the Nearest Relative. Similarly they make not make a recommendation if they employ the Nearest Relative, or they work under the direction of the registered medical practitioner.
3.8 There may also be potential for conflicts of interest in situations where assessors have professional relationships with each other that are not line management relationships. Examples of such situations might include:

- clinical supervisory relationships;
- relationships relating to professional collaboration (such as educational or research activities);
- professional or career mentorship;
- when one assessor acts as a referee for another; and
- where one assessor might be construed as being professionally senior to another.

In such circumstances, or in those where the assessors are in a more indirect line management relationship, but nonetheless feel that this relationship compromises (or could be seen to compromise) the objectivity or independence of their decision-making, one of the assessors should consider choosing to withdraw from the application process.

**Potential conflict of interest for financial reasons**

3.9 The Conflicts Regulations provide that an assessor will have a conflict of interest if he or she stands to make financial gain from whether or not they make an application or provide a medical recommendation. This does not apply to the payment of any fee paid to a doctor for the purposes of considering whether to make a recommendation in consequence.

3.10 If there could be any suspicion that a doctor providing a medical recommendation is doing so for pecuniary advantage, arrangements should be made for another doctor to make the recommendation.

3.11 AMHPs will also have a conflict of interests if they have a financial interest in the maintenance of a patient for whom they are considering making an application for admission to a hospital.

**Potential conflict of interest for business reasons**

3.12 An assessor may be asked to undertake an assessment with another assessor (or the Nearest Relative if they are the applicant for admission to hospital) with whom they are involved in the same business venture, even one not associated with the provision of services for the care and treatment of persons suffering with mental disorder. In such circumstances, the Conflicts Regulations provide that the assessor should withdraw from the application process.
Potential conflict of interest for personal reasons

3.13 An assessor may be related to another assessor, the patient or the patient’s Nearest Relative, in which case the Conflicts Regulations provide that the assessor should withdraw from the application process.

3.14 The regulations set out the nature of the personal relationships in view; an assessor is considered to be in a personal relationship with another assessor, the patient or the patient’s Nearest Relative if he or she is:-

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

References to step relationships and in-laws above are to be read in accordance with section 246 of the Civil Partnership Act 2004; as such these references are to such relationships arising by virtue of civil partnership as well as marriage.

Other circumstances

3.15 There may be circumstances not covered by the regulations where the AMHP or doctor nonetheless feels that there is (or could be perceived to be) a potential conflict of interest. If this is the case, the assessor should consider withdrawing from the application process. This would be appropriate in any situation where the assessor believes that the objectivity and/or independence of their decision is (or could be seen to be) undermined, because of their relationship in relation to the other assessors, patient, Nearest Relative or hospital.

3.16 By virtue of section 12A of the Act, the Conflicts Regulations only cover conflicts in relation to AMHPs making applications and section 12 doctors making medical recommendations. The Conflicts Regulations do not cover potential conflicts of interest relating to Supervised Community Treatment. It would be good practice to ensure that the Responsible Clinician and the AMHP responsible for making the decision as to whether to place a patient on Community Treatment Order, or any decision to recall them does not have any financial interest in the outcome of the decision. Similarly, neither the Responsible Clinician nor AMHP should be a relative of the patient or of each other.

3.17 Similar consideration needs to be given to other decisions taken under the Act, for example renewal of detention.
3.18 The regulations do not cover reports made to a Court under Part 3 of the Act; doctors should ensure that any potential conflict of interest in providing the report is set out in that report to the Court, and where possible avoided.

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

3.20 The independence of the AMHP is an important principle; however, it is equally important to note that the AMHP does not operate in a vacuum and that supervision/consultation and legal advice play an important role in enabling the AMHP to fulfil their functions.

3.21 AMHPs and doctors should arrive at their own independent decisions, although in most cases these independent decisions will be informed by and take into account the views of a number of professionals, carers and others involved.
4. **Places of safety and police powers**

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

### Understanding the legal framework

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

4.2 Powers of entry under section 135(1) or (2) may be used by a police constable when it is necessary to gain access to a mentally disordered person who is not in a public place and, if necessary, remove him or her to a place of safety.

4.3 Local Authorities should develop guidance for Approved Mental Health Professionals outlining how, and when, applications for a magistrates’ warrant under section 135 should be made. The guidance should include advice on the information which should be included in applications, including setting out what alternatives to applying for a warrant have been considered. If a suitable place of safety has been identified, this information should also be included. In most cases a hospital would be considered to be a suitable and appropriate place of safety when section 135 is being considered.

4.4 In executing a warrant under section 135(1), the constable must be accompanied by an AMHP and a doctor. Where the warrant is executed in respect of a patient who is liable to detention or recall, the constable may be accompanied by a doctor and/or by any person authorised under the Act to take or retake the patient. It is good practice for the constable to be accompanied by the patient’s Responsible Clinician.

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

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

4.6 Section 136 allows for the removal to a place of safety of any person found in a place to which the public have access, who appears to a constable to be suffering from mental disorder and to be in immediate need of care or control.

4.7 Removal to a place of safety may take place if the constable believes it necessary in the interests of that person, or for the protection of others. The power of “removing” a person, allows the constable to use force, but only if absolutely necessary. The least restrictive means of controlling and restraining the person should always be used and the person should be treated humanely and with due
sensitivity. Regard must be shown for their human rights, dignity, privacy and any particular care needs such as those associated with their physical health.

4.8 The purpose of removing a person to a place of safety in these circumstances, is to enable examination by a doctor and for an interview by an Approved Mental Health Professional (AMHP). The purpose of the examination and interview is to ensure any necessary arrangements are made for the person’s care and treatment.

4.9 Section 136 is not an emergency admission order. It enables an individual who falls within its criteria to be detained in a place of safety for the purposes of examination and interview; when that process has been complete within the 72 hour detention period or the doctor has concluded that the person is not mentally disordered, the authority to detain the patient ceases.

### Local policies on police powers and places of safety

4.10 Local Health Boards (LHBs), NHS Trusts, local social services authorities, police forces and ambulance service should ensure that they have jointly agreed policies for the use of section 135 and section 136, as well as the operation of agreed places of safety within their localities. The policy should clearly define each agency’s responsibility in respect of persons to whom section 135 and section 136 applies.

4.11 In particular the policy should define the responsibilities of:-

- LHBs and NHS Trusts in commissioning and providing safe and secure clinical facilities for the containment of a person requiring examination or interview;
- NHS Trusts and local social services authorities in providing prompt assessment and where appropriate, admission to hospital for assessment and/or treatment;
- the police service, in providing attendance where a patient’s health or safety, or the protection of others so requires;
- the police, NHS Trusts and local social services authorities for the safe and prompt conveyance of the person to the place of safety;
- the police, AMHPs and health professionals in deciding whether it is appropriate to transfer the person from one place of safety to another; and
- the police officers, doctors and AMHPs for the satisfactory return of the person to the local community (where the assessment has not led to admission to hospital or other accommodation).

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

4.12 Local policies should ensure that police officers know whom to contact prior to removal to a place of safety under section 136.
4.13 A person who is removed to a place of safety under section 136 may be subject to supervised community treatment, conditional discharge, or may be on leave of absence and their recall to hospital may need to be considered. The policy should set out the arrangements for contacting the patient’s Responsible Clinician as quickly as possible. Similar provisions in the policy will need to relate to patients who are subject to guardianship.

4.14 The policy should include provision for the use of section 136 to be monitored. This will enable checks to be made of how and in what circumstances it is being used, including its use in relation to people from black, minority ethnic communities and children and the parties to the policy to consider any changes in mental health services that might result in a reduction of its use.

4.15 Where local policies establish target times for the commencement of the examination or interview, NHS bodies and local social services authorities should review local practice against these targets.

**Identifying an appropriate place of safety**

4.16 The process for identification of the most appropriate place of safety to which the person is removed must be clearly outlined in the local policy. Whilst this is a matter for local agreement, consideration must be given to the availability and appropriateness of such facilities, depending on each individual circumstance.

4.17 It is preferable for a person thought to be suffering from mental disorder to be detained in a hospital. Only in exceptional cases would a police station be the most appropriate environment for the reception, observation, examination and assessment of someone who appears to have a mental disorder.

4.18 Every effort must be made to ensure that a police station is only used where it is absolutely necessary to provide short term containment, where the person is considered too violent for the available hospital setting, or they pose a high risk to others patients or staff.

4.19 It is never acceptable that a police station is considered as the first place of safety for all persons to whom sections 135 or 136 would apply, or an automatic option in cases where more suitable accommodation is not immediately available.

4.20 In identifying the most appropriate place of safety for an individual, consideration should be given to the impact that the proposed place of safety may have on the person held and the examination and interview. Therefore, it is essential that the police station is used either in the exceptional circumstances outlined above or when it is deemed the safest option for the person, other patients or staff.

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

- where the place of safety will be a hospital, immediate contact is made with both the hospital and the local social services authority by the police,
and this should take place prior to arrival at the place of safety. This will allow the hospital and the local social services authority to make arrangements to receive the person into the place of safety and for the examination and interview to commence as soon as practicable;

- where a police station is to be used as the place of safety, health and social care agencies should be contacted to discuss supporting the care and welfare of the person whilst in police detention. Contact must be quickly made with the local social services authority and the appropriate doctor (which is likely to be the forensic physician attached to the police station). This will enable the examination and interview to be commenced as quickly as possible to ensure that the person spends no longer than necessary in police custody but is either returned to the community or admitted to hospital. Early assessment will also allow consideration to be given to the possibility of a transfer to an alternative place of safety as soon as this is considered to be safe and appropriate in all of the circumstances; and

- agencies work together, to ensure that no unnecessary delays occur and result in professionals being diverted from their normal statutory duties.

4.22 Section 26 and Schedule 2 of the Police and Criminal Evidence Act (PACE) 1984 preserves the power to remove under section 136(1) as a power of arrest. This allows for section 32 of that Act to apply and enable a constable to search a person at a place other than a police station. The preserved power also enables the removed person to be detained under section 136(2) of the Mental Health Act and for the custody officer to ascertain everything the detained person has with him².

**Examination and interview**

4.23 Wherever possible, the examination and interview should be undertaken jointly by the doctor and AMHP. The examination should begin as soon as possible after the arrival of the individual at the place of safety.

4.24 Local policies should ensure that the doctor undertaking the examination is, wherever possible, approved under section 12(2) of the Act. Where the examination has to be conducted by a doctor who is not approved, the reasons for this should be recorded.

4.25 It is desirable that a consultant psychiatrist in learning disabilities and an AMHP with special experience in learning disabilities make a joint assessment if it appears that the detained person has a learning disability and or an autistic spectrum disorder.

4.26 Similarly where the detained person is under the age of 18 years, or is known to have recently moved into adult mental health services, it is desirable that a Child and Adolescent consultant psychiatrist and an AMHP with special experience in CAMHS undertake a joint assessment.

² Section 54, Police and Criminal Evidence Act 1984
4.27 If, in exceptional circumstances, the doctor has completed the examination of the person prior to the arrival of the AMHP and concluded that the person is not mentally disordered within the meaning of the Act, the person can no longer be detained under section 136 and should be immediately discharged from detention. If the doctor sees the person first and concludes that the person is mentally disordered within the meaning of the Act but that admission to hospital is not necessary, or the person agrees to informal admission, the individual must still be seen by an AMHP who must consult with the doctor about any arrangements that might need to be made for his or her treatment or care.

4.28 The role of the AMHP includes:-

- interviewing the person;
- contacting any relevant carers, relatives and friends;
- ascertaining whether there is a psychiatric history, through collaboration with other professionals;
- considering any possible alternatives to admission to hospital;
- making arrangements for compulsory admission to hospital; and
- making any other necessary arrangements.

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

4.29 Parts 4 and 4A of the Act, do not apply to a person detained under section 136. In the absence of consent, a person aged 16 and over can only be treated if they lack the capacity to consent to the necessary treatment and the treatment is administered in accordance with the Mental Capacity Act 2005. Chapter 30 of this Code gives further guidance to consent to treatment of children and young persons.

**Transfer between places of safety**

4.30 The Act allows for the patient to be taken to one or more places of safety before the end of the 72 hour period. It is however recommended, that where the place of safety is a police station, this should be on an exceptional basis and for as short a time as possible.

4.31 The person may be taken to the second or subsequent places of safety by a police constable, an AMHP or a person authorised by either the police constable or the AMHP. Matters to be considered in the conveyance of the detained person under these provisions are set out in chapter 7 of this Code.
4.32 Where a person has been removed to a place of safety under section 136, they are entitled to have another person, of his or her choice, informed of the removal and of his or her whereabouts.\(^3\)

4.33 Where the place of safety is a police station, the individual has a right of access to legal advice.\(^4\) The conditions of detention and treatment of the person must be in accordance with PACE Code C (paragraph 1.10). This requires, among other things, that the person must be notified of their rights and entitlements both orally and in writing. Although section 132 of the Mental Health Act 1983 would not apply to a person in police detention, the local joint policy should require that the same information is given orally and in writing to the person on their arrival at the place of safety as would be given to them if the place of safety were a hospital.

4.34 Where the place of safety is a hospital, the Hospital Managers must ensure that the provisions of section 132 of the Act are complied with. In addition, access to legal advice should be facilitated whenever it is requested.

**Making ‘necessary arrangements’**

4.35 Following completion of the examination and interview, it is the joint responsibility of the doctor and the AMHP, to consider if any arrangements are necessary to provide for the persons’ care and treatment needs.

4.36 Where compulsory admission is indicated:-

- and hospital is the place of safety the person should be admitted under section 2 or section 3 of the Act. A person detained under section 136 should not have their detention extended by use of sections 5(2) or 5(4) of the Act;

- if the police station is the place of safety, compulsory admission to hospital should be under section 2 or 3 as appropriate. It is unlikely that section 4 would be appropriate if there was an urgent need to secure the transfer of the patient to hospital, as the powers of transfer between places of safety should be invoked; and

- where the patient is a community patient and compulsory admission is required, the community treatment order should be revoked.

**Record keeping**

4.37 A record of the person’s time of arrival at the place of safety must be made immediately he or she reaches the place of safety. If the person is subsequently

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\(^3\) Section 56, Police and Criminal Evidence Act 1984  
\(^4\) Section 58, Police and Criminal Evidence Act 1984
transferred to an alternative place of safety, this should be recorded and the information regarding the time of arrival at the original place of safety passed to the new place of safety.

4.38 Records should also be made of any visitors to the person detained in the place of safety, the purpose of the visit, any interventions necessary and requests made by the person.

4.39 A record should be made of the time that the period of detention under section 136 comes to an end, and the outcome of the examination and interview.
5. Admission to hospital under Part 2 of the Act

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

## Considering section 2 or section 3

5.2 In considering whether a person should become liable to detention in hospital under the Act, careful consideration must be given to which section, if any, would be the most appropriate, with particular regard to the principle of least restriction. Professional judgement must be applied in determining whether the grounds for detention as set out in section 2 or section 3 are applicable and only when this has been done can a decision be reached as to which, if either, section applies.

### Section 2 pointers:

- the diagnosis and/or prognosis of a patient’s condition is unclear;
- there is a need to carry out an in-patient assessment in order to formulate a treatment plan;
- a judgment is required as to whether the patient will accept treatment on a voluntary/informal basis following admission;
- a judgment has to be made as to whether a particular treatment proposal, which can only be administered to the patient under Part 4 or 4A 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;
- where it has not been possible to undertake any other assessment in order to formulate a treatment plan; and
- the patient has not previously been admitted to hospital either informally or compulsorily and has not been in regular contact with the specialist psychiatric services and it has not been possible to formulate a treatment plan.

### Section 3 pointers:

- the patient is considered to require compulsory admission for the treatment of a mental disorder, which is already known to his clinical team, and has been assessed in the recent past by that team; and
- the patient is detained under section 2 and assessment indicates a need for compulsory treatment under the Act beyond the existing period of detention. In such circumstances an application for detention under section 3 should be made at the earliest opportunity and should not be delayed until the end of the existing period of detention.
5.3 Decisions should not be influenced by the possibility that:–

- a proposed treatment plan has been formulated but the treatment to be administered under the Act will last less than 28 days;
- access to a Mental Health Review Tribunal 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. The use of section 3 must be justified by the patient’s need to be admitted for treatment under the terms of that section, not considerations about future care and treatment; and
- a patient’s Nearest Relative objects to admission under section 3.

5.4 A further section 2 application cannot be made if the patient is already in hospital following admission under that section\(^5\).

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

5.5 Application for admission for assessment under section 4 can be made by an AMHP or by the Nearest Relative. Such an application should only be made when the grounds for admission for assessment are met and the matter is of urgent necessity and securing a second medical recommendation would cause unsafe delay.

**Urgency necessity**

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

5.7 An emergency arises where the mental state or behaviour of a patient cannot be immediately managed. To be satisfied that an emergency has arisen, there must be evidence of:–

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

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\(^5\) *R v Wilson ex parte Williamson* [1996] COD 42.
Availability of the second medical recommendation

5.8 If the AMHP is considering an application for admission and no second doctor is available, he or she should discuss the case with the doctor providing the first recommendation, who should fully assist in securing the availability of a second doctor to consider the patient’s case. If such a problem persists, the AMHP should have access to an officer in the local social services authority who is sufficiently senior to take up the matter with the relevant Local Health Board and NHS Trust as applicable. The Local Social Services Authority, on whose behalf the AMHP is acting, should make it clear to the AMHP that there is, under such circumstances, an obligation to report the matter in this way to a senior officer.

Actions to be taken on admission under section 4

5.9 If a patient is admitted under section 4 an appropriate second doctor should examine him or her as soon as possible after admission, to decide whether the patient should be detained under section 2. Although the further involvement of an AMHP is not necessary at this stage, the local social services authority should be informed of the ‘conversion’ to section 2 so they can inform the patient’s Nearest Relative.

5.10 If the second examining doctor considers that the patient meets the criteria for detention under section 3, an application under that section should be considered by the AMHP. The recommendation made in respect of the section 4 admission cannot be used to support an application under section 3. This does not preclude the first medical examiner giving a further recommendation if he or she also considers the criteria for detention under section 3 are met.

5.11 Hospital Managers should monitor the use of section 4 and ensure that second doctors are available to visit a patient within a reasonable time after being requested.
6. Guardianship

6.1 This chapter provides guidance on the purpose of guardianship (under section 7 of the Act), the process for assessment, the components of effective guardianship, and the duties of the Local Social Services Authority (LSSA) and the powers of the guardian.

**Purpose of guardianship**

6.2 The purpose of guardianship is to enable vulnerable, mentally disordered people to receive care in the community where it cannot be provided without the use of compulsory powers. Such care may, or may not, include specialist medical treatment for mental disorder. It provides an authoritative framework for working with a patient, with a minimum of constraint, to achieve as independent a life as possible within the community. Where it is used it must be part of the patient’s overall care and treatment plan.

**Assessment for guardianship**

6.3 AMHPs and doctors should consider guardianship as a possible alternative to admission to, or continuing care in hospital. This could be as a package of care in the community or to support a placement in care.

6.4 As with applications for admission to hospital, Approved Mental Health Professionals (AMHPs) and doctors making recommendations should consider whether the objectives of the proposed application could be achieved in another, less restrictive way.

6.5 Where the patient lacks capacity to make some or all important decisions concerning their own welfare, one obvious alternative means will be to rely on the Mental Capacity Act 2005 (MCA), and especially the protection from liability for actions taken in connection with care or treatment provided by section 5 of that Act. 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.

6.6 Possible situations in which guardianship might be considered include cases where:-

- it is thought to be important that decisions about where the person is to live are placed in the hands of a single person or authority over a continuing period – for example where there have been long-running or particularly difficult disputes about where the person should live;
- the person is thought likely to respond well to the authority and attention of a guardian, and so be more willing to comply with necessary treatment and care for their mental disorder (whether they are able to consent to it, or it is being provided for them under the MCA);
• it appears necessary in the interests of the welfare of the patient or for the protection of other persons to use the guardian’s power to require a patient to reside in a particular place; and
• there is a particular need to have explicit authority for the person to be returned to the place the person is to live (for example, a care home).

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

### Components of effective guardianship

6.8 An application for guardianship should be accompanied by a comprehensive care plan established on the basis of multi-disciplinary discussions. It should take account of the patient’s views, including any applicable advance statements. The care plan should include care arrangements, suitable accommodation, treatment and personal support and may be used to support applications for guardianship as long as it indicates which of the powers under the Act are necessary to achieve the plan. If no powers are required guardianship should not be used.

6.9 Key elements of the plan should include:

- within the context of the patient’s capacity, his or her recognition of the ‘authority’ of, and willingness to work with, the guardian;
- support from the LSSA for the guardian;
- suitable accommodation to help meet the person’s needs;
- access to day care, education and training facilities; and
- effective co-operation and communication between all persons concerned in implementing the care plan.

The guardian should be willing to ‘advocate’ on behalf of the person in relation to those agencies whose services are needed to carry out the care plan.

6.10 It is important that any procedures instituted by LSSAs are sufficient to ensure proper process while being no more onerous than the minimum necessary to ensure the proper use of guardianship. Guardianship can and should be used in a positive and flexible manner.
6.11 Each LSSA should establish a policy setting out the arrangements for:-

- receiving, considering and scrutinising applications for guardianship. Such arrangements should ensure that applications are properly but speedily dealt with;
- monitoring the progress of the guardianship including steps to be taken to fulfil the authority’s statutory obligations in relation to private guardians and to arrange visits to the patient (see the ‘Mental Health (Hospital, Guardianship, Community Treatment and Consent to Treatment) (Wales) Regulations 2008;
- ensuring the suitability of any proposed private guardian, and that he or she is able to understand and carry out the statutory duties, including the appointment of a nominated medical attendant;
- ensuring that patients under guardianship receive, both orally and in writing, information about their reception into guardianship;
- ensuring that the patient is aware of his or her right to apply to a Mental Health Review Tribunal and that a named officer of the LSSA will give any necessary assistance to the patient in making such an application;
- maintaining detailed records relating to the person under guardianship;
- ensuring the review of the guardianship towards the end of each period of guardianship; and
- discharging the person from guardianship as soon as it is no longer required.

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

- to require the patient to live at a place specified by the guardian. A patient who is absent without leave from the specified place may be returned within the statutory time limit by those authorised to do so under the Act;
- to require the patient to attend at specified places and times for medical treatment, occupation, education or training. If the patient refuses to attend, the guardian is not authorised to use force to secure such attendance, nor does the Act enable medical treatment to be administered in the absence of the patient’s consent; and
- to require access to the patient to be given at the place where he or she is living to persons detailed in the Act. A refusal without reasonable cause to permit an authorised person to have access to the patient is an offence under section 129 but no force may be used to secure entry.
6.13 Any guardian must be a person who acts for the welfare of the individual, and can appreciate any special disabilities and needs of the mentally disordered person and will discharge their duties in an appropriate manner. The guardian should display an interest in promoting the patient's physical and mental health and in providing for his or her occupation, training, employment, recreation and general welfare in a suitable way.

6.14 The LSSA must satisfy itself that the proposed guardian is capable of carrying out his/her functions and should assist the guardian with advice and other facilities.

6.15 If the patient consistently resists the exercise of the guardian's powers, there should be a full review of the care of the patient, and consideration given to an alternative care delivery approach, which may include the discharge of the guardianship order.

General matters

6.16 Points to remember:-

- guardianship does not restrict the patient's access to hospital services on an informal basis. A patient who requires treatment, but does not need to be detained, may be admitted informally;
- guardianship can also remain in force if the patient is admitted to hospital under section 2 or 4 but not under section 3;
- it is possible in certain circumstances for a patient liable to be detained in hospital by virtue of an application under Part 2 of the Act to be transferred into guardianship and for a person subject to guardianship under Part 2 of the Act to be transferred into the guardianship of another LSSA or person approved by such authority or to be transferred to hospital. (See section 19 of the Act and Part 5 of the Mental Health (Hospital, Guardianship, Community Treatment and Consent to Treatment (Wales) Regulations 2008); and
- the authority to convey the person to any place named in their care plan is contained in section 18(7).

6.17 Particular practice issues:-

- guardianship must not be used to require a patient to reside in hospital except where it is necessary for a very short time in order to provide shelter whilst accommodation in the community is being arranged;
- where an adult is assessed as requiring residential care, but owing to mental incapacity is unable to make a decision as to whether he or she wishes to be placed in residential care, those who are responsible for his or her care should consider the applicability and appropriateness of guardianship for providing the framework within which decisions about his or her current and future care can be planned, (refer also to chapter 33 on the interface with the MCA); and
• while the reception of a patient into guardianship does not affect the continued authority of an attorney or deputy appointed under the MCA, such attorneys and deputies will not be able to make decisions about where a person subject to guardianship is to reside, nor make other decisions which conflict with those of a guardian.

**Guardianship under section 37**

6.18 Guardianship may be used as an alternative to hospital orders by courts where the prescribed criteria, which are similar to those of a hospital order, are met. The court should be satisfied that the LSSA or named person is willing to act as guardian. The LSSA should be satisfied with the arrangements. In considering the appropriateness of guardianship they should be guided by the same principles as apply under Part 2 of the Act. The powers and duties conferred on the LSSA or private guardian and the provisions as to duration, renewal and discharge are the same as in guardianship applications except that the power to discharge is not available to the Nearest Relative.
7. **Conveyance of patients**

7.1 This chapter provides guidance regarding the conveyance of patients in the circumstances set out in the Act.

### Authority to convey

7.2 The Act provides authority to convey individuals in a number of circumstances. The guidance in this chapter will apply whether conveyance is to enable:

- the admission of individuals to be assessed or treated;
- the transfer of patients liable to be detained between hospitals;
- the transfer of patients who have been received into guardianship to a community setting;
- the transfer of individuals to and between places of safety (section 135 and 136);
- the return of patients liable to be detained to hospital if they are absent without leave; and
- the return to hospital of a person subject to supervised community treatment (SCT) who has been recalled.

7.3 The following table identifies responsibility for co-ordinating conveyance in the circumstances in the Act:-

<table>
<thead>
<tr>
<th>Reason for conveyance</th>
<th>Legal Authority</th>
<th>Responsibility for co-ordinating conveyance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Admission to hospital</td>
<td>Section 6(1)</td>
<td>The applicant (i.e. the AMHP or Nearest Relative)</td>
</tr>
<tr>
<td>Transfer between hospitals</td>
<td>Section 19, and regulation 20&lt;sup&gt;6&lt;/sup&gt;</td>
<td>Hospital Managers</td>
</tr>
<tr>
<td>Conveyance into guardianship or between places for guardianship</td>
<td>Section 18(7)</td>
<td>The applicant (i.e. the AMHP or Nearest Relative) or Guardian</td>
</tr>
<tr>
<td>Transfer between places of safety</td>
<td>Section 135(3A) or section 136(3)</td>
<td>Police or AMHP or person authorised by them, depending on place of safety.</td>
</tr>
</tbody>
</table>

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<sup>6</sup> Mental Health (Hospital, Guardianship, Community Treatment and Consent to Treatment) (Wales) Regulations 2008
<table>
<thead>
<tr>
<th>Reason for conveyance</th>
<th>Legal Authority</th>
<th>Responsibility for co-ordinating conveyance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Return of patients absent without leave</td>
<td>Section 18</td>
<td>Police, AMHP, hospital staff or Hospital Manager.</td>
</tr>
<tr>
<td>Recall from SCT</td>
<td>Sections 17E &amp; 17F</td>
<td>Responsible Clinician</td>
</tr>
<tr>
<td>Transfer to hospital from prison/court</td>
<td>Sections 35 (9a), 37(4), 38(4), and 40(1)</td>
<td>Court</td>
</tr>
</tbody>
</table>

**General matters**

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

- a clear statement of the roles and obligations of each authority and its staff;
- the form of any authorisation to be given, for example by the Approved Mental Health Professional (AMHP) to ambulance staff;
- guidance on powers in relation to conveying patients; and
- responsibility for conveying patients outside authority areas.

7.5 Those responsible for conveyance have a professional obligation to ensure the most humane and least threatening method of conveying the patient is used, consistent with ensuring that no harm comes to the patient or to others. The factors that should be taken into account when deciding the most appropriate method for conveyance are:-

- the Guiding Principles in chapter 1 particularly in relation to dignity of patients and least restrictive practice;
- the wishes and views of the patients to be conveyed, including any relevant care plan or advance statement;
- the nature of the mental disorder and its course;
- the impact that any particular mode of conveying the patient will have on the patient’s relationship with the community to which he or she will return;
- the availability of various transport options;
- the distance to be travelled;
- the patient’s need for support and supervision during the period of travel;
- the availability of transport to return home those who accompany the patient (including whether the professionals in attendance will need to return to their own vehicles); and
• the risk of harm in the event of the patient absconding before admission to hospital.

### Conveying to hospital for admission

7.6 A duly completed application for admission under the Act (which includes the required medical recommendations) gives the applicant, whether an AMHP or Nearest Relative, the authority to convey the patient to hospital.

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

7.8 If the Nearest Relative is the applicant and they require assistance to ensure the safe conveyance of their relative then the Local Social Services Authority (LSSA) should ensure the availability of an AMHP to help them. If this is not possible, other professionals involved in the admission should give advice and assistance.

7.9 If the AMHP or authorised person is refused access to the premises where the patient is, and forcible entry will be needed to remove the patient, an application should be made for a warrant under section 135(2). For further guidance on removing patients under warrant see Chapter 4 of this Code.

7.10 When conveying a patient to hospital the AMHP (or any other person with the authority to convey) has the power of a police constable. The task of conveying the patient may be delegated, for example, to ambulance staff and assistance may be sought from the police. The AMHP (or any other person with the authority to convey) retains ultimate responsibility to ensure that the patient is conveyed in a lawful and humane manner and should give guidance to those asked to assist.

7.11 The patient should not normally be conveyed by car unless the AMHP is satisfied that they do not present a danger to themselves or others and that this is the most appropriate method of transporting the person. In these circumstances there should always be an escort for the patient other than the driver.

7.12 If the patient is likely to be violent or dangerous the police should be asked to help. Where possible an ambulance should be used, otherwise the police may be asked to provide a suitable vehicle. While the police may have to exercise their duty to protect persons or property while the patient is being conveyed they should, where possible, comply with any guidance given by the AMHP.

7.13 If the patient is conveyed by ambulance, the AMHP may accompany the patient and, where requested by the applicant, the ambulance authority should make the necessary arrangements to enable this to happen. The patient may be accompanied by another person, provided the applicant is satisfied that this will not increase the risk of harm to the patient or others.
7.14 The AMHP should telephone the receiving hospital to ensure that the patient is expected and give the likely time of arrival. If possible the AMHP should ask the name of the person who will be formally receiving the admission documents.

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

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

7.17 The AMHP should leave a report at the hospital when the patient is admitted, giving reasons for the admission and any practical matters about the patient’s circumstances which the hospital should know and, where possible, the name and telephone number of a social worker who can give further information. LSSAs and NHS Trusts should develop and use a common form on which AMHPs can make this report. This report should also be included in any community case records should these not be shared with hospital case records.

7.18 There may be circumstances where the receiving hospital is a considerable distance from the area where the AMHP operates which would make it impracticable for the AMHP to accompany the patient to hospital. In these circumstances it is acceptable for the information set out in paragraph 7.16 to be delivered by phone, facsimile or other electronic means that comply with local or national procedures for passing confidential information.

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

### Conveying patients recalled from Supervised Community Treatment (SCT)

7.20 The Responsible Clinician will have responsibility for co-ordinating the recall. The decision by the Responsible Clinician to recall a patient subject to SCT provides the legal authority for the patient to be taken and conveyed to hospital by the Responsible Clinician, or any AMHP, officer on the staff of the hospital, constable or person authorised in writing by the Responsible Clinician.

7.21 The way to achieve the patient’s return to hospital will need to be considered in the light of the assessment of any risk, the need for urgency, the factors outlined in paragraph 7.5 above and any other practical considerations.
7.22 In those circumstances where the person being recalled may be violent or
dangerous the police should be asked to help. In these circumstances an ambulance
may be the preferred mode of transport. However, if the assessed level of risk
indicates that a police vehicle should be used, then a suitable for vehicle for
conveying such a patient should be used. While the police may have to exercise
their duty to protect persons or property while the person is being conveyed they
should have due regard to any professional guidance given by the person authorised
to convey the person to hospital.

7.23 When conveying patients between hospitals or places of safety it is necessary
to consider the most appropriate method of securing the agreed transfer that takes
into consideration the patient’s views and feelings alongside the need to manage any
identified risks to the safety of the patient or others.

7.24 It is not always necessary for conveyance to be undertaken by ambulance but
where this is identified as the most appropriate means for transfer then this should
be facilitated.
8. Holding powers

8.1 This chapter provides guidance on the use of holding powers available to doctors, Approved Clinicians and nurses and the matters which should be considered in relation to the application of these powers.

In-patients

8.2 Section 5 of the Act provides for applications for admission for assessment or treatment to be made in respect of mentally disordered patients who are already receiving treatment in hospital as informal patients. It provides a procedure that can be used if it is considered that an informal patient who it is felt requires inpatient care might leave the hospital before there is time to undertake an assessment as to whether the grounds for detention under section 2 or section 3 of the Act are met.

8.3 As section 5 may only be used in respect of an informal patient in a hospital, it is important that Hospital Managers have a clearly identified definition of inpatient status. For the purposes of this Code, an informal inpatient is considered to be a compliant patient who has arrived at the ward and who has not provided any evidence of resistance (verbal or physical) to the admission procedure. The availability of a bed for the patient is a pre-condition to attaining in-patient status. A patient does not lose their in-patient status until they have removed themselves (or been removed) from the hospital.

8.4 It is important that informal patients are aware of how they may discharge themselves from inpatient status.

8.5 A patient who is being treated in an out-patient department, in a day hospital or as a day patient cannot be detained under section 5 of this Act. Admission procedures should not be implemented with the sole intention of then using section 5(2).

8.6 Section 5 should not be used to prolong the detention of a patient where the authority to detain is about to expire (section 5(6)) or to provide time for an application to be made to the county court under section 29(4) of the Act.

8.7 Section 5 should not be used immediately after the use of section 136 of the Act because there should have already been sufficient time for an assessment to be undertaken. However it is recognised that a patient initially admitted under section 136 who subsequently agrees to remain an inpatient without compulsion, may at a later point need to be held under the powers of section 5.

Doctor and Approved Clinician’s holding power (section 5(2))

8.8 The power may only be used by the doctor or Approved Clinician in charge of the patient’s treatment, or their nominated deputy. Section 5(3) of the Act provides that the doctor or approved clinician may nominate one, but only one, other person to act on their behalf under the section, in the doctor/Approved Clinician’s absence.
The person to whom this power has been delegated cannot in turn delegate the power to another. To ensure that there is appropriate cover in case it is necessary for section 5(2) to be used, it is good practice to ensure that there is an identified nominated deputy for every duty period. The delegation should be formally made, and preferably in writing.

8.9 The delegate of a doctor may be another doctor or an Approved Clinician; the delegate of an Approved Clinician may be another clinician so approved, or a doctor. In both cases the delegate must be on the staff of the hospital in which the patient is currently an inpatient. The delegate may find it useful to consult with a senior colleague before exercising the power under section 5, but any decision to apply the holding power should be their own.

8.10 It may occasionally be necessary to make a report under section 5(2) in respect of a patient who is not in a psychiatric hospital or the psychiatric wing of a general hospital. Where such a patient is receiving treatment for mental disorder (in addition to inpatient treatment for other illnesses or disorders) the doctor or Approved Clinician for the purposes of section 5(2) will be the person in charge of the patient’s treatment for the mental disorder.

8.11 Where an in-patient is not receiving treatment for mental disorder the doctor who is in charge of the treatment of the patient would have the power to furnish the report. In these cases there would not be an Approved Clinician in charge of their treatment. The person in charge may be an Approved Clinician, by virtue of other circumstances, but they would not be acting as such in this patient’s case.

8.12 The period of detention under section 5(2) commences when the report of the doctor or approved clinician (or their deputy) is furnished to the Hospital Managers, or someone authorised to receive such a report on their behalf. Statutory Form [x] should be used for this purpose. The use of the power, its commencement and expiry dates and times must be accurately recorded in the patient’s case notes.

8.13 Arrangements for an assessment to be made to consider the use of section 2 or section 3 should be put in place as soon as the report is furnished to the Hospital Managers. The patient should also be informed of the provisions and effects of the section 5(2) that he or she is being held under and the reasons for it (see also chapter 17).

8.14 Part 4 of the Act does not apply to a patient detained under section 5(2). Treatment under that Part therefore, can only be given with the patient’s consent, or where the patient (aged 16 or over) lacks the capacity to consent, in accordance with the Mental Capacity Act 2005.

8.15 There is no procedure within the Act for discharging the patient from section 5(2). However detention under section 5(2) it will end if:-

- the result of the assessment is a decision not to make an application under section 2 or 3; or
• the power is invoked by a doctor who has been nominated under section 5(3) and the doctor or Approved Clinician in charge subsequently decides that no assessment for possible detention needs to be carried out; or
• an application under section 2 or 3 is made; or
• the patient is discharged for clinical reasons before an assessment can be undertaken (for example, the patient’s violent conduct results in an arrest and removal to police custody).

The maximum period a patient may be held under section 5(2) is 72 hours, which will include any time the patient is held under section 5(4) of the Act (see paragraphs 8.20 onwards).

8.16 The patient should be informed that he or she is no longer detained under section 5(2). Such a decision, the reasons for it and its time should be specifically recorded.

8.17 The power cannot be renewed, but it is recognised that circumstances may arise following the patient’s reversion to informal status, its use may be considered again.

8.18 If a patient absents him or herself from hospital, whilst held under this power, they cannot be retaken once the 72 hour period has expired (section 18(5)).

8.19 It is not possible for patients detained under section 5(2) to be transferred to another hospital under section 19 of the Act, because they are not detained by virtue of an application made under Part 2 of the Act. The section 5(2) will automatically lapse if the patient is moved from the hospital named on the Form [x], because this provision only provides authority for the patient to be detained in “the hospital” i.e. the hospital which was providing in-patient treatment to the patient at the time when the power was invoked.

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

8.20 A nurse of the prescribed class may invoke section 5(4) of the Act in respect of an inpatient who is receiving treatment for mental disorder for a period of not more than six hours. This section may be used only where it is immediately necessary to prevent the patient leaving the hospital and it is not practicable to secure the immediate attendance of a practitioner or clinician who can furnish a report to the Hospital Managers under section 5(2) of the Act.

8.21 A nurse of the ‘prescribed class’ is defined in the Mental Health (Nurses) (Wales) Order 2008 as a nurse registered in sub-part 1 or 2 of the Nurse’s part of the Register of the Nursing and Midwifery Council, with a recordable qualification in mental health or learning disability nursing. Where a nurse may have to apply the power to patients from outside his or her specialist field it is good practice for employers to arrange suitable post-basic education and training, especially in the use of section 5(4). Close working between nurses in different specialities is also important.
8.22 The use of this power is entirely the personal and professional decision of the nurse, who cannot be instructed to exercise this power by anyone else.

8.23 A patient cannot be made subject to section 5(4) if he or she does not meet the grounds set out in that section. Therefore before invoking this power the nurse should assess:-

- the likely arrival time of the doctor or approved clinician, against the likely intention of the patient to leave. Most patients who express a wish to leave hospital can be persuaded to wait until a doctor or approved clinician arrives to discuss their case further. Where this is not possible the nurse must assess the impact of any delay upon the patient;
- the consequences of a patient leaving hospital immediately, including the harm that might occur to the patient or others, taking into account:
  - the patient’s expressed intentions including the likelihood of the patient committing self harm or suicide, or harming others;
  - any evidence of disordered thinking;
  - the patient’s current behaviour and in particular any changes in usual behaviour;
  - the likelihood of the patient behaving in a violent manner;
  - any recently received messages or information from relatives or friends;
  - any recent disturbances on the ward;
  - any relevant involvement of other patients;
  - any known unpredictability on the patient’s part and any other relevant information from other members of the multi-disciplinary team.

8.24 Formal structured assessment should normally precede any action on the part of the nurse, but in extreme circumstances it may be necessary to invoke the power on the basis of a briefer assessment. The suddenness of the patient’s determination to leave and the urgency with which they attempt to do so should alert the nurse to potentially serious consequences if the patient were to be successful in leaving.

8.25 The holding power starts after the nurse has recorded his opinion on the statutory Form [x]. Entries should also be made in the patient’s case notes of the use of this power and the reasons for the same. The expiry date and time must also be accurately recorded in the patient’s notes.

8.26 The patient should be informed of the provisions and effects of the section 5(4) and the reasons for using it.

8.27 A nurse invoking section 5(4) is entitled to use the minimum force necessary to prevent the patient from leaving the hospital.
8.28 During the continuation of the period of detention under section 5(4), the doctor or Approved Clinician in charge of the treatment of the patient (or their nominated deputy) should attend as soon as possible, and within the six hours of the power, and examine the patient with the view of furnishing a report under section 5(2). All discussions, including attempts to contact the doctor/Approved Clinician must be recorded in the patient’s notes.

8.29 The use of section 5(4) is an emergency measure and the doctor or Approved Clinician with the power to use section 5(2) in respect of the patient should treat it as such and arrive as soon as possible. The doctor or Approved Clinician should not wait six hours before attending, simply because this is the maximum duration of the holding power. If the doctor or Approved Clinician has not arrived within four hours, the duty consultant should be contacted and should attend.

8.30 Where no doctor or Approved Clinician has attended within six hours an oral report (suitably recorded) should be made immediately to the responsible senior manager, and a written report should be submitted to that manager and the Hospital Managers on the next working day. The responsible senior manager should nominate a suitable person to supervise the patient, should he or she wish to leave the hospital.

8.31 The six hours of the power is a maximum, which cannot be renewed or extended. Any detention by virtue of section 5(4) will end at the expiry of the six hour period, or on the arrival of the doctor, Approved Clinician or their deputy entitled to make a report under section 5(2). The power does not continue if a report under section 5(2) is not made.

8.32 The details of any patient who remains subject to the power at the time of a shift change must be handed over to staff coming on duty.

8.33 Part 4 of the Act does not apply to a patient held under section 5(4) – see also paragraph 8.14 above.

**Statements of intent**

8.34 Although entries into notes which appear to fetter the discretion of the doctor/Approved Clinician/nominated deputy must be avoided (for example “For section 5(2) if he tries to leave”), it is acceptable for the doctor or Approved Clinician in charge to make an entry to the effect that the use of powers under section 5(2) should be considered if the patient makes an attempt to leave. It is not acceptable to record ‘not to leave the ward’ or ‘ntlw’ in an informal patient’s case notes.

**Hospital Manager’s responsibilities**

8.35 Hospital Managers should ensure that there are suitably qualified, experienced and competent nurses available on all wards where there is a possibility
of section 5(4) being invoked, particularly acute admission wards, and wards where there are acutely disturbed patients, or patients requiring intensive nursing care.

8.36 Hospital Managers should also ensure that the staff who may need to consider using section 5(2) or section 5(4) are familiar with the chapters of this Code concerned with supporting patients safely and therapeutically (chapter 15) and information for patients (chapter 17).

8.37 Hospital Managers should monitor the use of section 5, including how quickly a patient is assessed for detention, and/or discharged from the holding power. It would be good practice to also monitor the attendance times of doctors and Approved Clinicians following the use of section 5(4), together with outcomes following their attendance.
9. **Receipt and scrutiny of documents**

9.1 This chapter provides guidance on the receipt and scrutiny of the documents prescribed by the Mental Health (Hospital, Guardianship, Community Treatment and Consent to Treatment (Wales) Regulations 2008 (“the regulations”). The authority for compulsion (including guardianship) and treatment under the Act is conferred by these statutory documents, and it is essential that robust systems are in place to ensure that the documentation complies with the legal framework.

9.2 There is a difference between “receiving” documents and “scrutinising” such documents. Receipt is the record made by the Hospital Managers of application and recommendations; scrutiny is the study of those documents to ensure that the requirements of the Act and the regulations have been met. Scrutiny includes administrative scrutiny and medical scrutiny (see paragraph 9.10 below). Reference to ‘receipt’ in the context of this chapter refers to the formal receipt of documents by or on behalf of the Hospital Managers.

9.3 Documents should be scrutinised at the same time as they are received, if possible, otherwise as soon after as possible.

### Receipt and scrutiny of guardianship applications

9.4 The Local Social Services Authority (LSSA) should prepare a checklist for the guidance of those delegated to receive documents, to detect errors that can be corrected within 14 days of receipt (see section 8(4)) or that might invalidate the application. When a person is being received into guardianship the person ‘receiving’ the papers on behalf of the LSSA should check their accuracy with the AMHP making the application.

9.5 It is good practice for the LSSA to arrange for the medical recommendations to be medically scrutinised, to ensure that they show sufficient legal grounds for detention. The scrutiny of the medical recommendations should be carried out at the same time as the administrative scrutiny.

### Receipt and scrutiny of applications for admission to hospital

9.6 The Hospital Managers should formally delegate their duties to receive and scrutinise admission documents to a limited number of officers who have received suitable training to perform this function and understand the requirements of the Act. Depending on the type of unit to which patients are admitted, it may be appropriate to ensure that there is 24 hour cover available for the receipt and scrutiny of documents. A manager of appropriate seniority should take overall responsibility on behalf of the Hospital Managers for the proper receipt and scrutiny of documents.

9.7 The hospital should have a checklist for the guidance of those delegated to receive documents, to detect errors that might either invalidate applications, or that can be corrected within 14 days of receipt (refer section 15).
9.8 When a patient is being admitted on the application of an Approved Mental Health Professional (AMHP) the person “receiving” the admission documents should check their accuracy with the AMHP. The “receiving” officer should have access to a manager for advice, especially at night.

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

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

9.11 If admission documents reveal a defect which cannot be rectified under section 15, either the Hospital Managers or the Responsible Clinician should exercise their powers under section 23 to discharge the patient from the section. If an application is found to be fundamentally defective, authority for the patient’s detention can only be obtained through a new application.

**Rectifiable and non-rectifiable errors**

9.12 Those delegated to scrutinise documents must be clear about what kind of errors on application forms and medical recommendations can and cannot be corrected.

9.13 Sections 8(4) and 15 of the Act allow for the rectification of “incorrect” or “defective” applications or medical recommendations for guardianship or admission to hospital, within 14 days of these being received by or on behalf of the Hospital Managers. There is no equivalent power of rectification for documents issued by a court, to documents completed under s5, those given in support of a transfer under section 19 or to the renewal of detention, or documents relating to supervised community treatment.

9.14 Rectification is primarily concerned with dealing with matters of inaccurate recording, and it cannot be used to enable a “fundamentally defective application to be retrospectively validated”. It also cannot be used to “cure a defect which arises because a necessary event in the procedural chain leading to the detention has simply not taken place at all”. Therefore a document may be “incorrect”, for example, if names, dates or places are mis-stated, but which, if corrected, would not make the decision to admit a patient an unjustified one, and “defective” if the

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7 Re S-C (Mental Patient: Habeas Corpus) [1996] 1 All ER 532, CA
8 R v South Western Hospital Managers, ex parte M [1994] 1 All ER 161
signatory has failed to complete all the sections, or delete alternative options. An unsigned form should not be accepted as rectifiable.

9.15 When an AMHP makes an application for admission to hospital or reception into guardianship, he or she should carefully check that the medical recommendations prepared by the registered medical practitioners are compliant with the requirements of both the Act and the regulations. The AMHP must pay particular attention to the correct completion of the medical recommendations and application form. Wherever possible, errors on forms should be remedied before their acceptance, with appropriate consultation between the AMHP and the doctor.

9.16 Applications and recommendations do not have to be completed on original statutory forms, and photocopies of an original form or computer-generated forms may be used. However, forms must correspond to the requirements prescribed in the regulations.

### Monitoring of receipt and scrutiny

9.17 Hospital Managers and LSSAs are responsible for ensuring that patients are detained lawfully; they should therefore monitor the receipt and scrutiny of admission, guardianship and supervised community treatment documents on a regular basis.

9.18 Hospital Managers retain responsibility for the performance of their duties by those delegated for such purposes; in view of this, details of defective admission documents, whether rectifiable or not, and of any subsequent action, must be given to the Hospital Managers on a regular basis. Similarly, details of defective guardianship documents should be passed to the LSSA on a regular basis. Where previously unnoticed errors are discovered during monitoring, these should be brought to the attention of Hospital Managers or LSSAs for immediate consideration.

9.19 Hospital Managers and LSSAs should ensure that those delegated 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.
10. Duties of Hospital Managers

10.1 This chapter explains who Hospital Managers are, and their role under the Act. Functions of Hospital Managers may be delegated and this chapter sets out how delegation may occur, together with the governance arrangements associated with such delegations.

### The ‘Hospital Managers’

10.2 Hospital Managers have a central role in operating the provisions of the Act. In relation to hospitals vested in NHS trusts, the Trusts themselves are defined as the "managers" for the purposes of the Act. In the case of a hospital vested in a Local Health Board, it is the Board. In relation to independent hospitals, the person or persons in whose name the hospitals are registered under the Care Standards Act 2000 are the managers for the purposes of the Act.

10.3 It is the Hospital Managers who have the authority to detain patients who have been admitted under the Act. For patients placed on Supervised Community Treatment (SCT), the Hospital Managers are those of the responsible hospital, that is, the hospital in which the patient was detained immediately before going onto SCT, or the hospital to which responsibility for the patient has subsequently been assigned.

10.4 The Hospital Managers must ensure that patients are detained only as the Act allows, that their treatment and care accord fully with its provisions, and that the patients are fully informed of, and are supported in exercising, their statutory rights. Hospital Managers are also required to ensure that a patient’s case is dealt with in line with other legislation which may have an impact, including the Mental Capacity Act 2005, the Human Rights Act 1998 and the Data Protection Act 1998.

### Exercising the functions of the Hospital Managers

10.5 Hospital Managers may delegate their duties in three main ways:-

- most of the Hospital Managers' responsibilities may be delegated to officers (with the express exception of their power to discharge patients under section 23);
- their power of discharge (section 23) may be performed by a committee or sub-committee authorised by the Hospital Managers for that purpose; and
- they may authorise a committee or sub-committee to monitor the performance of duties undertaken on behalf of the Hospital Managers, which should report formally to the Board with an account of its activities not less than once a year.
10.6 Regulations\(^9\) permit NHS trusts and LHBs to delegate functions to committees or sub-committees whose members need not be directors of the trust or members of the board. However, in such circumstances, the Trust or Board will retain the ultimate responsibility for the performance of the Hospital Managers’ duties, and in view of this the committees and/or sub-committees should, where possible, include members of the Board.

10.7 The diagram below sets these delegations arrangements out, together with relationships between the Hospital Managers and the persons and committees to whom their functions may be delegated.

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**Diagram:**

- **Hospital Managers**
  - Retains ultimate responsibility for the performance of all delegated duties

- **Certain functions delegated to ‘officers’**
  - Functions performed by officers and staff of the hospital. Guidance on these functions is given in paragraphs [xx to xx]

- **Monitoring of performance of functions**
  - A sub-committee of the Hospital Managers who review functions performed on behalf of the HMs, and report at least annually to the Board

- **Hospital Managers’ power of discharge**
  - Delegated by virtue of s23 to a sub-Committee of the Hospital Manager; for NHS bodies members must not be employees (or officers of NHS trusts).

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10.8 The Hospital Managers should ensure that those acting on their behalf are competent to undertake the functions delegated to them by ensuring that they are properly informed about the working of the Act and receive suitable training in their role.

10.9 Appointments to the committee or sub-committee for the exercise of the Hospital Manager’s power of discharge should be made for a fixed period and any re-appointments should be preceded by a review.

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The main responsibilities which the Act confers on the Hospital Managers are set out below. This is expanded upon, where necessary, in the relevant chapters of this Code. The exercise of the Hospital Managers' powers to discharge patients is dealt with in chapter 27.

**Admission**

10.11 It is the Hospital Managers' duty to ensure that the grounds for admitting the patient are valid and that all relevant admission documents are in order. Any officer to whom the responsibility is delegated must be competent to make such a judgment, and to identify any error in the documents which may require rectification. Guidance on the receipt, scrutiny and rectification of documents is given in chapter 9 of this Code.

10.12 Where a patient is admitted under the Act following an application by his or her Nearest Relative, the Hospital Managers should request the relevant local social services authority (LSSA) to provide them with a social circumstances report for the patient as required by section 14.

**Appointment of the Responsible Clinician**

10.13 Hospital Managers have a duty to ensure that patients under their care, who are subject to compulsion, are allocated an appropriate Responsible Clinician. Decisions about the appropriateness of a Responsible Clinician should be based on the individual needs of the patient concerned. As the needs of the patient will change over time, it is important that the appropriateness of the Responsible Clinician is kept under review by the Hospital Managers. It is acceptable for the patient’s Responsible Clinician to change during an episode of care or treatment, if such a change in Responsible Clinician enables the needs of the patient to be met more effectively. For instance:-

- during the initial phases of the treatment of a patient with acute psychosis, where there may be an emphasis on pharmacological therapy, it may be appropriate for the Responsible Clinician to be an Approved Clinician who is a registered medical practitioner (or other prescriber);
- if psychological therapies are central to the patient’s treatment, it may be appropriate for a psychologist to act as the Responsible Clinician; and
- a nurse may be the most appropriate practitioner to act as the patient’s Responsible Clinician if the care plan emphasises continuing mental healthcare or rehabilitation.

10.14 Consideration should be given to a patient’s request for an alternative Responsible Clinician, which should be facilitated where appropriate or practical.
10.15 Hospital Managers should ensure that the Responsible Clinician for each patient is clearly identified. Other Approved Clinicians who are involved in the delivery of aspects of the patient’s care should also be clearly identified.

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

10.17 Hospital Managers should maintain a register of Approved Clinicians employed by or contracted to them.

**Transfer between hospitals**

10.18 Section 19 of the Act, and the Mental Health (Hospital, Guardianship, Community Treatment and Consent to Treatment (Wales) Regulations 2008 (“the regulations”) allow the Hospital Managers to transfer a detained patient from one hospital to another, including to another hospital managed by them. For restricted patients, the Hospital Managers’ power is subject to the prior agreement of the Secretary of State for Justice.

10.19 Transfers are potentially an interference with a patient’s private and family life and should always be made for valid reasons. Officers to whom this responsibility is delegated must ensure that consideration is given to the reasons for the transfer and that the needs and interests of the patient have been considered. Valid reasons for transfer might be clinical, for example the need for the patient to be in a more suitable environment or in a specialist facility. There could also be social reasons, for example to move the patient closer to home or some other place at the request of the patient or a relative, or to return ‘out of area’ patients to their home areas when this would be in the best interests of the patient. It is important to explain the reasons for the transfer to the patient and where appropriate, the patient’s family, carers or friends, and to record the reasons.

10.20 A detained patient may themselves wish to be transferred to another hospital, for example to be closer to family or friends. Hospital Managers should record any representation made by the patient, or someone acting on their behalf, and give the request careful consideration. The kind of factors that Hospital Managers need to consider when deciding whether to transfer a patient may include:-

- whether the transfer would give the patient greater access to family or friends;
- whether any wish expressed by or on behalf of the patient to be treated by another care team or individual is reasonable and would be facilitated by such a transfer;
- the availability of appropriate beds at the potential receiving hospital;
• whether the transfer would be appropriate to enable the patient to be in a more culturally suitable or compatible environment; and
• where applicable, the views of the commissioner funding care.

Other factors may be relevant in a particular case.

10.21 Before reaching a decision, the Hospital Managers should discuss the matter with the multi-disciplinary team responsible for the patient’s care and treatment and where it is practicable to do so, the patient, their Nearest Relative, and other interested persons. The matter should also be discussed with the clinician who would be responsible for the patient at the hospital to which the transfer is proposed.

10.22 The patient, and anyone who made a request on behalf of the patient, should be informed of the decision reached by the Hospital Managers together with the reasons for their decision (including the views of commissioners as applicable), in writing.

10.23 Section 19A allows the responsibility for patients on SCT to be assigned to another hospital, in accordance with the Regulations. Section 17F of the Act and regulation 23 enables the Hospital Managers to transfer a patient on SCT who has been recalled to hospital from one hospital to another. As above, officers to whom this responsibility is delegated must ensure that consideration is always given to the reasons for the assignment and that the needs and interests of the patient have been considered.

**Transfers into/from guardianship**

10.24 Section 19 of the Act, and the regulations also allow the Hospital Managers to transfer a patient who is liable to detained in hospital into guardianship; a patient who is subject to guardianship may be transferred into the guardianship of another person or local social services authority, or transferred to a hospital.

10.25 As with transfers between hospitals, Hospital Managers and Guardians (including local social services authorities) should ensure that full consideration is given to the reasons for any transfer and that that the needs and interests of the patient have been considered.

**Responsibilities under SCT**

10.26 When a Responsible Clinician indicates that SCT is appropriate for a patient, it is the responsibility of the Hospital Managers to liaise with the relevant authorities, usually the LSSA, to ensure arrangements are put in place for suitable aftercare services in line with the specifications drawn up by the multi-disciplinary team.

10.27 When a patient is recalled from SCT, the patient may only be detained for a maximum of 72 hours. The period commences from the point when the notice given under section 17E begins. It is the responsibility of the Hospital Managers to ensure that no patient is detained on recall for longer than 72 hours without having their
community treatment order revoked. Arrangements should be put in place to ensure that the time of recall is recorded and the length of stay monitored.

10.28 The Hospital Managers have a duty to ensure a patient is referred to the MHRT as soon as is practical if the community treatment order is revoked.

Information for patients and relatives

10.29 Sections 132, 132A and 133 require the Hospital Managers to give certain information to detained patients, community patients and patients’ Nearest Relatives. Guidance on the exercise of these duties is given in chapter 17.

10.30 Hospital Managers also have the duty to inform certain qualifying patients, including community patients and those liable to be detained, that support is available to them from an Independent Mental Health Advocate (IMHA) and how that support can be obtained. Guidance on the role of IMHAs is given in chapter 21.

Correspondence of patients

10.31 Section 134 allows the Hospital Managers to withhold outgoing mail from a detained patient if the addressee has requested this in writing to them, the patient’s Responsible Clinician or the Welsh Ministers. The fact that mail has been withheld must be recorded in writing and the patient must be informed.

10.32 Hospital Managers should have a written policy for the exercise of these powers, which may include guidance on other forms of correspondence and communication (for example, via mobile phones or electronic mail) which are out with the provisions of section 134. There are no powers to withhold the mail of patients who are not liable to be detained, and any policy prepared by the Hospital Managers should address this.

Mental Health Review Tribunals (MHRTs)

10.33 Hospital Managers should ensure that support is given to patients who wish to make an application to the MHRT.

10.34 Hospital managers are under a duty to refer cases to the MHRT where patients have not exercised their right to apply for an MHRT hearing (or been referred by the Welsh Ministers or the Hospital Managers), within the first 6 months of their detention under Part 2 of the Act (or subsequent SCT). The first 6 months includes any period of detention under section 2 of the Act which occurred immediately prior to detention under section 3.

10.35 Any applications made by a patient when they were detained under section 2 (if applicable) should be disregarded by the Hospital Managers in exercising the duty set out above. Similarly where a patient has applied in the first 6 months following his or her detention for a MHRT hearing but has withdrawn the application, it should not be treated or recorded as an application, and the patient’s case should therefore still be referred.
10.36 Hospital managers are required to refer a patient’s case to the MHRT if three years (or if the patient has not attained the age of eighteen years, one year) have passed since the last MHRT hearing and a patient has not applied to the MHRT. This provision covers patients on hospital orders as well as patients detained under section 2 for assessment, section 3 for treatment or subject to a community treatment order.

10.37 If a patient is absent without leave, the Hospital Managers do not have to refer the patient until they return.

10.38 Where an MHRT hearing has been arranged, the Hospital Managers should inform the relevant Local Health Board and LSSA in order that they are able to consider the need for a section 117 care planning/Care Programme Approach meeting before the MHRT takes place and, if necessary, to compile a report for the MHRT. Although the requirement to put in place after care arrangements does not arise before the MHRT makes a decision, the Hospital Managers should consider whether it is necessary to start making plans prior to the hearing.

Referrals by the Welsh Ministers

10.39 The Welsh Ministers may at any time refer the case of a Part 2 or unrestricted Part 3 patient to the MHRT. Anyone may request such a referral and the Welsh Ministers will consider each such request on its merits.

10.40 Hospital Managers should always consider asking the Welsh Ministers to exercise their power of referral in the case of a patient whose detention under section 2 is extended pending a decision of the county court under section 29 (appointment of acting Nearest Relative) where the patient in question is for any reason unable to make a request. If the patient’s case has not already been considered by the MHRT, or a significant period has passed since that hearing, Hospital Managers should consider making a request as soon as the detention is extended. A failure to do so could result in a breach of the patient’s rights under the Human Rights Act 1998.

Discharge

10.41 The exercise of the Hospital Managers’ own powers to discharge patients is dealt with in chapter 27 below.

Victims

10.42 In line with the guidance set out in chapter 32 of this Code, Hospital Managers will be notified by the local probation board of a victim’s wish to receive information and make representations (in line with the relevant provisions within the Domestic Violence, Crime and Victims Act 2004).

\[\text{Ref: R v Mental Health Review Tribunal Ex parte Hall [1999] 3 All ER 132}\]
10.43 In such circumstances, the Hospital Managers then have a duty to forward any representations made by victims to the relevant persons and bodies responsible for making decisions on discharge or community treatment orders and for passing any information received from those persons or bodies to the victim.

10.44 Hospital Managers must inform the victim if the patient’s discharge is being considered or if the patient is to be discharged. Because unrestricted patients cannot be conditionally discharged, Hospital Managers must inform the victim who has requested to receive information whether the patient is to be subject to a community treatment order and, if so, to inform the victim of any conditions relating to contact with the victim or victim’s family; any variation of the conditions and the date on which the order will cease. Victims also have the right to make representations about the conditions to be attached to community treatment orders, which Hospital Managers must forward to the Responsible Clinician.
11. Treatment for mental disorder

11.1 This chapter provides guidance on the treatment of patients who are suffering or appear to be suffering from a mental disorder. It sets out the circumstances in which consent from the patient must be obtained and what steps to take if the patient does not have capacity to consent. Chapter 14 deals with circumstances in which treatment may be given to a patient without their consent or where treatment requires a second medical opinion.

The Mental Health Act 1983

11.2 One of the primary functions of the Act is to provide a legal framework within which treatment may, where necessary, be given to patients who do not wish at the time to receive it. This includes patients who have the capacity to consent to the treatment, but do not do so; it also includes those patients who lack capacity to consent but who nonetheless are clear that they do not wish to be treated. The Act provides a framework of legal authority and safeguards within which such treatment may be given.

Definition of Medical Treatment

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

11.4 People with learning disabilities, which are lifelong forms of mental disorder, only come within the treatment provisions of the Act if their learning disabilities are accompanied by abnormally aggressive or seriously irresponsible behaviour - or by another recognised form of mental disorder - which may improve with appropriate treatment.

Relationship with the Human Rights Act

11.5 Clinicians who rely on the framework provided by the Mental Health Act 1983 to provide necessary treatment are performing functions of a public nature and are therefore subject to the provisions of the Human Rights Act 1998. It is unlawful for practitioners to act in a way which is incompatible with a patient’s Convention rights.

11.6 Adherence to the requirements of the Mental Health Act 1983 and good clinical practice should ensure there is no such incompatibility, but clinicians should always bear in mind that:-

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

11.7 In determining whether treatment is a medical necessity, the questions a court is likely to ask itself may include the following:-

- how certain is it that the person suffers from a treatable mental disorder;
- how serious a disorder it is;
- how serious a risk is presented to others;
- how likely is it that, if the patient does suffer from such a disorder, the proposed treatment will alleviate the condition;
- how much alleviation there is likely to be;
- how likely it is that the treatment will have adverse consequences for the patient; and
- how severe may they be.

These are no more than the questions which a clinician should consider before prescribing or administering treatment.

### Capacity and consent to treatment: introduction

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

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

11.10 Where a patient is aged 16 or over and lacks the capacity to consent to treatment, the framework for treatment in their best interests is found in the Mental Capacity Act 2005 (MCA). This Act does not apply in cases where Part 4 and 4A of the Mental Health Act themselves provide the authority for treatment.

11.11 A summary of the interface between the MCA and the Mental Health Act is provided in chapter 33, however to fully understand how the Act works and is to be applied clinicians and other decision-makers should refer to the MCA and to the Code of Practice which accompanies it.

11.12 Chapter 30 of this Code provides further guidance for treatment of children.

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11 R (on the application of N) v Dr M and others [2002] EWCA 1789.


**Capacity to make treatment decisions**

11.13 A person is assumed to have capacity to consent to treatment unless it can be established that they lack capacity. He or she will lack capacity to consent if they are unable to make a decision for him or herself in relation to a matter because of an impairment of, or a disturbance in the functioning of, the mind or brain.

11.14 The assessment of a patient’s capacity to make a decision about his or her own medical treatment is a matter for clinical judgment, guided by current professional practice and subject to legal requirements. It is the personal responsibility of any doctor or other professional proposing to treat a patient to determine whether the patient has capacity to give valid consent. Such professionals must be familiar with the requirements of the Mental Capacity Act 2005 and with professional practice. In assessing capacity the following points should be adhered to:-

- recognition that the capacity of the patient may vary over time and that any assessment of the patient’s capacity should only be made as and when a particular treatment is proposed; and
- all assessments of a patient’s capacity should be fully recorded in the patient’s case notes.

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

**Consent: the basic principles**

11.16 ‘Consent’ is the voluntary and continuing permission of the patient to receive a particular treatment, based on an adequate knowledge of the purpose, nature, likely effects and risks of that treatment including the likelihood of its success and any alternatives to it. Permission given under any unfair or undue pressure is not ‘consent’. A patient’s co-operation with treatment does not amount to consent if that patient lacks the capacity to give such consent.

11.17 Consent will not be valid if the patient has not been given adequate information. It is the duty of all professionals involved in any proposed treatment to use all reasonable care and skill to provide clear and appropriate information to the patient about the treatment and to provide information about possible alternative treatment.

11.18 The duty will not be discharged by simply giving standard information leaflets to the patient. The information should be relevant to the particular patient, the particular treatment and the relevant medical knowledge and practice. The information provided should be in language that is best understood by the patient, taking account the particular patient’s ability to retain and to understand that
information. In every case sufficient information must be given to ensure that the patient understands in broad terms the nature, likely effects and risks of that treatment including the likelihood of its success and any alternatives to it. Additional information is a matter of professional judgment for the professional proposing the treatment.

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

11.20 The patient should be informed that they may withdraw their consent to treatment at any time and that fresh consent is required before further treatment can be given or reinstated. The patient should also receive an explanation of the likely consequences of not receiving the treatment (see also paragraphs 13.48 of chapter 13).

11.21 Information given to the patient should be noted in the patient's case notes.

11.22 Guidance on giving information to patients is set out in chapter 17 of the Code, and further information about the general principles of consent can be found in “Reference Guide to Consent to Examination and Treatment”.

| Treatment |

Consent to treatment

11.23 Valid consent from a patient must be obtained before starting any form of medical intervention unless there is legal authority to treat that patient without consent. Parts 4 and 4A of the Act provide the legal authority for patients to be treated for a mental disorder without consent in specified circumstances.

11.24 In addition to a valid consent from the patient some serious forms of medical treatment will require a second opinion from a registered medical practitioner appointed by the Mental Health Act Commission (refer chapter 13).

Treatment where consent is refused

11.25 A patient capable of giving consent can only be given medical treatment for mental disorder against his or her wishes in accordance with the provisions of Part 4 or 4A of the Act. A patient on a community treatment order or conditional discharge and who is capable of consent cannot be treated without their consent when they are in the community. A community patient or conditionally discharged patient cable of consent can only be treated against his or her wishes on recall to hospital in accordance with the provisions of Part 4 of the Act.
11.26 Even where the Act authorises treatment despite a patient’s refusal to consent, efforts should first be made to obtain such consent.

11.27 It should always be remembered that nothing in the Act authorises treatment without consent, where that treatment is not for mental disorder.

**Emergency treatment**

11.28 In an emergency, where it is not possible immediately to apply the provisions of the Mental Health Act, a patient suffering from a mental disorder which is leading to behaviour that is an immediate serious danger to him or herself or to other people may be restrained. If the patient has the capacity to consent to treatment, even such an emergency does not provide a lawful basis for administering invasive medical treatment without consent.

**Treatment plans**

11.29 Treatment plans are essential for informal, detained and community patients. Responsible clinicians should co-ordinate the formulation of a treatment plan in consultation with their professional colleagues. The plan should form part of the care plan under the Care Programme Approach (or its equivalent), and be recorded in the patient's case notes.

11.30 A treatment plan should include a description of the immediate and long-term goals for the patient with a clear indication of the treatments proposed and the methods of treatment. The patient's progress and possible changes to the care programme should be reviewed at regular intervals.

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

11.32 Wherever possible the whole care programme should be discussed with the patient, with a view to enabling him or her to contribute to it and express agreement or disagreement. Additionally, consultations with others should address the understanding those others have of the views of the patient, either past or present, and any evidence supporting this understanding. Clinicians will need to make judgments as to the relative weight to give to contrary or inconsistent views.

11.33 The care programme should be discussed with the patient's relatives or carers, with the consent of the patient if he or she is capable of giving consent, and, if the patient is not capable, on the basis of whatever discussions are necessary in the best interests of the patient. The continued involvement of carers is particularly important if the person they care for requires treatment under compulsory powers.

11.34 For patients who are placed in services away from their home area, it is important that services from their home area remain engaged with their care. This may be achieved through attendance at care planning meetings, and other discussions.
**Advance statements and decisions to refuse treatment**

11.35 Guidance on this area is given in chapter 23 of this Code.
12. Appropriate medical treatment

12.1 This chapter provides guidance on the application of the “appropriate medical treatment” test in the grounds for detention and supervised community treatment (SCT) under the Act.

The ‘appropriate medical treatment test’

12.2 The purpose of the appropriate medical treatment test is to ensure that no one is detained (or remains detained), or is subject to SCT, unless they are actually to be offered medical treatment (within the definition of medical treatment at Section 145(1) of the Act) which is appropriate, taking into account the nature and degree of their mental disorder and all their particular circumstances, including cultural, ethnic and religious considerations. The test is intended to ensure that detention will be clinically appropriate – not simply preventive detention without the offer of medical treatment.

12.3 The appropriate medical treatment test requires a professional decision on whether an appropriate package of treatment for mental disorder is to be made available for the individual in question.

12.4 Where the appropriate medical treatment test forms part of the grounds for detention, it follows that the medical treatment in question is treatment for mental disorder in hospital. Where it is part of the criteria for SCT it refers to the treatment for mental disorder that the person will be offered while subject to the community treatment order.

Purpose of medical treatment for mental disorder

12.5 Section 145(4) of the Act provides that references in the Act to medical treatment for mental disorder are to be construed as references to 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. It follows that medical treatment could not be “appropriate” unless it is for that purpose.

12.6 “Symptoms” and “manifestations” cover the way a disorder is experienced by the individual concerned and the way in which the disorder manifests itself in the person’s thoughts, emotions, communication, behaviour and actions. It is recognised that not every thought or emotion or every aspect of the behaviour of a patient suffering from mental disorder will be a manifestation of that disorder.

Applying the ‘appropriate medical treatment test’

12.7 The test encompasses the question of whether proposed medical treatment is clinically appropriate for the nature and degree of the patient’s mental disorder and all other factors relating to the patient’s circumstances which need to be weighed in the balance including, for example:-
- age-appropriate accommodation;
- whether the treatment is available, practically to the patient, rather than theoretically;
- the location of the available treatment;
- its implications for the patient’s family and social relationships;
- its implications for the patient’s education or work;
- the patient’s gender, culture and ethnicity;
- any other health problems they are experiencing;
- the consequences of not providing it, in terms of the risk and nature of potential harm; and
- the alternative, which for some offenders will be a prison sentence.

12.8 Available treatment need not be the most appropriate medical treatment that could ideally be made available. Nor does it need to address every aspect of the person’s disorder. But the treatment to be offered must be an appropriate response to the patient’s condition and situation.

12.9 Where appropriate medical treatment is available no one should be excluded from detention, or discharged, solely because it cannot be shown that the treatment is not only for the right purpose but is likely to produce any particular benefit or outcome. What is appropriate will vary greatly between patients. It will depend, in part, on what might reasonably be expected to be achieved given the nature and degree of the patient’s disorder. For example, treatment which is aimed merely to prevent a disorder worsening is unlikely, in general, to be appropriate in cases where standard treatment approaches would aim and be expected significantly to alleviate the patient’s condition. On the other hand, given the definition of medical treatment in the Act, for some patients decision-makers may conclude that specialist care under the clinical supervision of an Approved Clinician in a safe and secure therapeutic environment with a structured regime may be sufficient to constitute appropriate medical treatment in the light of the nature and degree of their mental disorder and their other circumstances. Simply detaining someone – even in a hospital – does not constitute medical treatment.

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

12.11 The reason for which a patient is detained is also relevant to whether the appropriate medical treatment test is met. So, for example, where a patient is detained under section 3 because medical treatment is necessary in the interests of his or her own health or safety, and clinicians conclude that his or her condition
poses no risk to others, medical treatment would not be considered appropriate if it were directed solely at the protection of other people.

12.12 It is not necessary for decision-makers to be satisfied that appropriate medical treatment will be available for every aspect of the patient’s condition, nor for the whole course of the patient’s treatment. What is appropriate may change over time, as the patient’s condition changes or clinicians obtain a greater understanding of the patient’s case. But decision-makers must satisfy themselves that medical treatment is available which is appropriate, given the patient’s condition and circumstances as they are currently understood. If they are not personally able to provide or secure appropriate services, they need to establish whether there is a suitable service provider willing to accept the patient before concluding that appropriate treatment is not available.
13. Medical treatment under the Act and second opinions

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

13.2 Specific guidance for the relevant sections of Part 4 and 4A are given below, together with guidance towards the end of the chapter on seeking second opinions.

**General**

13.3 Part 4 of the Act provides specific statutory authority for specific types of medical treatment for mental disorder to be given to most patients liable to be detained, without their consent in certain circumstances. Provisions affecting medical treatment of supervised community treatment (SCT) patients in the community are found in Part 4A of the Act.

13.4 Part 4 also provides specific safeguards to all patients (whether subject to compulsion under the Act or not) in relation to treatments that give rise to special concern.

13.5 Both Part 4 and 4A of the Act only apply to medical treatment for mental disorder. This includes treatment to alleviate the symptoms and manifestations of mental disorder as well as treating the underlying cause of the condition. Part 4 and Part 4A do not apply to the treatment of physical disorders unless it can reasonably be said that treating the physical disorder is ancillary to the treatment of the mental disorder (for example, treating self-inflicted wounds). If in doubt the person in charge of the treatment should seek appropriate legal advice.

13.6 It should not be assumed that a patient subject to the Act lacks capacity to consent to any or all of their treatment; for detained patients and those subject to supervised community treatment, the patient’s consent should be sought for all proposed treatments, even if they may be lawfully given under the Act without consent. It is the professional responsibility of the person in charge of the treatment to ensure that valid consent has been sought. The interview(s) at which such consent is sought should be properly recorded in the patient’s case notes.

13.7 The provisions of Part 4 and 4A are summarised below in the relevant parts of this chapter.

**Responsibilities for operating Part 4 and 4A**

13.8 Promoting the welfare of the patient by the implementation of the requirements under Part 4 and Part 4A and their safeguards requires careful planning and management. Every professional involved in the medical treatment of mental disorder should be familiar with all provisions of the Act, but it is the

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12 *B v Croydon Health Authority* [1995] 2 WLR 294
responsibility of the Approved Clinician in charge of the treatment in question to ensure that there is compliance with the Act’s provisions relating to medical treatment.

13.9 The patient’s Responsible Clinician is responsible for ensuring that Part 4 and Part 4A procedures are followed in relation to that patient. Such responsibility is a continuing one and will apply even if another professional is in charge of the relevant aspect of the patient’s treatment.

13.10 Overall responsibility for ensuring that these provisions of the Act are complied with rests with the Hospital Managers who should ensure that proper arrangements are made to enable Responsible Clinicians and Approved Clinicians in charge of treatment to discharge their responsibilities, but all professional staff involved with the implementation of Part 4 and Part 4A should be familiar with the provisions and the procedures for their implementation.

13.11 Patients have a statutory right to be informed about the provisions of Part 4 and Part 4A of the Act as it relates to them. Further guidance is given in chapter 17.

13.12 The Approved Clinician in charge of the treatment will often be the patient’s Responsible Clinician. There may, however, be circumstances where the Responsible Clinician is not (or does not feel) appropriately qualified to be in charge of a particular treatment, for example, the prescribing of medication where the Responsible Clinician is not a registered medical practitioner or a nurse prescriber. In such cases, the Responsible Clinician will maintain his or her overarching responsibility for the patient’s case, but the part of the patient’s treatment that they are not appropriately qualified to be in charge of, should be managed by an appropriately qualified Approved Clinician.

13.13 Where the Approved Clinician in charge of a particular treatment is not the patient’s Responsible Clinician, he or she should ensure that the Responsible Clinician is kept informed about the treatment and that treatment decisions are discussed with the Responsible Clinician.

13.14 The Act sets out when the person in charge of a treatment must be an Approved Clinician, and when this is not applicable. The person in charge of a particular treatment need not be an Approved Clinician where:-

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

13.15 The person in charge of a treatment must be an Approved Clinician where the treatment is given:-

- under section 58;
- under s58A to a person other than an informal patient under 18 year old; or
- to a person who lacks capacity under Part 4A.
Section 57 – Treatments requiring consents and a second opinion

Quick summary:-

- Concerned with neurosurgery for mental disorder (sometimes known as ‘psychosurgery’) and the surgical implantation of hormones for the reduction of male sexual drive.

- Can only be given if the patient consents and three independent people appointed by the Mental Health Act Commission have certified that the patient understands the treatment and has consented to it.

- These provisions apply to all patients whether or not they are liable to be detained or otherwise subject to the Act.

13.16 A decision to give treatment under section 57 requires careful consideration because of the ethical issues and possible long term effects. Before the person in charge of the treatment refers the case to the Mental Health Act Commission (MHAC) for a second opinion:

- the referring professional should personally satisfy him or herself that the patient is capable of giving valid consent and has consented;

- if the patient is not subject to detention he she is to be advised of their right to independent mental health advocacy (IMHA) services. A detained or community patient should be reminded of their right to IMHA services;

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

- for neurosurgery for mental disorder, the consultant considering the patient's case should have fully assessed the patient as suitable for such surgery. The case should be referred to the MHAC before the patient is transferred to the neurosurgical centre for the operation. The MHAC organises the attendance of two appointed persons and a doctor. The appointed persons and the doctor will usually visit and interview the patient at the referring hospital at an early stage in the procedure; and

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

13.17 Section 57 refers to treatments such as the surgical implantation of hormones only for the reduction of male sexual drive where it is administered as a medical treatment for mental disorder. If there is any doubt as to whether it is a mental disorder which is being treated, independent legal and medical advice should be sought. The advice of MHAC should also be obtained about arrangements for implementing section 57 where necessary.
The ‘appropriate medical treatment test’

Quick summary:-

- Concerned with the administration of medicine beyond three months.
- These treatments can only be given if the patient consents or an independent medical practitioner appointed by the Mental Health Act Commission certifies treatment may be given.
- These provisions apply to all patients liable to be detained, except those detained under sections 4, 5, 35, 37(4), 135 and 136. The provisions also apply to community patients recalled to hospital or where the community treatment order is revoked (unless section 62A applies – see below). The provisions do not apply to those conditionally discharged under section 42(2), and sections 73 and 74.

Medication during the first three months

13.18 The three month period starts from the first occasion when medicine (of any type) for mental disorder is given to a patient to whom this provision applies. The period starts irrespective of whether or not the patient consents to the treatment. Medication does not necessarily have to be administered continuously throughout the three months, but the three month period must be continuous.

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

13.20 This period gives time for the Approved Clinician in charge of the treatment in so far as it relates to the medication to develop a treatment programme suitable for the patient's needs. Even though the Act allows treatment to be given without consent during the first three months the Approved Clinician in charge of the treatment should ensure that the patient's valid consent is sought before any medication is administered. The patient's consent or refusal should be recorded in the case notes. If such consent is not forthcoming or is withdrawn during this period, the Approved 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

13.21 A system should be in place for reminding both Approved Clinicians in charge of treatment and detained patients at least four weeks before the expiry of the three month period.
13.22 Before the three month period ends the Approved Clinician in charge of the patient's medication should personally seek the patient’s consent to any continuing medication, and such consent should be sought for any subsequent administration of medication. A record of the discussion with the patient with reference to his or her capacity to consent should be made by the Approved Clinician in charge of the patient’s medication in the medical notes.

13.23 If the detained patient consents to receiving medication, the Approved Clinician in charge of the medication must certify accordingly using Form [x]. On the certificate the Approved Clinician in charge of the medication should indicate all drugs proposed, including medication given "as required", either by name or, ensuring that the number of drugs authorised in each class is indicated, by the classes described in the British National Formulary (BNF). The maximum dosage and route of administration should be clearly indicated for each drug or category of drugs proposed.

13.24 The original Form [x] should be kept with the original detention papers, and copies kept in the case notes and with the patient's medicine chart, so as to ensure that the patient is given only medication to which he or she has consented. It is important that all such additional copies are cancelled if the patient's consent is withdrawn or the patient ceases to be capable of consenting.

13.25 If the patient's consent is not forthcoming, the Approved Clinician in charge of the medication must comply with the safeguard requirements of section 58. Urgent treatment may be authorised within the circumstances set out in section 62.

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

**Section 58A – Electro-convulsive therapy (ECT)**

**Quick summary:-**

- **Concerned with the administration of ECT at any time.**
- **For patients over 18 years, this treatment can only be given if the patient consents or an independent medical practitioner appointed by the Mental Health Act Commission certifies treatment may be given if the patient is incapable of consenting. These provisions apply to all adult patients liable to be detained, except those detained under sections 4, 5, 35, 37(4), 135 and 136. The provisions also apply to community patients recalled to hospital or where the community treatment order is revoked (unless section 62A applies – see below). The provisions do not apply to adult patients who are conditionally discharged under section 42(2), and sections 73 and 74.**
• For all patients (including informal patients) under 18 years, this treatment can only be given if an independent medical practitioner appointed by the Mental Health Act Commission certifies treatment may be given if a patient capable of consenting gives their consent or is incapable of consenting but it is appropriate the treatment is given.

13.27 Section 58A(1) provides that ECT (and any other treatment which may be provided for by regulations made by the Welsh Ministers), can only be given when the patient either gives consent, or is incapable of giving consent. This provision is subject to the provisions about emergency treatment in section 62 of the Act. There are currently no other treatments covered by section 58A. This guidance therefore refers to ECT only.

13.28 It is good practice to give patients to be treated with ECT a leaflet 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.

Patients 18 years of age and older

13.29 When ECT is proposed, valid consent should always be sought by the patient's Approved Clinician in charge of the treatment.

13.30 Where a detained patient 18 years of age or older consents to treatment with ECT that consent must be certified by either the Approved Clinician in charge of the patient's treatment or a Second Opinion Appointed Doctor (SOAD) using Form [x]. The proposed maximum number of applications of ECT which may be administered must be specified on the form. In addition, a record of the discussion with the patient with reference to his or her capacity to consent should be made by the Approved Clinician in charge of the treatment in the patient’s case notes. Such information should be included in the patient's treatment plan.

13.31 Consent or a second opinion will be required again prior to the administration of further ECT if the patient withdraws consent or there is a break in the continuity of the patient's detention. If there is a change in the Approved Clinician in charge of the treatment prior to the administration of further ECT that Approved Clinician should be satisfied that the patient continues to consent to administration or that the certificate issued by the SOAD remains valid.

13.32 If the patient's valid consent is not forthcoming or is withdrawn, the treatment cannot be given except as provided for in the urgent circumstances as provided for in section 62(1A).

13.33 If the patient ceases to be capable of consenting to ECT and the Approved Clinician in charge of the treatment considers that such treatment must commence or continue, the requirements set out in section 58A(5) should be initiated as soon as possible.

13.34 Where a detained patient is incapable of consent, the SOAD must certify (using Form [x]) that the patient is not capable of understanding the nature, purpose and likely effects of the treatment and that it is appropriate for the patient to receive
the treatment prior to the treatment being administered. Before doing so, the SOAD has a statutory obligation to consult two other persons - one must be a nurse concerned with the patient’s medical treatment and the second must be another person professionally concerned with the patient’s medical treatment who is neither a nurse nor a doctor. The patient’s Responsible Clinician and the person in charge of their treatment (if they are not the Responsible Clinician) are excluded from being consulted by the SOAD.

13.35 The SOAD is prevented from giving such a certificate if it would conflict with:-

- a valid and applicable advance decision of the patient not to receive the treatment as provided for by the Mental Capacity Act 2005; or
- a decision made by a deputy or donee as defined by the Mental Capacity Act 2005, where the deputy or donee has the authority to refuse such treatment on behalf of the patient; or
- an order of the Court of Protection.

13.36 If subsequent to the issuing of the SOAD certificate, a deputy or donee for the patient objects to the treatment with ECT, the authority for treatment will immediately lapse. Similarly where a valid and applicable advance decision by the patient (made under the Mental Capacity Act 2005) objecting to ECT is identified, the authority for treatment will immediately lapse.

13.37 If a decision of the Court of Protection objects, on behalf of the patient, to the treatment of the patient with ECT, the authority for treatment will immediately lapse. In addition to the Court of Protection, the courts that have the jurisdiction to order that a treatment not be given. If such an order is made, legal advice should be sought on the validity of any extant certificate and the legal authority for continuing any such treatment of the patient.

13.38 If, subsequent to the issuing of the SOAD certificate, the patient gains the capacity to understand the nature, purpose and likely effects of being treated with ECT, the authority under Form [x] will immediately lapse. Where consent is then given by the patient to continue treatment, the Approved Clinician in charge should complete a Form [x], or a second opinion should be obtained. If the patient's valid consent is not forthcoming or is withdrawn, the treatment cannot be given except as provided for in the urgent circumstances as provided in section 62(1A).

13.39 Arrangements should be made for ensuring that invalid consent forms or invalid SOAD certificates are clearly marked as lapsed.

**Patients not yet 18 years of age**

13.40 As for adult patients, for patients under 18 years for whom ECT is proposed, valid consent should always be sought by the patient's Approved Clinician in charge of the treatment. A record of the discussion with the patient with reference to his or her capacity to consent should be made in the case notes.
13.41 Where a child patient who is either a detained patient or an informal patient not subject to a community treatment order (CTO) consents to such treatment, a SOAD must certify the patients capacity to consent as set out in section 58A(4)(c)(i) (using Form [x]) and that it is appropriate for the treatment to be given.

13.42 If the detained patient's valid consent is not forthcoming or is withdrawn, the treatment cannot be given except as provided for in the urgent circumstances as set out in section 62(1A). There is no legal authority to treat an informal patient under 18 years who is capable of consent and does not give that consent unless the provisions of section 62(1A) apply.

13.43 If subsequent to a SOAD certifying that ECT may be given and the patient withdrawing their consent, the authority for treatment will immediately lapse. If having given consent, the patient ceases to be capable of consenting to ECT, the authority under Form [x] will immediately lapse and the Approved Clinician in charge of the treatment will need to comply with the requirements of section 58A(5) which should be initiated as soon as possible, if it is proposed that such treatment should be continued.

13.44 If there is a break in the continuity of the patient's detention, the authority under Form [x] immediately lapses and the Approved Clinician must comply with the requirements at 58A which should be initiated as soon as possible.

13.45 Arrangements should be made for ensuring that invalid forms are clearly marked as lapsed.

13.46 Where an informal child patient (who is not subject to a CTO) is incapable of consent and there is authority to treat such a patient, the SOAD must similarly certify that the patient is not capable of understanding the nature, purpose and likely effects of the treatment and that it is appropriate for the patient to receive the treatment. Before doing so, the SOAD must first consult two other persons; one of whom must be a nurse concerned with the patient's medical treatment and the other another person professionally concerned with the patient's medical treatment who is neither a nurse nor a doctor. The person in charge of the patient's treatment is excluded from being a person whom the SOAD is required to consult.

13.47 The position set out in paragraphs 13.27 to 13.29 above apply to patients aged 16 or 17 years.

**Section 60 – withdrawal of consent**

13.48 A patient being treated in accordance with sections 57, 58 or 58A may withdraw their consent to that treatment at any time. Fresh consent for the implementing of procedures as required by those sections will then be required before further treatment can be carried out or reinstated, except as provided for under the urgent treatment provisions within section 62. 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; and
• of the power of the clinician in charge of the treatment to begin or continue urgent treatment under section 62, if applicable.

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

### Section 62 - urgent treatment

**Quick summary:**

- Applies only in respect of urgent administration of treatments falling with sections 57, 58 and 58A.

13.49 Any decision to treat a patient urgently under section 62 is the responsibility of the person in charge of the treatment in question or, in the absence of the person in charge of the treatment, of the person for the time being in charge of the treatment (in both cases, this person must be an Approved Clinician if the treatment is being given to a formal patient). The following matters must be considered:-

• there must be legal authority to treat the patient. Section 63 provides the authority for the treatment of those detained patients to whom section 63 applies. Section 62 provides the circumstances in which those patients can be treated in the absence of the application of the provisions at sections 57, 58 or 58A as appropriate. Section 62 also applies to informal patients for whom sections 57 and 58A also apply. The legal authority to treat such patient must be established before section 62 provides the circumstances in which those patients can be treated in the absence of the application of the provisions at section 57 or 58A;
• treatment can only be given where it is immediately necessary to achieve one of the objectives set out in section 62. It is insufficient for the proposed treatment to be simply ‘necessary’ or ‘beneficial’ or in order to treat a patient who would otherwise be required to consent to the treatment;
• the section specifically limits the use of "irreversible" or "hazardous" treatments. The person in charge of the treatment, or other appropriately qualified person, is responsible for judging whether treatment falls into either of these categories, and whether therefore the Act allows it to be given, having regard to generally accepted medical opinion;
• urgent treatment given under section 62 should only continue for as long as it is immediately necessary to achieve the statutory objective(s); and
before deciding to give treatment under section 62, the Approved Clinician in charge of the treatment, or the other clinician for the time being in charge of the treatment should wherever possible discuss the proposed urgent treatment with others involved with the patient's care.

13.50 The provisions at section 62(2) for continuing the treatment of a patient relate to where the SOAD certificate lapses as provided for at section 60 or is withdrawn as provided for at section 61(3) and where the circumstances provide for compliance with section 57, 58 or 58A as appropriate. Where compliance with the relevant section is not possible, for example where the patient has withdrawn consent for ECT and continues to competently refuse consent, compliance with section 58A is not possible and section 62(2) does not provide for continuing treatment with ECT.

13.51 The Hospital Managers should monitor the use of section 62 in their hospitals. They should ensure that a form is devised to be completed by the person in charge (or for the time being in charge) of the treatment in question every time urgent treatment is given under section 62, giving details of:-

- the proposed treatment;
- why it is of urgent necessity to give the treatment;
- the length of time for which the treatment was given; and
- if the treatment was given under section 62(2), the basis on which compliance with the relevant section was considered applicable.

Section 63 – treatments not requiring patients’ consent

13.52 Apart from the forms of treatment specified in sections 57, 58 and 58A, treatment for a detained patient's mental disorder which is given by or under the direction of the Approved Clinician in charge of the treatment does not require the patient's consent, although consent should wherever practicable always be sought.

13.53 Medical treatment is defined in section 145. The treatment must be for the mental disorder(s) from which the patient is suffering, but this need not be for the disorder on the basis of which the patient was first detained.

13.54 As well as applying to medication administered in the first three months, section 63 will extend to a wide range of therapeutic activities involving a variety of professional staff, including psychological and social therapies. In practice, it is unlikely that these psychological and social therapies could be undertaken without the patient's acceptance and active co-operation. Acceptance in relation to such procedures requires a clear expression of agreement between the patient and the therapist before the treatment begins. The agreement should be expressed positively in terms of willingness to co-operate rather than as an indication of passive submission.
13.55 The role of the SOAD under both Part 4 and Part 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 judgment as to whether the proposed treatment is appropriate in the light of the general consensus about treatment for the condition in question. The SOAD is responsible for any opinion he or she gives. Any opinion cannot be appealed against to the Mental Health Act Commission.

13.56 When interviewing a patient, the SOAD must determine whether the patient is capable of giving valid consent. If the patient does not give or is not capable of giving consent, the SOAD has to determine whether the treatment proposed by the person in charge of that treatment is appropriate for the patient’s mental disorder and should be given.

13.57 In reaching his or her judgment, the SOAD should consider not only the therapeutic efficacy of the proposed treatment but also, where a capable patient is withholding consent, the reasons for doing so should be given their due consideration. Where a patient who is not capable of consenting has made a valid and applicable advance decision under the Mental Capacity Act refusing the treatment in question, that refusal must be taken into account. Where an advance statement requesting an alternative treatment has been made, the patient’s wishes, as set out in that statement, should be given due weight.

Responsibilities of the Hospital Managers

13.58 Hospital Managers should ensure that:-

- in relation to the administration of medication to a patient, a system exists for informing a patient liable to be detained prior to the expiry of the ‘three month period’ that his or her consent, or a second opinion, will be required prior to the administration of further medication (see section 58(1)(b);
- a system exists for informing a community patient that at the expiry of the specified period a second opinion will be required, even if that patient is consenting to treatment;
- in the case of either of the above, a system exists for reminding the Approved Clinician in charge of the treatment in question prior to the expiry of the three month period set by section 58 or (as the case may be) the one month period set by section 64B that the appropriate certification will be required for treatment to continue; and
- a system exists for reminding the Approved Clinician in charge of the treatment when a new certificate will be needed, either at the end of the period specified in the SOAD’s certificate, or where an expiry date has been set as a result of the review of the treatment as required under section 61.
Arranging and preparing for the visit of the SOAD

13.59 If a SOAD visit is required, the person in charge of the treatment in question is responsible for ensuring that a request for a second opinion is made. Arrangements should be made with the Mental Health Act Commission for the SOAD’s attendance; for a community patient this should be at a mutually agreed place, for example at an outpatient clinic which the patient might visit weekly.

13.60 The Hospital Managers in consultation with the person in charge of the treatment are responsible for ensuring that the patient is available to meet the SOAD and that the following people are available in person at the time the SOAD visits:-

- the person in charge of the treatment in question;
- the patient’s Responsible Clinician (if that person is different from the person in charge of the treatment);
- the statutory consultees;
- any other relevant persons;
- and, where required by section 58A in the case of a patient who lacks capacity to consent, that the following persons have been given a reasonable opportunity to be available in person -
  - any donee or deputy of the patient with appropriate authority related to the patients treatment with ECT; and
  - any person who can advise of a patient’s advance decision to refuse treatment with ECT where that advance decision is not otherwise documented.

13.61 Information relating to the proposed treatment 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. In addition, the following documents should also be available:-

- copies of the statutory documents relating to the patient’s detention under the Act, with the original documentation available for viewing by the SOAD if he or she requests. Where the patient is subject to a community treatment order, copies of the order should also be available to the SOAD;
- the patient's case notes including records of past responses to the proposed and similar treatment and the past expressed wishes of the patient regarding the proposed and similar treatments;
- any advance decisions and advance statements of the patient relevant to the proposed treatment; and
- any court orders (including those of the Court of Protection) regarding the proposed treatment.

13.62 Adequate facilities must be made available for the visit.
The SOAD visit

13.63 During a visit the SOAD should:-

- in the case of a detained patient or community patient, satisfy him or herself that the patient's detention or CTO papers are in order;
- 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;
- wherever possible, discuss the case with the person in charge of the treatment in question face to face;
- consult with two other persons professionally concerned with the patient's care as required by the Act (i.e. the statutory consultees). The SOAD should be prepared, where appropriate, to consult a wider range of persons professionally concerned with the patient's care than those required by the Act (e.g. the GP) and, with the patient's consent, the patient's Nearest Relative, family, carers or advocates; and
- consult with (in the case of certificates issued under section 58A for patients who do not have capacity to consent) the patient, clinical staff and, with the patient's consent, the patient's Nearest Relative, family, carers or advocates on the existence of relevant advance decisions or orders of the Court of Protection and on the existence of a deputy or donee.

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

13.65 The SOAD may not be able to reach a decision at the time of the first visit. In these circumstances the patient should be told of the delay. Once a decision has been reached, the SOAD should record details of the visit and the reasons for the decision they have made. They should provide the person in charge of the treatment with a copy of those reasons. The SOAD should also indicate whether, in his or her 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.

13.66 Where it is intended to impose the authorised treatment without delay, or where the written statement of reasons will be required on the day of the SOAD visit, the Commission should be so informed when the request for a second opinion is made.
13.67 It is the personal responsibility of the person in charge of the treatment to communicate the results of the SOAD visit to the patient. In most cases, communication of the result of the visit need not be postponed until a statement of reasons has been received by the SOAD. When the statement of the SOAD is received, the patient should be given the opportunity to see it as soon as possible, unless the person in charge of the treatment (or the SOAD) thinks that it would be likely to cause serious harm to the physical or mental health of the patient or any other person.

13.68 Documents provided by the SOAD consequent to his or her visit, including a copy of their decision will comprise part of the patient’s case notes and should be held in those notes. The person in charge of the treatment should record their actions in providing the patient with the reasons supplied by the SOAD.

13.69 For patients treated under Part 4, only when the SOAD has signed form [x] mass treatment may be given without the patient’s consent, except as provided in section 62. For patients treated under Part 4A only when the SOAD has signed the Part 4A certificate (form [x]) may treatment be given for which such a certificate is required even if the patient consents to it.

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

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

13.72 If the patient’s situation subsequently changes the person in charge of the treatment in question may contact MHAC and request a further second opinion.

Role of the statutory consultees

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

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

- another person similarly concerned, who has direct knowledge of the patient in their professional capacity, and who is neither a nurse, a doctor, the person in charge of the treatment or the patient’s Responsible Clinician; for example, a social worker, occupational therapist, psychologist, psychotherapist, or pharmacist.

13.74 For community patients treated under Part 4A, the SOAD must consult two persons who have direct knowledge of the patient in their professional capacity. One of these must not be a doctor, and neither of the two may be the patient’s Responsible Clinician or the person in charge of the treatment in question. Consultees could, depending on the circumstances of the case, include an AMHP, psychologist, psychiatric nurse, or occupational therapist.
13.75 Any person whom the SOAD proposes to consult must consider whether he or she is sufficiently concerned professionally with the patient’s care to fulfil the function. If not, or if the person feels that someone else is better placed to fulfil the function, he or she should make this known both to the person in charge of the treatment in question and to the SOAD in good time.

13.76 Consultees should expect a face to face discussion with the SOAD and to be listened to with consideration; only in exceptional cases should the discussion take place via the telephone. Consultees should ensure that they make a record of their consultation with the SOAD which is placed in the patient's case notes.

13.77 Amongst the issues that a consultee should consider are:-

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

### Review of treatment

**General**

13.78 All treatments, whether or not section 61 of the Act applies to them (see below), should be regularly reviewed and the patient's treatment plan should include details of when this will take place. Although the Act does not require reviews of the validity of forms [x etc] it is good practice for them to be reviewed at regular intervals. When such a review is carried out and it is found that the conditions are satisfied a new form [x etc] as applicable should be completed.

13.79 A new form should also be completed or new SOAD referral made as appropriate:-

- if there is a change in the treatment plan from that recorded;
- if consent is given again after being withdrawn;
- when there is a break in the patient's detention;
- when there is a permanent change of the Approved Clinician in charge of the treatment in question;
• when the patient’s detention is renewed or at annual intervals (whichever is earlier); and
• if there is a change in the hospital where the patient is detained.

13.80 If the patient subsequently withdraws his or her consent and it is considered that the treatment should still be given, a second opinion must be sought.

13.81 When a Part 4A certificate review is carried out, a new Part 4A certificate should be completed if there is a change in the treatment plan from that recorded or if the conditions applied to the certificate are to change.

Section 61

13.82 Section 61 of the Act sets out the circumstances in which a report on the treatment and the patient’s condition must be given by the Approved Clinician in charge of the treatment to MHAC on behalf of the Welsh Ministers. Where the SOAD’s certificate is time limited, or has been made conditional on a review of the treatment taking place at a date earlier than the first statutory review, a report following such review should be provided to MHAC. The MHAC have developed a form for the purposes of section 61, and copies of this form are available from MHAC’s offices.

13.83 When submitting a report under section 61 in respect of a patient who had not previously consented to the section 58 treatment, or who has attained the age of 18 years and consented to section 58A treatment, the person in charge of the treatment should advise MHAC if a patient for whom a certificate of second opinion had previously been issued has since given consent and the consent is still valid.

13.84 Once the treatment has been reviewed and the MHAC’s review form completed, a copy of that form should be given to the patient.

13.85 After receipt of a review report, MHAC will, when necessary, send a SOAD to reassess the patient and decide whether the treatment should continue.
14. Psychological treatments

14.1 This chapter outlines the background to psychological treatments and provides guidance in respect of the issues regarding consent to such treatments. The chapter also outlines the competencies, training and supervision required to offer such treatment, as well as providing guidance on the treatment of children.

14.2 Psychological treatments form an important part of modern mental health care. They are part of a holistic approach, which looks at the needs of individuals rather than simply trying to treat symptoms and labelling people with a diagnosis.

14.3 In addition to considerations of psychological interventions with the individual patient, the person in charge of the treatment and the clinical team should also make routine use of a psychological perspective to assist the formulation of a patient’s presenting problems and difficulties and to inform multi-disciplinary care planning and management of the individual.

14.4 A number of clinical guidelines have been published for mental health reflecting careful review of the evidence available for psychological treatments. Healthcare professionals are expected to take these fully into account when exercising their clinical judgement. Such guidance does not, however, override the individual responsibility of staff to make decisions appropriate to the circumstances of the individual patient under the Act.

14.5 The provision of psychological interventions can be usefully thought of as relating to 3 levels, which can inform the treatment of those under the Act:-

- First level - Psychological treatment as an integrated component of mental health care. This includes good practice in routine patient care, such as listening skills, basic counselling and stress management and problem solving. This reflects an initial level of training and basic mental health care.

- Second level - Prescribed psychological interventions following structured packages such as behavioural modification and structured counselling with specific treatment targets. This reflects an intermediate level of training.

- Third level - Formal psychological interventions based on theoretical models and evidence but individually tailored to a patient’s unique needs. This reflects an advanced level of training.

14.6 This chapter is primarily concerned with the second and third levels described above although the principles also apply to first level work. First level activities should still be recorded in the clinical records as evidence about the patient’s presentation, engagement and response to their care.
14.7 At admission into hospital (whether under the Act or informally) at referral meetings, initial clinical team review and then at subsequent regular intervals following, psychological therapies should be considered as a routine treatment option and the clinical team’s deliberations recorded in the case record(s).

14.8 Any programme of psychological intervention should form part of the agreed care plan and be recorded in the case record(s) as such. At no time should it be used as an isolated and spontaneous reaction to a particular type of behaviour.

14.9 Any decision to use second or third level psychological treatments should be preceded by full discussion between the professional staff concerned and the patient. Additionally carers, advocacy and voluntary sector workers, when involved should also be consulted following the patient’s informed consent to take part in any level two or three psychological therapy.

14.10 Psychological interventions should be regularly reviewed by the clinical team and the results of reviews recorded in the patient’s case record(s). Objective evaluations of such treatments should also be recorded in the case record(s).

Consent to treatment

14.11 Prior to the use of treatments that require authorisation under section 57 of the Act, the person in charge of the treatment should ensure that options for psychological treatments have been fully explored and evidence for this recorded in the case record(s).

14.12 Prior to use of electro-convulsive therapy authorised under section 58A of the Act, the Responsible Clinician should ensure that options for psychological treatments have been fully explored and evidence for this recorded in the case notes.

14.13 In making recommendations for psychological treatments the Responsible Clinician (following discussion within the clinical team), or the Mental Health Review Tribunal, should show consideration of the nature of the mental disorder, the patient’s ability to make use of psychological interventions, their acknowledgement of problems, their amenability to and motivation to engage in such work and its treatment targets.

Training and supervision of staff offering psychological treatments

14.14 Staff participating in the delivery of second and third levels of psychological treatments, need to ensure that they are appropriately trained. Such training should be updated in line with continuing professional development guidelines. They should also have appropriate supervision and be subject to robust clinical governance arrangements.
14.15 Formal supervision has an important role in ensuring the quality of care. Where psychological treatments that fall within the second or third levels form part of the care plan and may be reviewed as part of the evidence for an individual’s ongoing detention under the Act, such work would preferably be formally supervised by another practitioner qualified to provide interventions at or above that level. When supervised by another profession in the delivery of psychological treatments, issues regarding professional accountability remain within that disciplines line management structures.

**Psychological treatments and children**

14.16 When considering the provision of psychological therapies to children and young people who are under the Act liable to be detained or to recall, due consideration should be given to relevant evidence and best practice guidance relating to the use of such therapies with children and young people.
15. Supporting patients safely and therapeutically

15.1 This chapter relates to interventions that are sometimes employed to ensure the safe, supportive and therapeutic management of patients whose behaviour presents a risk to themselves or others.

15.2 Although this is intended as guidance on the management of patients subject to compulsion, the principles set out in this chapter should apply to all patients under the care of mental health services. Indeed, in some circumstances, there may be legal authority for taking immediately necessary steps in relation to patients who are not subject to the Act.

General principles

15.3 Individuals in need of care and treatment for mental disorder may, as a consequence of their illness, present risks to themselves or others. Such risks are usually associated with behaviours that challenge care staff. These might include: hyperactivity, absconding, self-harming, sexual dis-inhibition, sexually inappropriate behaviour towards others, aggressive and threatening behaviour towards others and physical violence.

15.4 When managing such behaviours, staff should aim to support patients in a therapeutic not a punitive manner, and in such ways that ensure their safety and optimise their privacy and dignity.

15.5 Interventions employed to manage the risks associated with these behaviours should be undertaken with the principle of "least restriction" in mind at all times. They should always be carried out in a manner that minimises patient distress and discomfort, and should never be carried out in such a manner that requires deliberately subjecting patients to physical pain.

15.6 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.

Prevention

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

15.8 Effective preventive management of behaviours that challenge care staff is dependent on staff understanding 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; and
• the presence of an unsuitable patient mix within care environments.

15.9 Although individual care planning is fundamental to the appropriate management of behaviours that challenge, problems may be minimised by considering the environment of care, patient involvement in their care, and systematically identifying and managing problem areas. General measures to be taken might 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 the patient;
• providing each patient with a defined personal space and a secure locker;
• ensuring patients have 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 are able to make telephone calls;
• keeping patients fully informed of what is happening to them and why;
• seeking patients' co-operation with, and encouraging their participation in, their care planning;
• identifying those patients in need of special levels of observation;
• involving patients in identifying their own trigger factors and early warning signs of disturbed behaviour, and agreeing with them methods of managing disturbed behaviour; and
• ensuring that patients' complaints are dealt with quickly and properly.

15.10 Effective patient observation is fundamental to the successful prevention of untoward patient related incidents, including aggression and violence. Observation must be seen as a fundamental aspect of patient engagement and all aspects of care management. It should not be considered simply as a task to be carried out on prescription.

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

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

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

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

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

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

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

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

15.18 Where a patient is deprived of liberty in a hospital for mental health treatment under the Deprivation of Liberty Safeguards (DoLS) of the Mental Capacity Act 2005, if restraint is necessary this may well indicate that the patient objects to treatment, or to being in the hospital. In such a situation, the patient has therefore ceased to be eligible to be deprived of their liberty under a DoLS authorisation. Consequently, consideration must given as to whether the patient can and should be detained under the Mental Health Act.

15.19 Interventions used to restrain patients may take several forms. The most commonly used being verbal and/or physical restraint.
15.20 Clinically acceptable methods of restraint include:

- limiting a patient’s disruptive behaviour by giving firm instructions;
- the use of holding techniques; and
- confining patients to a limited space or closed room.

15.21 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.

15.22 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 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; and
- absconding or the risk of absconding.

15.23 Any methods aimed at reducing and eliminating unacceptable behaviour should take account of the:

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

15.24 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; and
- be carried out in a way that demonstrates respect for the patient's gender and cultural sensitivities.
15.25 Throughout the period when a physical intervention is being used relevant Welsh Assembly Government and other national guidance, including NICE guidelines, should be adhered to.

15.26 Service providers should have in place a system of post-incident support and review, which allows the organisation, their staff and patients to learn from the experience of using restraint.

15.27 Such post-incident 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 when the restraint occurred; and
- visitors who witnessed the incident.

### Medication

15.28 Medication should never be used as a substitute for adequate staffing when managing patients. Other than in exceptional circumstances, the control of behaviour that challenge using medication should only be used after careful consideration, and as part of an agreed treatment plan.

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

15.30 Restraint may be used in order to administer medication (or other forms of treatment) to an unwilling patient, where there is legal authority to treat the patient without consent. It should never be used unless there is such legal authority.

15.31 The use of restraint to administer treatment in non-emergency circumstances should be properly documented in the patient’s notes, along with the justification for it.

### Seclusion

15.32 Seclusion is the supervised confinement of a patient in a room, which may be locked to protect the patient, or others, from significant harm. Its sole aim is to contain severely disturbed behaviour which is likely to cause harm.
15.33 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.

15.34 Seclusion should not be used:-

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

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

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

15.37 If the need for seclusion is disputed by any member of the multi-disciplinary team, the matter should be referred immediately to a senior manager.

15.38 A suitably skilled practitioner should be readily available within sight and sound of the seclusion room at all times throughout the period of the patient’s seclusion, and present at all times with a patient who has been sedated.

15.39 The aim of observation is to monitor the condition and behaviour of the patient and to identify the time at which seclusion can be terminated. The level should be decided on an individual basis and the patient should be observed continuously. A documented report must be made at least every 15 minutes.

15.40 The need to continue seclusion should be reviewed:-

- every 2 hours by 2 nurses (or other suitably skilled practitioners); and
- every 4 hours by a doctor, or a suitably qualified approved clinician.

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

15.42 Any room used for the seclusion of patients should:-

- provide privacy from other patients, but enable staff to observe the patient at all times;
be safe and secure, and not contain anything which could cause harm to the patient or others;
be adequately furnished, heated, lit and ventilated; and
be quiet, but not soundproofed, and with some means of calling for attention.

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

15.44 Special consideration should be given when using the guidance set out in this chapter to inform the care and treatment of children and young people. When managing children and young people who exhibit any of the behaviours that challenge, as referred to in this chapter, staff should always ensure that such interventions are delivered in accordance with best practice guidance relevant to the age of the patient being cared for.

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

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

15.47 Written local policies on the locking of clinical areas should be in place. These should be on clearly on display within all relevant environments of care, and explained to each patient on admission.

15.48 The professional in charge a clinical area, during any span of duty, is responsible for the care and protection of patients and staff and the maintenance of a safe environment of care, within that clinical area. The professional in charge of an environment of care during a span of duty 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.

15.49 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 taking such action;
• inform all other patients 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 of the action taken;
• inform the relevant Responsible Clinicians or nominated deputies; and
• keep a record of the action, using local incident reporting procedures.

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

15.51 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.

15.52 Locking doors, placing staff on reception to open doors appropriately, use of electronic swipe cards are all methods which providers may deploy to ensure the safety of their patients (including protection from outsiders whose presence on a ward would put patients' health at risk).

15.53 If managing access and egress by means of permanently locked external doors is considered to be the most appropriate approach to maintaining the safety of patients there must be in place a process of regular review of such practice, to ensure there are clear benefits for patients of such action, and that such action is not simply used for staff convenience.

15.54 There are patients who, whether or not they understand the risk involved, persistently or purposefully attempt to leave a ward or hospital. In these cases, consideration must be given to whether they are in fact being deprived of their liberty and, if so, whether authorisation needs to be sought under the Deprivation of Liberty Safeguards of the Mental Capacity Act. Alternatively, assessment for formal detention under the Act should be considered or the person moved to a safer environment.

15.55 Service commissioners 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.

15.56 Service commissioners and providers are responsible for ensuring that their staff have an understanding of extant legislation and national clinical guidance on these issues, and that they are properly trained to work within the context of locally agreed policies and procedures. These policies must take into account relevant best practice guidance, particularly NICE guidelines and Welsh Assembly Government policy.

Supporting clinical staff

15.55 Service commissioners 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.

15.56 Service commissioners and providers are responsible for ensuring that their staff have an understanding of extant legislation and national clinical guidance on these issues, and that they are properly trained to work within the context of locally agreed policies and procedures. These policies must take into account relevant best practice guidance, particularly NICE guidelines and Welsh Assembly Government policy.
15.57 Service commissioners and the senior management teams of service provider organisations must satisfy themselves that clinical areas in which patients that are likely to present with behaviours that challenge are cared for, benefit from appropriate staffing levels and skill mix at all times.

15.58 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; and
- audit and evaluation processes.
16. Personal searches

16.1 This chapter provides guidance on the approach which should be taken to personal searches, and gives guidance on the areas which should be included in the development and application of local policies regarding searches.

Objectives for searching

16.2 The objectives for conducting a search are firstly for the creation and maintenance of a therapeutic environment in which treatment may take place and secondly the maintenance of the security of the establishment and the safety of patients, staff and the public. It is recognised that these two objectives, may be by necessity, in conflict with one another. However, necessary and lawful searches of both patients and visitors make an important contribution to the effective management of in-patient settings, but unlawful, insensitive and unnecessary searches can create management difficulties.

Approaches to be taken in undertaking searches

16.3 The general principle is that the use and kind of search undertaken should be proportionate to the identified risk, and involve the minimum possible intrusion on the individual’s privacy. Random searches should only occur in exceptional circumstances, i.e. potentially violent and/or dangerous situations.\(^{13}\)

16.4 In all cases, the consent of the patient should be sought before a search is attempted. If consent is duly given, the search should be carried out with due regard for the dignity of the individual and the need to ensure maximum privacy. If consent is refused by a patient, the person with overall responsibility for the patient’s care and treatment should first be contacted in order that any clinical objection to searching by force may be raised. If a clinical objection is raised, but the person empowered to search wishes nonetheless to proceed, the matter should be referred to the senior manager of the hospital, or his or her on-call deputy, for decision.

16.5 Where a patient physically resists being searched, physical intervention should only proceed on the basis of a multidisciplinary assessment. Following every search undertaken where patient consent has been withheld, there should be a post-incident review; the review should include consideration of the approach taken if there is physical resistance to the search.

16.6 If a decision is made not to proceed with the search, then alternative options must be considered to deal with the situation.

16.7 Where a patient’s belongings are removed during a search, the patient should be given a receipt and told where the items will be stored.

\(^{13}\) R v Broadmoor Special Hospital Authority ex parte S [1998] COD 199.
16.8 Searches are the responsibility of nursing staff except in exceptional circumstances when the assistance of others, including the police, may be needed.

**Hospital Managers’ policy**

16.9 The Hospital Managers should ensure that there is an operational policy on searching patients detained under the Act, the patient’s belongings, and the environment in which they live, and on searching visitors. When preparing the policy Hospital Managers should consider the position of informal patients at the same time.

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

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

16.11 The policy should cover:-

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

16.13 The exercise of powers of search should be audited regularly and the outcomes reported from time to time to the Hospital Managers. Where indicated, consideration should be given to working with the police on specialised searching for detection of illicit drugs.
17. **Information for detained patients, those subject to supervised community treatment or guardianship, and Nearest Relatives**

17.1 This chapter sets out the information that must be given and explained to all detained and community patients. It gives guidance on how and when that information should be given, and also considers the delivery of information to the Nearest Relative of the patient.

17.2 This chapter also considers the information that should be given to patients who have been received into guardianship, as well as informal patients.

17.3 Where this chapter gives guidance on the duty to give information about independent mental health advocates, this should be read in conjunction with chapter 21 of this Code.

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**The information that must be given to the patient**

17.4 There is both information that must be imparted to all patients upon detention under the Act, and also particular information relevant to an individual’s case. Sections 132(1) and 132A(1) of the Act require that patients who are detained under the Act or who are subject to supervised community treatment (SCT) are informed of the provision of the Act under which they are detained, and their right of application to the Mental Health Review Tribunal. In addition to this information all patients detained under the Act or subject to SCT should be provided with the following information where relevant.

**Information on detention, renewal and discharge**

17.5 The patient should be informed:–

- of the provision of the Act under which they are detained or liable to recall and the reasons for their detention or community treatment order;
- that they will not automatically be discharged when the current period of detention or community treatment ends;
- that their detention will not automatically be extended when their current period of detention or community treatment ends; and
- of their right to have their views about being detained, being subject to a community treatment order, or being discharged considered before any decision is made.

17.6 For the patient to be able to adequately and effectively challenge the grounds for the detention, should they wish, they should be informed of the facts of their detention rather than the broad reasons why a section may be applied to a person.\(^\text{14}\)

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\(^\text{14}\) *X v United Kingdom (1981) 1 BMLR 98, also Van der Leer v Netherlands (1990) 12 EHRR 567*
The patient should receive copies of the detention papers (or equivalent court orders, directions from the Secretary of State, or transfers from another jurisdiction) unless the Hospital Managers are of the opinion 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 of third parties (for example, addresses of assessors) before providing the papers to the patient.

17.7 If the section under which the patient is being detained changes, then the information should again be given within the context of the new section under which they are being detained.

**Information on appeal against detention**

17.8 The patient should be informed:-

- of the role of the Mental Health Review Tribunal (MHRT) and their rights of application to it;
- how an application to the MHRT may be made, and that free legal aid will be available; and
- how to contact other organisations, including advocacy services, which may be able to help them in their application to the MHRT.

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

17.10 Patients who are liable to be detained and community patients also have the right to ask the Hospital Managers to review their detention or community treatment order with a view to discharge. Such patients should be informed of this right, and the process of application, and given assistance in making an application if required.

**Information on consent to treatment**

17.11 The patient must be informed:-

- of the nature, purpose, likely and intended effects of the treatment which is planned;
- of their right to withdraw their consent to treatment at any time and of the need for consent to be given to any further treatment; and
- how and when treatment can be given without their consent, including by the second opinion process and when treatment has begun if stopping it would cause serious suffering to the patient.
17.12 A second opinion appointed doctor is require to provide a detained patient who is capable of consenting to treatment, but is refusing to give consent, with the reasons for his or her decision to certify the administration of that treatment to the patient.\(^{15}\)

**Information on the Mental Health Act Commission**

17.13 Patients must be informed about the role of the Mental Health Act Commission and of their right to meet the Commissioners. Patients should therefore be reminded of the role of the Mental Health Act Commission when the Commission visits a hospital or unit. Patients may also make a complaint to the Commission, and they should be informed of the process for this and support made available to them to do this, if required.

**Information about Independent Mental Health Advocates (IMHAs)**

17.14 “Qualifying patients” should be informed, as soon as it is practicable after they become a qualifying patient, that support is available to them from an IMHA and how that support can be obtained. The person to whom the responsibility falls for meeting the duty to inform qualifying patients is set out in the table below:

<table>
<thead>
<tr>
<th>“Qualifying patient”</th>
<th>Person responsible for meeting duty to inform the qualifying patient (the “responsible person”)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient liable to be detained(^{16})</td>
<td>The Hospital Managers</td>
</tr>
<tr>
<td>A patient who is liable to detained but has been conditionally discharged(^{17})</td>
<td>The Responsible Clinician (for the patient)</td>
</tr>
<tr>
<td>Patient subject to guardianship</td>
<td>The responsible local social services authority</td>
</tr>
<tr>
<td>A community patient</td>
<td>The Hospital Managers (for the responsible hospital)</td>
</tr>
<tr>
<td>A patient for whom treatment under section 57 is proposed, if they do not already fall under one of the categories above</td>
<td>The registered medical practitioner or approved clinician with whom the patient first discusses the possibility of such treatment</td>
</tr>
<tr>
<td>A patient under 18 years for whom treatment under section 58A is proposed, if they do not fall under one of the categories above</td>
<td></td>
</tr>
</tbody>
</table>

17.15 The support available to a qualifying patient from an IMHA includes support with obtaining and understanding the type of information set out in this chapter, as well as support in exercising any rights which may be exercised under the Act by the patient. It is important therefore that engagement protocols are in place for referrals to be made in order to engage an IMHA speedily so that patients can be provided

\(^{15}\) *R (on the application of Wooder) v Feggetter and the Mental Health Act Commission* [2002] EWCA Civ 554; [2002] MHLR 178

\(^{16}\) Otherwise than by virtue of sections 4, 5(2), 5(4), 135 or 136 of the Act

\(^{17}\) By virtue of sections 42(2), 73 or 74 of the Act
with support to understand and be engaged in the process as early as possible. The IMHA’s role is to provide help and support to the patient and he or she will not make any decisions on behalf of the patient. Chapter 21 of this Code provides further guidance on Independent Mental Health Advocates.

Additional information

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

17.17 Where section 134 could apply to a patient, those patients should also be informed of this provision which deals with the withholding of a detained patient’s correspondence.

17.18 Patients should be informed of the provisions for making an application to the County Court under section 29 of the Act, and provided with assistance in exercising their right of application should they wish. Further guidance on this is given in chapter 19 of this Code.

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

17.20 Under the Data Protection Act 1998, patients also have a right of access to information held about them. Patients also have a right of access to information under the Freedom of Information Act 2000. In line with the positive obligations of both Acts, Hospital Managers should ensure that patients are reminded of their rights in this regard.

17.21 Nothing in the Act precludes the giving of information to patients on other matters, such as understanding care planning (and the Care Programme Approach), admission guidance, and welfare benefits.

How to deliver and explain information

17.22 Hospital Managers are required to take such steps as are practicable to ensure that the patient understands the areas of information set out in section 132 and 132A of the Act. This duty cannot be met by simply informing a person of that information, and Hospital Managers must take proactive steps to ensure that the information has been properly understood.

17.23 A patient liable to be detained or subject to SCT must be provided with the reasons for detention or community treatment in simple, non-technical language that can be understood; the reasons must contain the essential legal and factual grounds for the use of the Act in his or her particular case.
17.24 Information should be given to the patient both orally and in writing – these are not alternatives. Leaflets which can be used for providing the basis for written information have been prepared by the Welsh Assembly Government, and these can be augmented with other documents prepared by the Hospital Managers.

17.25 However merely repeating what is already written on the information leaflets is inadequate, and those providing information to the patient should ensure that full and clear explanations are given.

17.26 In line with the Guiding Principles of this Code, everything possible should be done to overcome any barriers to effective communication. These barriers may be caused by any one of a number of reasons – for example the patient’s first language is not English or Welsh, or he or she may not read and write in English or Welsh. They may have difficulty in understanding technical terms and jargon, or maintaining attention for extended periods of time; he or she may have a hearing or visual impairment and have difficulty reading. There may also be barriers to communication associated with the person’s mental disorder, for example, the patient may lack mental capacity.

17.27 Members of the multidisciplinary team need to assess and identify how communication difficulties affect each patient individually so that they can address the needs of patients in ways that best suit them. This will require patience and sensitivity. Specialist help should also be made available to staff as required, either from within the hospital itself, the local social services authority or voluntary organisation. The patient’s relatives and friends should not normally be used as an intermediary or interpreter. Staff should make every attempt to identify an interpreter that is appropriate to the patient’s needs and give consideration to the patient’s gender, religion, dialect and age in reaching a decision on the interpreter to be used. Professional advocates can be invaluable in helping patients to understand the questions and information being presented to them and in helping the patients to communicate their views to staff.

17.28 For children, particular consideration must be given to communicating this information in a way that is understood by them and which is sensitive to their needs for emotional reassurance and advice in receiving such information.

When information should be delivered and explained

17.29 The Act requires that information should be provided to a patient as soon as practicable after the commencement of the detention or community treatment order.

17.30 It is good practice to ensure that there is an ongoing and regular explanation of the rights and restrictions for patients; a fresh explanation should also be considered:-

- on application to the MHRT, or when a patient becomes again eligible for application to the MHRT;
- on application to the Hospital Managers for consideration of discharge;
on changes in consent to treatment status (for example, when the expiry of the initial three month period is nearing);
when any change in proposed treatment is considered;
before each Care Programme Approach meeting;
when renewal of detention or community treatment is being considered, and again if the period of detention or community treatment order is extended. For patients who are subject to restriction or limitation orders (where their detention is not ‘renewed’ by the Responsible Clinician), this should be read as being on the anniversary of any order or direction being made;
when it is known that the Mental Health Act Commission will be visiting; and
when the reason for being a ‘qualifying person’ in respect of the IMHA provisions changes.

This list is not exhaustive.

17.31 When a patient is discharged from detention or a community treatment order, or the authority for detention or CTO expires, this fact should be made clear to them.

Duty to deliver and explain the information

17.32 The duty to ensure that a patient has been informed about his or her legal situation and rights falls to the Hospital Managers, but it is recognised that it would usually be more appropriate for staff working with the patient to provide them with the information.

17.33 It is never acceptable that a patient is reliant upon other patients to provide information and explanation.

17.34 A record should be made in the patient’s case notes each time an attempt is made to explain the information to the patient, together with the outcome of that explanation, and any plans for the further presentation of the information.

Information for the Nearest Relative

17.35 The Act requires that the Hospital Managers also furnish the person appearing to them to be the patient’s Nearest Relative with a copy of any information given to the patient in writing (as set out above) unless the patient requests otherwise.

17.36 This information should explain the effect of the provisions of the Act applying to the patient and the rights of application to the Mental Health Review Tribunal, as well as information that help is available to the patient from an IMHA and how that help may be obtained.
17.37 When a patient detained under the Act or subject to SCT is given information, he or she should be advised that the written information will also be supplied to his or her Nearest Relative, unless he or she requests otherwise.

17.38 The Nearest Relative should also be advised of the patient’s discharge from detention or CTO at least seven days before the date of discharge, unless the patient or Nearest Relative has requested that information about discharge should not be given.

Information for patients subject to guardianship

17.39 Although the only duty the Act imposes in respect of patients received into guardianship is that the responsible local social services authority must ensure patients receive and understand information on the help available to them from an IMHA, it is clearly best practice to ensure that patients also understand the provisions of the Act as they apply including their rights of application to the Mental Health Review Tribunal.

Information for informal patients

17.40 Whilst the Act does not impose any duty regarding the provision of information to informal patients, these patients should be made aware of their legal position and rights. Hospital Managers may wish to consider developing patient information leaflets for informal patients setting out their legal position and rights clearly.

17.41 Local policies and arrangements regarding movement around the unit, grounds and community for individual patients or groups of patients must be clearly explained to the patient(s) concerned. Failure to do so could result in a patient mistakenly believing they are not allowed freedom of movement, and a deprivation of their liberty could result.

The Hospital Managers’ information policy

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

- the correct information is given to the patient and the patient's Nearest Relative;
- the information is given in accordance with the requirements of the law and at a suitable time and in an accessible format including where appropriate with the aid of assistive technologies and interpretative and advocacy services;
- the member of staff who is to give the information has received sufficient training and guidance and is identified in relation to each patient detained under the Act or subject to a community treatment order;
• a record is kept of the information given, including how, when, where and by whom it was given and an assessment of how well the information was understood by the recipient;

• a regular check is made that information has been properly given to each patient, and understood by them;

• information is given to the patient when they are placed onto a community treatment order and when the CTO is revoked, as their rights will be different; and

• steps are taken to find out whether a patient who lacks capacity has an attorney or deputy with authority to make decisions about their personal welfare (see chapter 33 of this Code). Where there is such a person, that person acts as the agent of the patient, and should be informed in the same way as the patient themselves about matters within the scope of their authority. This applies to patients subject to compulsion, guardianship and informal patients.
18. Visiting patients in hospital

18.1 This chapter provides guidance on the patients' right to be visited and also covers those circumstances, where it may be necessary to consider the exclusion of visitors. The chapter also refers to the particular consideration of child visitors, as well as the physical aspects of the visiting facilities themselves.

The right to be visited

18.2 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 friends and relatives is recognised as an important element in a patient's care and treatment. Patients' legal representatives and criminal justice professionals may have a need to visit patients.

18.3 In cases, where the patient is meeting with their advocate, such meetings should be private wherever practicable.

18.4 Every effort must be made to assist the patient, where appropriate, to make contact with relatives, friends and advocates. In particular patients should have readily accessible and appropriate day time telephone facilities.

18.5 Restricting visitors to informal patients could amount to a deprivation of liberty and may indicate that an authorisation under the Deprivation of Liberty Safeguards of the Mental Capacity Act may need to be sought.

Grounds for excluding a visitor

18.6 The decision to prohibit a visit by any person whom the patient has requested to visit and/or agreed to see, should be regarded as a serious interference of the rights of the patient and as such, should only be enforced in exceptional circumstances. This should only occur after other means to deal with the problem have been exhausted.

18.7 Any decision to exclude a visitor should be fully documented and available for independent scrutiny by the Mental Health Act Commission.

18.8 There are two principal grounds, which could justify the exclusion of a visitor:-

• a restriction on clinical grounds; and/or
• a restriction on security grounds.

A restriction on clinical grounds

18.9 It may be the case that a patient's relationship with a relative or friend is considered to be counterproductive to therapy. Such engagement must be to an extent that a noticeable arrest of progress, or even deterioration, in the patient's
mental state is evident and/or can reasonably be anticipated if contact were not to be restricted.

18.10 The grounds for any decision by the Responsible Clinician, following full discussion with the patient's multi-disciplinary care team, should be clearly documented and explained to the patient and the person concerned, both orally and in writing.

**A restriction on security grounds**

18.11 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/alcohol into the hospital;
- transfer of potential weapons;
- unacceptable aggression; and
- unauthorised media access.

18.12 The decision to exclude a visitor on the grounds of his or her behaviour should be fully documented and explained to the patient orally and in writing. Where possible and appropriate the reason for the decision should be communicated to the person concerned.

18.13 Hospital Managers should regularly monitor the exclusion from the hospital of visitors to detained patients.

### Visiting of patients by children

18.14 Mental health professionals must consider the needs of children whose parent or relative is an inpatient (whether formal or informal) and make appropriate and safe arrangements for them to visit, should this be considered to be in the child’s best interests.

18.15 Hospitals should have written policies regarding the arrangements for patients being visited by children, which should be drawn up in consultation with local social services authorities. Although it is important to maintain parent/child relationships, a visit by a child should only take place following full multi-disciplinary and/or multi-agency agreement that such a visit would be in the child's best interests. Decisions to allow such visits should be regularly reviewed.
Facilitation of visiting

18.16 The hospital should be sufficiently flexible to enable regular visits to the patient, if he or she wishes. Ordinarily, inadequate staff numbers should not be allowed to deter regular visiting.

18.17 The facilities provided for visitors should be comfortable and welcoming, and for children, child-friendly. In this respect, there may be instances where it is necessary and appropriate, for children to visit patients on the ward. In such circumstances, hospitals must have in place agreed policies and procedures, which deal with such instances.

18.18 In addition, consideration should be given to meeting the needs of visitors who have travelled long distances.
19. **The Nearest Relative**

19.1 The role of the Nearest Relative is an important patient safeguard; this chapter sets out this role and gives guidance on meeting the obligations of the Act. The chapter also gives guidance on seeking the displacement of a Nearest Relative through the County Court.

### The functions of the Nearest Relative

19.2 The Nearest Relative plays an role under the Act and represents a significant safeguard for patients who are detained under Part 2 or received into guardianship.

19.3 A Nearest Relative is the only person other than an Approved Mental Health Professional (AMHP) who may make an application for admission for assessment (section 2) or for treatment (section 3), and may make an emergency application for admission (section 4). However this is not an action to be taken lightly and the implications for the Nearest Relative’s relationship with the patient should be taken into account before proceeding (see chapter 2).

19.4 Aligned to this the Nearest Relative may request the Local Social Services Authority where the patient resides to consider making an application for admission to hospital and where an application is not made they must be provided with the reasons for the decision in writing.

19.5 The Nearest Relative also has the power to order the discharge of a patient liable to be detained under section 2 or section 3, or a patient who has been received into guardianship. In this the Nearest Relative has to provide 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. However, during this 72 hour period the patient’s Responsible Clinician can provide a “barring certificate” provided that sufficient grounds exist to prevent the discharge. As part of this process the Nearest Relative may appoint a registered medical practitioner to examine the patient prior to any order for discharge made by them.

19.6 The Nearest Relative is also able to apply to the Mental Health Review Tribunal (MHRT) in accordance with section 66 of the Act and will be a party to proceedings under the MHRT, unless the context requires otherwise.

19.7 Points to remember:-

- No application for admission for treatment may be made by an Approved Mental Health Professional (AMHP) without the Nearest Relative first being consulted, unless consultation is not reasonably practicable or would cause unreasonable delay.
- The Nearest Relative will receive information from the Hospital Managers in writing about, amongst other things, their right of discharge and their right of application to the MHRT – refer chapter 17.
• The Nearest Relative of a ward of court requires the leave of the court to exercise their functions under the Act (see section 33(2)).

Identifying the Nearest Relative

19.8 Section 26 of the Act defines ‘relative’ and ‘nearest relative’ for the purposes of Part 2 of the Act and also for patients who have been placed under hospital or guardianship orders by a court.

19.9 A person who has been identified as the Nearest Relative is not obliged to act as such. Indeed they may find it difficult to undertake the functions defined in the Act, or be reluctant for any reason to do this. However, 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 and AMHPs should consider proposing this in appropriate circumstances. Notice of any such delegation of powers must be given to the Hospital Managers or the responsible Local Social Services Authority (LSSA).

19.10 It is also important to note that a person who has been identified as a patient’s ‘next of kin’ has no powers under this Act unless he or she is also the patient’s Nearest Relative.

Guidance for professionals

19.11 Chapter 2 of this Code gives guidance to Approved Mental Health Professionals and others on consulting and informing the Nearest Relative during the assessment process.

19.12 Chapter 17 of this Code gives guidance to Hospital Managers and others regarding the duty to provide Nearest Relatives with statutory information.

Displacing the Nearest Relative

19.13 There are certain circumstances in which the Nearest Relative can be displaced by the County Court. The County Court may, by order, direct that the functions of the Nearest Relative are exercised by another person, or by a local social services authority.

Applicants for seeking displacement

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

• the patient;
• any relative of the patient;
• anyone with whom the person is residing (or was residing with prior to admission); and
• an AMHP.
19.15 When making an application an AMHP should seek legal advice from their LSSA. Authorities should ensure that they provide clear practical guidance to help the AMHP decide whether to make an application, and how to proceed. Before producing such guidance, the LSSA should consult with the County Court.

19.16 Where the applicant is the patient, support should be provided to them by the Hospital Managers and the LSSA; this may include ensuring that they have access to an advocate or are able to access appropriate legal advice. Support should also be available to enable the patient to attend the Court, as appropriate, provided this does not conflict with any requirements under section 17 of the Act.

19.17 Some patients may wish to displace their Nearest Relative but may be deterred from doing so by the need to apply to the County Court. In such circumstances the AMHP should consider whether they consider the grounds for seeking displacement are met, and if so, to consider making an application.

**Grounds for seeking displacement**

19.18 The grounds for making an application to the Court for displacement of the identified Nearest Relative are:-

- there is no Nearest Relative within the meaning of the Act;
- it has not been reasonably practicable to ascertain whether there is a Nearest Relative is, or who that relative is;
- the Nearest Relative is incapable of acting as such by reason of mental disorder or other illness;
- the Nearest Relative is believed to be unreasonably objecting to an application for admission for treatment or a guardianship application;
- the Nearest Relative has used, or is likely to use, his/her right to discharge without due regard to the welfare of the patient or the interests of the public; and
- the Nearest Relative is otherwise not a suitable person to act as such.

19.19 Given the significance of the role of Nearest Relative as an important patient safeguard where a patient has no Nearest Relative within the meaning of the Act, AMHPs should not assume that the patient will make an application to the Court to have one appointed but should consider doing so themselves.

19.20 The applicant must be able to demonstrate to the County Court that the grounds were met not only at the date of application but also at the date of the hearing, for the Court to make an order.\(^\text{18}\)

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\(^\text{18}\) *Lewis v Gibson* [2005] EWCA Civ 587
19.21 When determining whether to make an application on the grounds that the current Nearest Relative is unsuitable, the AMHP should consider the views of the patient and any concerns that the patient has about their Nearest Relative. The AMHP should distinguish between any concerns of the patient relating to the person who is the Nearest Relative and concerns the patient may have that relate to the role of the Nearest Relative (that is, no matter who should undertake that role). The AMHP should also seek to understand any concerns of the patient that relate to how the Nearest Relative chooses or may choose to use his or her powers.

19.22 In the case of children, it may be necessary to make an application to the County Court to have the Nearest Relative displaced if that person’s interests and the best interests of the child concerned are thought to have parted company.

19.23 Any applicant to the County Court will need to nominate someone to become the acting Nearest Relative should the application be successful. Although not a legal requirement, it would be appropriate for the agreement of the proposed nominee to be sought prior to an application being made.

**Effect of an application**

19.24 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.

19.25 A County Court may make an interim order when they are considering an application under section 29 of the Act. The Hospital Managers may rely on an interim order for the purposes of admission and detention of a patient.

19.26 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, and for a further seven days to allow the section 3 application to be made. This ‘extension’ would only apply if the grounds for the application were that the Nearest Relative unreasonably objects to an application under section 3 being made, or that they were or were likely to exercise their power of discharge without due regard to the patient or others.

19.27 In such cases, the Hospital Managers should always consider requesting the Welsh Ministers to refer the patient’s case to the Mental Health Review Tribunal (see also chapter 22).

**The ‘supplanted’ Nearest Relative**

19.28 The displacement of a Nearest Relative does not remove his or her legitimate interest in the welfare of the patient; authorities should consider this when making decisions about and arrangements for the patient’s care.

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19 Section 38 of the County Court Act 1984
20 See *R v Central London County Court ex parte London* [1999] 3 All ER 991 CA
21 *Surrey County Council Social Services v McMurray* November 11, 1994, CA
19.29 A supplanted Nearest Relative has a right to make an application to a Mental Health Review Tribunal (section 66(6)), which can be made once within each year after the Court's order.
20. Involvement of carers

20.1 This chapter re-emphasises the references in this Code about the importance of ensuring that carers are appropriately involved in the planning and delivery of care and treatment for patients and outlines the matters which should be considered in this process of involvement.

Identifying carers

20.2 Carers are “…people who look after relatives, friends or neighbours who are frail, sick, disabled or vulnerable” and are “…the cornerstone of health and social care in the community”\(^{22}\).

20.3 Some carers do not see themselves as carers, but see themselves primarily as a parent, child, wife or husband, partner, friend or neighbour. Some carers live in the same house as the person for whom they care. Others may live nearby and visit regularly or live further away and visit less often. Carers’ ages and backgrounds will vary.

20.4 Throughout this Code there are consistent messages that professionals must engage with carers in care planning and treatment processes.

How can carers be involved in care planning and treatment?

20.5 At each level of assessment through to care and treatment the views of the patient’s carers should be sought, this should also include (where applicable) after-care services.

20.6 More specifically, carers can provide relevant, detailed and contemporaneous information regarding the person and their presentation, which may not always be apparent or available to professionals. This can assist in identifying and targeting particular needs.

20.7 Empowering carers to participate in the decision making process, may be achieved through:-

- involvement in deciding the main objective(s);
- participating in deciding the most appropriate course of action to achieve those objectives;
- identifying any potential barriers and solutions;
- monitoring and reviewing the progress of the care plan; and
- evaluating outcomes.

\(^{22}\) Welsh Assembly Government (2007b)
20.8 In order to ensure carers are able to fully participate in the above, it is important that they have:-

- practical and emotional help and support provided to them in order for them to participate and to continue to care for the patient; and
- timely access to comprehensive, up to date and accurate information.

20.9 Professionals should also be mindful of their statutory duties under the Mental Capacity Act 2005 and, in particular, their duty to consult any person who is engaged in caring for the patient or is interested in their welfare where the patient does not have capacity to make decisions about their own care and treatment.

20.10 While recognising the vital role of carers in the care planning processes and the valuable contribution they make to the care of patients, professionals should try to address the concerns and accommodate the wishes of the carer insofar as those concerns or wishes do not conflict with what is in the best interest of the patient.

20.11 In engaging with carers, professionals should:-

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

20.12 Carers have a right to an assessment of their own needs even in circumstances where the person cared for has refused an assessment for, or the provision of, community care services. More detailed guidance on carers' assessments is in the Unified Assessment process guidance. The Carers (Equal Opportunities) Act 2004, which came into force in Wales in April 2005, places a duty on local authorities to inform carers of their right to an assessment, and requires carers’ assessments to consider whether the carer works or is undertaking education, training or other leisure activity, or wishes to do these things. The Act also provides for better co-operation between statutory agencies in the provision of services for carers.
21. Independent Mental Health Advocacy

21.1 Independent Mental Health Advocates (IMHAs) provide an important safeguard for certain patients treated under the compulsory powers of the Act. This chapter provides guidance about the role and functions of IMHAs for anyone who may need to appoint an IMHA.

| The role of the Independent Mental Health Advocate (IMHA) |

21.2 The IMHA provides assistance to qualifying patients to ensure that they understand the legal procedures of the Act and the rights and safeguards to which they are entitled. This may include assistance in obtaining information about any of the following:-

- the patient's rights under the Act;
- the provisions of the Act under which the patient qualifies for an IMHA;
- any conditions or restrictions to which the patient is subject;
- 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 in relation to treatment.

21.3 The IMHA will:-

- ensure that the voice of the patient is heard by supporting the patient to articulate their views and to engage with the multi-disciplinary team;
- support patients to access information, and to understand better what is currently happening and what is being planned, and to understand better the options available to them;
- support patients in exploring options, making better-informed decisions and in engaging with the development of their care plans;
- support the patient to ensure that they are valued for who they are; and
- support the patient to counteract any actual or potential discrimination.

21.4 IMHAs also help the patient to exercise his or her rights under the Act, including by the provision of representation.

21.5 IMHAs may also support patients in a range of other ways to ensure that they can participate in the decision-making process 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 to explore alternatives to the proposed treatment;

• supporting the patient to understand their rights of appeal;

• supporting the patient to apply to and obtain legal representation for Mental Health Review Tribunal or Hospital Managers' hearings;

• supporting the patient to understand and follow-up the decisions or directions made by the Mental Health Review Tribunal;

• supporting the patient to understand their rights in relation to their Nearest Relative;

• supporting the patient to understand, apply to and obtain legal representation for County Court hearings;

• supporting the patient by attending, if requested, Mental Health Review Tribunal or County Court hearings;

• supporting the patient to raise concerns or to access the relevant complaints process about any aspect of their hospital or supervised community treatment experience;

• supporting the patient to access relevant records;

• supporting the patient in relation to provision for appropriate aftercare; and

• signposting other services to the patient and vice versa.

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

### Qualifying patients for IMHA

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

• all patients liable to be detained under the Act – excluding those subject to sections 4, 5(2), 5(4), 135 or 136;

• patients subject to supervised community treatment; and

• patients subject to guardianship.

21.8 In addition, the right to access IMHA support applies to:-

• informal patients who discuss, with a registered medical practitioner or approved clinician, the possibility of being given a form of treatment to which 57 treatment applies;

• informal patients under the age of 18 who discuss, with a registered medical practitioner or approved clinician, the possibility of being given a form of treatment to which section 58A applies.
Patients’ rights to access an IMHA

21.9 A qualifying patient may request the support of an IMHA at any time. Certain professionals have a duty to inform qualifying patients of the availability of independent mental health advocacy and how they may be accessed. Patients may wish 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;
- prior to the initial discussion with their clinician about the proposed treatment plan;
- when the use of ECT is being considered;
- when an application has been made or is being considered to the Mental Health Review Tribunal or Hospital Managers;
- when they choose not to be legally represented at a Mental Health Review Tribunal hearing;
- when they wish to make, or have made, a complaint;
- when they wish to discuss any aspect of their care or treatment;
- when they wish to apply to displace their Nearest Relative (see chapter 19);
- when they are consulted about the conditions to be attached to a community treatment order (CTO);
- when a CTO is renewed, revoked, or when the conditions are revised; and
- when a meeting is convened to discuss aftercare.

21.10 A patient who qualifies for the support of an IMHA by virtue of a discussion about the possibility of treatment to which section 57, or section 58A if under 18 years, applies must be informed of the availability of such advocacy. However, any professional discussing the possibility of such treatment with a patient should not assume that the patient is already aware of their eligibility to receive IMHA support and should, where appropriate, inform them.

Providing information about the service

The ‘responsible person’

21.11 The 'responsible person' is in charge of giving information about the availability and accessibility of the IMHA service. The responsible person is defined as follows:

- where an individual is liable to be detained under the Act, the responsible person will be the manager of the detaining hospital or registered establishment;
• where an individual is subject to conditional discharge (under section 42(2), 73 or 74), the responsible person will be the Responsible Clinician;

• where the individual is subject to guardianship, the responsible person will be the responsible local social services authority (LSSA);

• where the individual is a community patient, the responsible person will be the managers of the responsible hospital; and

• where the possibility of section 57 or section 58A (if they are under 18) treatment is proposed with an individual, the responsible person will be the registered medical practitioner or Approved Clinician who first discusses this with them. They should be informed of the support available while the discussion is taking place, or as soon as practicable afterwards.

The role of the ‘responsible person’

21.12 The responsible person must:-

• ensure that they make known to the individual, both orally and in writing, that assistance is available to them from an IMHA; and

• how they can obtain that help.

21.13 Information about IMHA services will need to be communicated to qualifying patients in a way that each patient can understand, taking account of any special communication needs they may have. Such needs may arise, for example, where the patient has a visual or hearing impairment, a learning disability or where their first language is neither English nor Welsh. In addition, any information provided in writing should be clear and in a style and language which can be easily understood by the individual patient. This is especially important for children, and those with a learning disability or with an autistic spectrum disorder, as standard information may be presented using vocabulary which is too advanced or complex for them.

21.14 Where 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.

21.15 Further guidance on delivery information to patients and their Nearest Relative is given in chapter 17 of this Code.

21.16 In addition to informing people about the availability of independent mental health advocacy, the responsible person also has a duty to take appropriate steps to ensure that the patient has the opportunity of making use of IMHA support.

21.17 Where the patient would like an IMHA, it would be best practice for the responsible person to assist the patient to contact the local IMHA. For example, they might contact the IMHA on that patient’s behalf to make arrangements for the patient to meet with an IMHA if the patient would otherwise be unable to do this. They should not at this stage be disclosing any personal information about the patient to the IMHA service.
21.18 As a matter of best practice, the 'responsible person' should record in the patient’s medical records the steps taken to inform that patient of IMHA support, and how and where to access it. It would be best practice to keep other people who support the patient informed about whether or not the patient would like support from an IMHA, and any follow-up action required, where a patient has consented to such information being shared.

21.19 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 the fact that the patient was informed about independent mental health advocacy and did not want such support;
- check with the patient again at a later date that they remain of the same view, in the event that they may have changed their mind; and
- advise the patient about the availability of legal representation and how to access it.

**IMHAs and patient confidentiality**

21.20 IMHAs are expected to have in place, and adhere to, an agreed confidentiality policy. Under this, any information a patient shares with an IMHA should remain confidential unless the patient wishes it to be disclosed, or the IMHA has reasons to breach confidentiality.

21.21 In most circumstances the IMHA will share with the patient all information they obtain 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 the relationship between the patient and the IMHA.

**Supporting the role and work of the IMHA**

21.22 In order for patients to contact an IMHA they should have access to a telephone on which they can talk to an IMHA in private. The IMHA has the right to:-

- visit and interview the patient in private, subject to good practice (see paragraphs 21.23 and 21.24 below); and
- visit, interview and get the views of any person who is professionally concerned with the patient's medical treatment.

Hospital Managers and LSSAs should ensure that there are systems and provisions in place to support this.
21.23 It is good practice for the IMHA to meet with 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; or
- when clinicians or other members of the multi-disciplinary team advise against a meeting in private for reasons of the advocate's or patient's safety.

21.24 When it is inadvisable to hold the meeting in private, the IMHA may:-

- offer to postpone the meeting until it is convenient to meet in private;
- continue with the meeting, in the presence of staff, with the patient's consent; or
- continue the meeting on, for example, an open area of the ward, with the patient's consent.

21.25 For the purposes of supporting the patient, the right of the IMHA to visit and speak with any person who is currently professionally concerned with the patient's medical care and treatment is an important one. Facilitating communication between patients and professionals is a significant part of the advocacy role as it can impact positively on the patient's ability to be involved in their care planning. Although the IMHA has the right to speak with a professional concerned with the patient's medical care and treatment without that patient's consent, before the professional can disclose confidential information to the IMHA, consent from the patient is required.

21.26 IMHAs should be enabled, as appropriate, to:-

- have access to the unit and ward on which the patient under detention is resident; and
- attend relevant meetings and ward rounds when requested to do so by the patient.

21.27 It is best practice for information on independent advocacy to be displayed in public areas, on wards, as well as in forms which can be handed out to patients, their carers and others, such as leaflets.

21.28 Hospital Managers and LSSAs should have an IMHA policy which ensures that:-

- all relevant staff are aware of the patient’s right to independent mental health advocacy, its role, the legal requirements relating to IMHA under the Act and of best practice. It is important that staff know that advocates may support any qualifying patient;
- all relevant staff know when they need to give information about an IMHA;
• all relevant staff know how to access an IMHA;
• all relevant staff record an IMHA's involvement in a case and any information they provide to help decision-making;
• records show how a decision-maker considered the IMHA's information as part of their decision (this should include reasons for disagreeing with that advice, if relevant);
• all relevant staff give access to the IMHA of any relevant health or social care records when requested to under section 130B(3) of the Act;
• the IMHA gets information about changes that may affect the support and representation they provide; and
• all relevant people will be informed know when an IMHA is working to support a qualifying patient.

Access to records

Relevant records

21.29 Where the patient consents, the IMHA has a right to access and inspect a relevant patient's records. Relevant records include:-

• any records relating to the patient's detention or treatment in any hospital or registered establishment;
• any records relating to any after-care services provided to the individual under section 117; and
• any records of or held by a local social services authority, relating to the patient.

Conditions for access to records

21.30 The following conditions must be met for access to be granted:-

• where the patient can consent, they do consent; or
• where the patient lacks capacity or the competence to consent, the decision to allow access does not conflict with a decision made by a donee or deputy or the Court of Protection; and
• the holder of the records thinks it is appropriate and the records in question are relevant to the support to be provided by the IMHA.

21.31 When seeking access to records in the case of a patient who lacks capacity or the competence to consent, the advocate will be asked to declare why access is being sought and the nature of the information being requested.
21.32 Record holders should bear in mind the principle of respect for patient's past and present wishes and feelings, when considering the appropriateness and relevance of the request for access to records.

**Ending the IMHA’s involvement**

21.33 The purpose of independent mental health advocacy is to provide support upon specific issues relating to the use of compulsory powers of detention and treatment for qualifying patients. The IMHA will support the patient for the duration of the issue. Once all issues have been addressed the IMHA will close the case. However, patients can request IMHA support at a later date provided they remain a qualifying patient.
22. The Mental Health Review Tribunal

22.1 This chapter outlines the purpose of the Mental Health Review Tribunal (MHRT) and provides guidance to all those involved in the process of applications, preparing reports and attending hearings.

### Purpose of the MHRT

22.2 The MHRT is a significant safeguard for both the patient and their Nearest Relative. It is a statutory body responsible for hearing statutory appeals against liability to detention or to recall or reception into guardianship. MHRT panels include legal members, medical members and non-legal members who are required to have some special expertise. At a MHRT hearing there will be at least one doctor, lawyer and third member. The legal member will be the chair of the panel.

### Informing the patient of their rights of application

22.3 In line with the requirements of the Act, as set out in chapter 17 of this Code, the Hospital Managers must ensure patients are given information about their rights to apply to the MHRT and their entitlement to free legal advice and representation. It is good practice for hospitals to hold a list of local solicitors who undertake MHRT work for the use by patients.

22.4 Local protocols should be developed to ensure that staff are available to help patients make an application, this is especially important for community patients who may not have daily contact with practitioners. Practitioners should inform the patient of their right to represent their own case to a MHRT, and their right to representation by someone else.

22.5 Where a patient wishes to apply to the MHRT but is unable to do so, for example where they are unable to write, it is acceptable for someone else to make a written application on their behalf. There is no requirement for specific information to be included in an application. In fact a patient need only state that they want to make an application for it to be treated as such.

### Response to applications

22.6 When the MHRT receives an application it sends notice of the application to the patient, the Hospital Managers, the applicant (if it is someone other than the patient) and, if the patient is subject to a restriction order or direction, the Secretary of State for Justice.

22.7 The Hospital Managers have a duty to send a statement to the MHRT secretariat within 21 days of being notified of a hearing. The statement must contain the information about the patient as set out in [Schedule 1 to the Mental Health Review Tribunal Rules 1983]. In the case of a restricted patient, the report must also be sent to the Mental Health Unit in the Ministry of Justice, and the
Secretary of State for Justice who will send the MHRT a statement explaining why the Secretary of State has not used his own powers to discharge the applicant.

22.8 Hospital Managers should promptly inform the multidisciplinary team of the application, ensuring that a medical report is requested from the Responsible Clinician, and the most appropriate person is asked to prepare the social circumstances report.

22.9 It is important that key information is available in good time for any MHRT hearing. Missing, out of date or inadequate reports can lead to adjournments or unnecessarily long hearings which can disrupt the patient and the patient’s family and tie up valuable professional time. Where clinicians, social workers or other healthcare professionals are required to provide reports, they should do so promptly and certainly within the statutory timescale. Where those responsible for providing a report have failed to do so, the MHRT may direct that they do so by using a subpoena to compel attendance.

22.10 It is the responsibility of the MHRT to discharge any applicant where the detaining authority cannot demonstrate that the grounds for detention are met. The reports form the backbone of this evidence. Care should be given to ensure that all information is as up to date as possible and the necessary information is contained within the report to justify the decision to continue to treat under the Act. Where information is ‘hearsay’ it should be stated as such. All information should be clear and concise.

22.11 The Responsible Clinician should provide an up-to-date medical report, prepared for the MHRT, including the relevant medical history and a full report on the patient’s medical condition.

22.12 The social circumstances report should include up-to-date information on the patient’s home and family circumstances (including the attitude of the patient’s Nearest Relative). The patient’s cultural circumstances should be addressed and should underpin any considerations in the report. It should also consider the financial circumstances of the patient, their opportunities for employment or occupation and the housing facilities, which would be available to the patient if discharged. If community support and relevant medical facilities are available it should be noted in the report. If the patient is subject to supervised community treatment or conditional discharge the report should cover their progress in the community. The report should be written by the professional with the best knowledge of the patient’s social circumstances.

22.13 If the MHRT feels it needs more information on any report, it may request it, either in the form of a supplementary report or by its questioning of a witness at the hearing itself.
22.14 If a report prepared for the MHRT contains information which could be prejudicial to the health of the patient or the safety of others if disclosed to the patient, the report’s author should place that information in a separate addendum and say why it should not be disclosed. The MHRT may order that any such information be disclosed to the patient or withheld from them. In order to ensure fairness to the patient, the default position will be disclosure. It will be for anyone who opposes disclosure to establish why it would have an adverse effect.

22.15 Sometimes the MHRT will not sit immediately after receiving the report. In these circumstances the report writers should consider whether anything in the patient’s circumstances have changed and produce a concise update to the report. Any pending application will need to consider the new circumstances of the case and the report will need to provide a justification for continued detention or liability to recall under the new circumstances.

22.16 A party to MHRT proceedings may amend or supplement their application or statement at any time. However, once they have been notified of the hearing date, they will require the permission of the MHRT to do so, and such permission may be subject to conditions such as the payment of costs and expenses.

22.17 At the hearing the MHRT panel may ask the author of the reports to present the salient factors within their report, so it is good practice for the authors to re-familiarise themselves with the content of any report before the hearing.

22.18 The Hospital Managers must notify the MHRT immediately of any events or changes that might have a bearing on MHRT proceedings, for example where a patient is discharged, the section under which they are detained changes, or one of the parties is unavailable.

22.19 An application may be withdrawn by the person who made it at any time provided that the request is made in writing and the MHRT agrees. The application will also be considered to be withdrawn if the patient ceases to be treated under the Act. A patient cannot withdraw a referral made by the Hospital Managers, Secretary of State for Justice, or the Welsh Ministers.

22.20 Before the hearing of the application, the medical member of the MHRT will examine the patient. Practitioners must ensure that the medical member is able to see the patient in private and examine all his or her medical records.

22.21 A patient may commission an independent report on their medical condition or social circumstances if they wish to do so.
22.22 The managers of a hospital in which a MHRT hearing is to be held should provide suitable accommodation for that purpose. The hearing room should be private, quiet, clean, and adequately sized and furnished. It should not contain confidential information about other patients.

22.23 Accommodation must enable the patient to hold any private discussions, should this be necessary, e.g. with his representative, and the MHRT members must also be able to discuss their decision in private.

22.24 Where a patient is being treated in the community, the Hospital Managers should consider whether a hospital venue is appropriate or whether the hearing could take place in other suitable accommodation within a community setting. They may wish to discuss alternatives with the patient and the MHRT secretariat. It is never acceptable for the hearing to be held in the patient’s own home.

22.25 The Mental Health Review Tribunal for Wales has a Welsh Language Scheme and hearings can be held in English or Welsh depending on the language of choice of the patient.

22.26 Where necessary, the MHRT can and will provide free-of-charge, translation and interpretation services for the patient and their representatives involved in MHRT proceedings. Where the patient or their representatives are hard of hearing or have speech difficulties, or both, the MHRT can and will provide such services of sign language interpreters, lip speakers or palantypists as may be necessary. The Hospital Managers should inform the MHRT well in advance if they think any such services might be necessary.

22.27 It is not obligatory for a patient to attend their MHRT hearing but practitioners should encourage them to attend unless they judge that it would be detrimental to their health or wellbeing to do so.

22.28 It is important that the Responsible Clinician attend the MHRT, supported by other staff involved in the patient’s care as appropriate, as their evidence is crucial for making the case for the patient’s detention or supervised community treatment under the Act to continue. Wherever possible the Responsible Clinician, and other relevant staff, should attend for the full hearing so that they are aware of all the evidence made available to the MHRT and the MHRT’s decision and reasons.

22.29 The Responsible Clinician can attend the hearing solely as a witness or as the nominated representative of the detaining authority. As a representative of the detaining authority, the Responsible Clinician has the ability to call and
cross-examine witnesses and to make submissions to the MHRT. However this may not be desirable where it is envisaged that the Responsible Clinician will have to continue working closely with a patient. Hospital Managers should therefore consider whether they want to send an additional person to represent their interests, allowing the Responsible Clinician to appear solely as a witness. The Responsible Clinician should be clear in what capacity he or she is attending the MHRT and understand the implications of his or her response, if asked by the panel.

22.30 The MHRT must conduct the hearing in the manner it considers most suitable. It will try to ensure that the proceedings are flexible and informal.

22.31 The remit of the MHRT is to determine whether the grounds for detention, guardianship or community treatment (as the case may be) are met and whether the patient should be discharged. The MHRT will therefore need to consider the appropriateness of the treatment plan, but in doing so it is not its role to challenge every aspect of the clinician's decision on specific medical treatment.

22.32 Where the MHRT is not satisfied that the grounds for continued detention, guardianship or liability to recall are met it must discharge the patient. In the case of detained patients (except restricted patients) it may also recommend that the Responsible Clinician considers placing a patient onto a community treatment order, transferring the patient to another hospital or into guardianship or granting a period of leave to help facilitate discharge in the future. Responsible Clinicians should seriously consider a recommendation by the MHRT although they are not obliged to undertake the recommendation.

22.33 A MHRT panel can reconsider a case where a recommendation is not acted upon.

22.34 If, in the case of a restricted patient, the MHRT is satisfied that the conditions for detention are met it may not discharge the patient. If in the case of a restricted hospital order patient it concludes that they are not met, it may:-

- order the discharge of the patient subject to conditions if it concludes that the patient should remain liable to recall to hospital;
- order the patient’s absolute discharge (in which case any restriction order will also come to an end); and
- where the applicant is a conditionally discharged patient, amend the conditions of his or her discharge or order the patient’s absolute discharge.

22.35 Where a restricted patient has been transferred to hospital from prison, the MHRT may recommend discharge but the decision on discharge is for the Secretary of State for Justice. Where he decides against discharge, the Hospital Managers must arrange the return of the patient to prison unless the MHRT concludes that if the patient were returned to prison, the patient’s mental state might come to be of a nature or degree as to warrant the provision of medical treatment to them. If that is
the case, the MHRT may recommend that the patient continues to be detained in hospital. Where such a recommendation is made, the Secretary of State for Justice may refer the case to the Parole Board.

**Communication of the decision**

22.36 The Chairman of the MHRT panel will normally communicate the panel’s decision to all parties verbally at the end of the hearing. Provided it is practicable to do so and the patient wishes it, the MHRT will speak to 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 impracticable to discuss matters with them after the hearing, the managers should ensure that they are told the decision as soon as practicable.

**Complaints**

22.37 Complaints from users about the MHRT should be sent to the MHRT office. The MHRT has procedures in places to deal with complaints promptly.

**Further information on MHRT**

22.38 The MHRT for Wales can be contacted at:-

Mental Health Review Tribunal for Wales  
4th Floor  
Crown Buildings  
Cathays Park  
Cardiff  
CF10 3NQ
23. Advance statements of wishes and feelings

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

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

23.2 A patient with capacity who is 18 years or over may make an advance decision to refuse treatment at a time when he or she no longer has capacity to refuse or consent to treatment. If the advance decision is valid and applicable in accordance with the MCA it has the same effect as if the patient makes a contemporaneous decision to refuse treatment. If a clinician treats a patient without consent and that patient has made a valid and applicable advance decision that refuses such treatment, then that clinician could face criminal prosecution unless the treatment is authorised under Part 4 or 4A of the Mental Health Act.

23.3 Where a clinician proposes to treat a patient for a mental disorder under authority of Part IV or 4A of the Act and the patient has made a valid and applicable advance decision to refuse such treatment, the clinician is not legally bound to act in accordance with that decision. In these circumstances the effect of the advance decision is the same as if the patient had contemporaneously refused his or her consent. Even if the patient has made an advance decision to refuse his or her consent then, providing the clinician has the proper authority to do so, treatment may be given.

23.4 Where a patient who lacks capacity is subject to a community treatment order but has not been recalled to hospital, the clinician will not have authority to treat that patient if the patient has made a valid and applicable advance decision to refuse that treatment unless the treatment is immediately necessary to prevent harm to the patient (see section 64G).

23.5 Although the clinician may not be legally bound to act in accordance with the terms of an advance decision he or she should take the decision into account and should, if possible, consider alternative forms of treatment to which the patient has not refused his or her consent in advance and which may achieve the same beneficial effect.

23.6 If a clinician gives treatment that the patient has refused in advance then this should be recorded in the patient’s notes.

23.7 The fact that a clinician has authority under Part IV or 4A to treat a patient for a mental disorder without consent does not mean that the clinician will not be legally bound by an advance decision to refuse other forms of treatment.
Other advance statements

23.8 If an advance statement has been made that does not meet the criteria as set out in the MCA it is not valid and applicable for the purposes of the MCA. However this does not mean that the statement can be ignored. At the very least it must be noted as an expression of the patient’s feelings and wishes and should be taken into account in deciding what is in his or her best interests. In some cases it will be a helpful therapeutic tool to encourage the patient to set out their wishes in advance. This will encourage collaboration and trust between patients and clinicians. It is also a way in which patients’ expertise and experience in the management of crises in their own conditions can be harnessed in line with the recovery model.

23.9 An advance statement will only be relevant where a patient does not have capacity at the time when the treatment is proposed and cannot be consulted. However even where a patient has made an advance statement and lacks capacity he or she should, as far as is practicable, be involved in the decision process.

23.10 Patients’ expressions of their wishes about how they should be treated should always be kept or recorded on their case notes so that they are accessible by all treating professionals. If the professional to whom the wish is being expressed forms the opinion that, at the time the particular wish was expressed, the patient lacked capacity to understand the wish they were making this should also be recorded along with the basis for which that opinion was formed.

23.11 Whenever expressing a wish about their future treatment the patient should be encouraged to identify the circumstances in which they would or would not want such treatment to occur and to provide alternatives when there is particular treatment they would not want used. Using restraint as an example, the patient may have expressed the types of restraint they would prefer to be used, over any restraints they would wish were not used. The patient should also be encouraged to provide reasons why they are making any such wish.

23.12 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 in the event that they no longer have capacity. Although health professionals may have a legal duty of care towards their patients, they are under no legal obligation to provide a particular treatment because the patient demands it. The decision to treat is ultimately a matter for the professional’s judgment, acting in the interests of the patient. The patient should be made aware that wishes expressed in advance cannot compel practitioners to act in a particular way.

Children

23.13 Advance statements made by children will not be binding on health professionals but must be taken into account. As with adults, an advance statement made by a child must be treated in the same way as if the child has made the

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23 Burke v General Medical Council [2005] EWCA 1003.
statement contemporaneously. 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 his or her wishes as expressed in an advance statement should be complied
with.
24. Leave of absence from hospital

24.1 This chapter provides guidance on the use of leave of absence and the matters which should be considered in granting such leave under section 17 of the Act.

General matters

24.2 A patient who is detained can only leave hospital, or a specified hospital unit, lawfully by being:

- discharged from detention (including conditionally);
- transferred to another hospital or into guardianship (under section 19 of the Act);
- returned to custody, if applicable;
- made the subject of supervised community treatment; or
- granted leave of absence in accordance with the provisions of section 17 of the Act.

Leave of absence is therefore an important part of a patient’s treatment plan.

24.3 Only the patient's Responsible Clinician, with the approval of the Secretary of State for Justice in the case of restricted patients, can grant a detained patient leave of absence. A Responsible Clinician is not entitled to grant leave of absence to patients detained under sections 35, 36 and 38 of the Act.

24.4 A patient who has been granted leave of absence under section 17 of the Act continues to be ‘liable to be detained’.

24.5 Other than where the patient is detained in a specified hospital unit, no formal procedures under the Act are required in order to allow a patient to visit different parts of the hospital or hospital grounds, as part of their care programme. It may however be appropriate for Hospital Managers to ensure that there is a local policy in place for the granting of permission for detained patients to have ‘ground leave’ or leave to visit other parts of the hospital.

Granting leave of absence

Matters to be considered

24.6 When considering and planning authorised leave of absence the Responsible Clinician should:

- consider the benefits and any risks to the patient’s health and safety of granting or refusing leave;
• consider the benefits of granting leave for facilitating recovery of the patient;
• balance these benefits and risks against any risks that the patient may pose for the protection of other persons (either generally or specifically);
• consider any conditions which should be attached to the leave, for example requiring the patient not to visit particular places or persons;
• be aware of any child protection and child welfare issues in granting leave;
• take full account of the patients wishes regarding leave, and those of carers, friends and family who may be involved in any planned leave of absence;
• take account of any necessary support for the patient during their leave of absence;
• ensure that any community services that are providing support for the patient during his or her leave are involved in the planning of the leave, and know the leave dates/times and any conditions placed on the patient during their leave;
• ensure that the patient is aware of any contingency plans put in place for their support, including how they may seek to end the leave early if they wish; and
• consider SCT as an alternative to longer term leave (more than seven consecutive days) – see paragraph 24.11 below.

Unrestricted patients

24.7 The Responsible Clinician cannot delegate the decision to grant leave of absence to any other professional, including another Approved Clinician. The Responsible Clinician is responsible for ensuring and undertaking appropriate consultation, and may require any leave to be subject to conditions, which he or she considers necessary either in the interests of the patient, or for the protection of other people.

24.8 In the absence of the Responsible Clinician (for example, if he or she is on annual leave or otherwise unavailable), permission can be granted by the Approved Clinician who is temporarily in charge of the patient's treatment and who is, therefore, temporarily acting as the patient's Responsible Clinician.

24.9 The Responsible Clinician's power to grant leave of absence cannot be fettered by the Hospital Managers. The fact that the Responsible Clinician grants leave subject to certain conditions (e.g. residence at a hostel) does not place an obligation on the Managers or anyone else to fund or arrange the particular placement or services advocated. Responsible Clinicians should not grant leave on such a basis without first taking steps to establish that the necessary services, authorisation and/or accommodation are available.
24.10 Leave of absence can be granted by the Responsible Clinician for specific occasions, periods of time or for longer indefinite periods of time. Whilst such authorised leave may be extended in the patient's absence, granting leave should not be used as an alternative to discharging the patient or to considering the use of SCT.

24.11 In considering whether to grant leave in excess of seven consecutive days (either in the first instance or through extension of extant leave), the Responsible Clinician must consider whether the patient would be more appropriately made the subject of SCT. In granting leave in the community, rather than to another hospital, the Responsible Clinician is clearly indicating the possibility that the patient may need to be detained in hospital for treatment again, at some future point (whether specified or not). A patient on a community treatment order (CTO) will be treated while living in the community on an ongoing basis, and will only need to be detained in hospital should it be deemed necessary to use the power of recall.

**Restricted patients**

24.12 Any proposal to grant leave must be approved by the Secretary of State for Justice who should be given as much notice as possible, together with full details of the proposed leave.

**Informal patients**

24.13 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 of the Mental Capacity Act 2005), however patients may be asked by staff to inform them when they want to leave the ward.

**Short term leave**

24.14 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 which may be managed by other staff. As an example, the patient may be given leave for a shopping trip of two hours every week, with the decision on which particular two hours being left to the discretion of the responsible nursing staff. It is vital that such decisions fall within the terms of the leave granted by the Responsible Clinician, and that those terms and their implementation are reviewed periodically and the outcome explicitly recorded in the patient’s case notes.

**Longer periods of leave**

24.15 If the Responsible Clinician has determined that leave, rather than SCT, is the appropriate option for the patient, the leave must be properly planned and as far as possible well in advance.
24.16 Such leave may be used to assess an unrestricted patient's suitability for discharge from detention. The patient should be fully involved in the decision to grant leave and should in turn, be able to demonstrate that he or she is likely to be able to cope outside the hospital. Subject to the patient's consent there should be detailed consultation with any appropriate relatives, friends or other persons (especially where the patient is to reside with them) and liaison with community services. Leave should not be granted if the patient does not consent to the consultation of appropriate relatives, friends, other persons or community services that are to be involved in his or her care.

Recording and information

24.17 The granting of leave and the conditions attached to it, should be clearly recorded in the patient's case notes and copies given to the patient, any appropriate relatives or friends and any professionals in the community who may need to be informed of such plans. It is good practice for Hospital Managers to adopt a local record form on which the Responsible Clinician can authorise leave and specify any conditions attached to it.

Care and treatment while on leave

24.18 The Responsible Clinician's obligation for the patient's care remains the same whilst he or she is on leave although they are exercised in a different way. The duty to provide after-care under section 117 applies to patients who are on leave of absence, provided they would otherwise qualify (see chapter 24 of this Code).

24.19 Because the patient granted leave under section 17 remains 'liable to be detained' the provisions of Part 4 of the Act continue to apply. If it becomes necessary to administer treatment in the absence of the patient's consent under Part 4, consideration should be given to recalling the patient to hospital. The refusal of treatment may not on its own be sufficient grounds for recall.

Patients in custody or in other hospitals

24.20 The Responsible Clinician may direct that the patient remains in custody while on leave of absence, either in the patient's own interests or for the protection of other people. The patient may be kept in the custody of any officer on the staff of the hospital or of any person authorised in writing by the Hospital Managers. Such an arrangement is often useful, for example, to enable patients to participate in escorted trips, or to have compassionate home leave. This power however, can only be exercised within Wales and England.

24.21 Whilst it may often be appropriate to authorise leave subject to the condition that a patient is accompanied by a friend or relative (for example on a pre-arranged day out from the hospital), Responsible Clinicians should only specify that the patient is to be in the legal 'custody' of a friend or relative if that person understands and accepts the consequent responsibilities of being the patient's legal custodian, and if
it is appropriate for such a person to be legally responsible for the patient whilst on leave.

**Leave to another hospital**

24.22 Section 17 leave may be necessary to allow a patient to attend a general hospital for treatment, for example to undergo an operation. In these circumstances the Responsible Clinician should clearly set out the conditions for granting the leave, including any requirements for the patient to remain in the custody of staff. The Responsible Clinician must ensure that the staff in the second hospital understand the restrictions which the patient is under by virtue of their detention under the Act, as well as the safeguards they are afforded. It is important that those staff understand the limits and protections afforded by Part 4 of the Act to the patient. If the patient requires further leave of absence from the second hospital – for example, if their friends or family wish 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 the consultant or other professional in charge of their treatment in the second hospital.

24.23 Section 17 leave may also be used to grant a patient leave to another hospital for further treatment of their mental disorder, often as progression to a unit with lesser security (commonly referred to as ‘trial leave’). This can be a useful stage in the patient’s recovery programme. Therefore the Responsible Clinician can require that the patient, as a condition of leave, resides at another hospital in Wales or England and that he or she may be kept in the custody of an officer of that hospital.

24.24 Although, in these circumstances, day to day functions relating to the care of the patient can be delegated to an Approved Clinician at the second hospital, the functions of the Responsible Clinician to consider renewal of detention or granting further leave cannot be delegated.

24.25 The patient’s detention can be renewed during such a period of leave however consideration should be given as to whether it would be more appropriate to transfer the patient to the other hospital under the provisions of section 19 of the Act, rather than being given section 17 leave. For guidance on the exercise of the Hospital Manager’s responsibilities for considering the renewal of detention in these circumstances, refer to paragraph 27.8 of chapter 27 of this Code.

24.26 Section 17 leave is not required to allow a patient to be transferred from one hospital to another under section 19 of the Act. If a patient is being transferred between hospitals under section 19, that section of the Act provides the authority for the patient to leave the original hospital and be conveyed to the second hospital.

**Duration of leave and renewal of authority to detain**

24.27 A period of leave cannot last longer than the duration of the authority to detain, which was current when leave was granted. If the authority to detain an unrestricted patient might expire whilst the patient is on leave, the Responsible Clinician should examine the patient and consider writing a report.
renewing the detention, whilst the patient is still on leave, if the Responsible Clinician thinks that further hospital treatment is necessary and the statutory grounds are met. The renewal of detention and leave provides a further opportunity to consider if it would be more appropriate for the patient to be placed onto SCT instead.

### Recall to hospital

24.28 The Responsible Clinician may revoke the leave of absence of an unrestricted patient at any time, if he or she considers that this is necessary in the interests of the patient’s health or safety or for the protection of other people. A restricted patient’s leave may be revoked either by the Responsible Clinician or the Secretary of State for Justice. The effect of revoking the leave is that the patient again becomes an inpatient.

24.29 The Responsible Clinician must carefully consider the reasons for recalling a patient and the effect that this course of action may have on the patient’s care and treatment. As an example, the refusal to take medication may not on its own be a reason for revocation. The Responsible Clinician would have to be satisfied that the likely consequences of such a refusal would make it necessary in the patient’s interests or for the safety of others for the patient to be recalled.

24.30 If recall is considered necessary, the Responsible Clinician may, by notice in writing, revoke the patient’s leave. Such notice should be served on the patient or on the person for the time being in charge of the patient. The reasons for recall should be fully explained to the patient and a record of such placed in the patient’s case notes.

24.31 It is essential that any carers, friends or relatives of the patient, especially where the patient is residing with them whilst on leave, and practitioners in the community, have access to the patient’s Responsible Clinician if they feel that consideration should be given to the return of the patient to hospital, before his or her leave is due to end.

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24 R (on the application of DR) v Mersey Care NHS Trust [2002] EWHC 1810 Admin; [2002] MHLR 386
25. Absence without leave

25.1 This chapter gives guidance on the powers under section 18 of the Act to return a patient who is absent without leave.

**General matters**

25.2 Section 18 of the Act provides powers for the return of patients to hospital absent without leave that are liable to be detained or who have been recalled to hospital from supervised community treatment (SCT). Section 18 also applies to patients subject to guardianship, if they are absent without the leave of their guardian from the place they are required to reside.

25.3 All instances of absence without leave should be recorded in the patient’s case notes, and reported via local incident reporting mechanisms.

25.4 Reasons for a patient absconding may arise as a result of the patient’s inability to accept and co-operate in his or her treatment plan. Therefore where it is considered that a patient may try to abscond the Responsible Clinician should consider whether an alternative approach to treatment can be found. For example, where a patient is detained in hospital, consideration might be given to allowing a patient leave of absence or providing the patient with supervised community treatment, rather than making the patient subject to increased supervision.

**Patients who are liable to be detained**

25.5 Such patients are considered to be absent without leave if:-

- they have left the hospital without their absence being agreed by their Responsible Clinician (under section 17 of the Act);
- they have failed to return to the hospital at the time required to do so under the conditions of their leave under section 17;
- they are absent (without permission) from a place they are required to reside at as a condition of their leave under section 17; and
- they have failed to return to the hospital if their leave under section 17 has been revoked.

25.6 In these circumstances the patient may be taken into custody and returned to the hospital, or the place where he or she is required to live, by an Approved Mental Health Professional (AMHP), any officer on the staff of the hospital, any police officer, or any person authorised in writing by the Hospital Managers. If the patient is required to reside in another hospital as a condition of leave of absence, they may also be taken into custody by any officer on the staff of that hospital or by any person authorised by the managers of that hospital.
25.7 The patient may be initially taken to another hospital, for example because that is the closest hospital to where they are found. The temporary hospital may, if authorised by the managers of the detaining hospital in writing, detain the patient while arrangements are made for his or her return. Such authority can be provided by fax.

### Community patients

25.8 Patients on SCT are considered to be absent without leave if they fail to return to hospital upon being recalled, or if following recall they abscond from the hospital. They may be taken into custody by an AMHP, an officer on the staff of the responsible hospital, a constable, or anyone authorised in writing by the Responsible Clinician or the Hospital Managers and returned to the hospital to which they were recalled.

### Patients subject to guardianship

25.9 A person absent without leave whilst subject to guardianship may be taken into custody by any officer on the staff of the local social services authority (LSSA), or by any person authorised in writing by the guardian, or the LSSA. The patient may only be returned to the place they are required to reside at; there is no power to take the patient to a new place of residence.

### Local policies

25.10 It is the responsibility of the Hospital Managers, and of the LSSA (where a patient is subject to guardianship), to ensure that there is a clear written policy in relation to the actions which must be taken when a patient is absent without leave. All staff should be familiar with this policy.

25.11 The policy should include guidance as to:-

- the immediate action to be taken by any member of staff who becomes aware that a patient has gone absent without leave, including the requirement that they immediately inform the nurse in charge of the patient's ward who should in turn ensure that the patient's Responsible Clinician is immediately informed;
- the circumstances when a search of the hospital and its grounds should be initiated;
- the circumstances when other local agencies with an interest, including the local social services authority, should be notified, in the case of a patient detained in hospital;
- the circumstances when the police should be informed, in the case of a patient detained in hospital or, in the case of an SCT patient, absent without leave following recall to hospital. This should be the subject of agreed local arrangements with the police and in such circumstances the
police may be asked to assist in returning a patient to hospital only if absolutely necessary, but they should always be informed immediately of the absence without leave of a patient who is considered to be vulnerable, dangerous or who is subject to restrictions under Part 3 of the Act. There may be other cases where, although the help of the police is not needed, a patient’s history makes it desirable to inform them that he or she is absent without leave in the area. Whenever the police are asked for help in returning a patient they must be informed of the time limit for taking him or her into custody;

- the circumstances which would prompt an application being made under section 135(2) of the Act. Those people who have a power to return a patient to hospital (see paragraphs 25.6 and 25.8) do not have the power under section 18 of the Act to force entry into premises where the patient is staying. If powers of entry are required an application under section 135(2) should be made for a warrant authorising a policeman to enter the premises and remove the patient. Chapter 4 gives further guidance.

- how and when the patient’s Nearest Relative should be informed. In almost all cases the patient’s Nearest Relative should be informed immediately the patient goes absent without leave and any exception to this requirement should be clearly set out in the policy; and

- the action, which should be taken in the case of someone received into guardianship who is absent without leave from the place where he or she is required to reside. This should include immediate notification of the specified guardian and the local social services authority.
26. Supervised Community Treatment

26.1 This chapter provides guidance on the purpose of supervised community treatment (SCT) including the process for assessing the suitability of the use of SCT and the management of community treatment orders (CTOs). This chapter also provides guidance on the duties of the practitioners and agencies involved in the management of patient subject to SCT.

26.2 The purpose of supervised community treatment (SCT) is to provide eligible patients with a statutory framework for the delivery of their aftercare in the community. This is achieved by the Responsible Clinician placing the patient on a community treatment order (CTO). The CTO allows conditions to be applied to the patient and provides the means to recall the patient to hospital should this become necessary.

26.3 SCT therefore provides the option of earlier and safer discharge from hospital and enables timely return to hospital for treatment under compulsion if required using the power of recall. The framework helps to prevent relapse, but where relapse does occur, it enables the effective management of risk and helps to prevent crisis by removing obstacles to the efficient delivery of treatment and care.

26.4 Given the constraints inherent within SCT practitioners should pay particular attention to the guiding principles in chapter 1 when considering its use.

### Eligibility for supervised community treatment

26.5 Only patients who are detained under an unrestricted treatment or hospital order are eligible for SCT.

26.6 Patients can only be placed onto SCT if they meet the following grounds:-

- 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 persons that they should receive such treatment;
- subject to the patient being liable to be recalled as mentioned below, such treatment can be provided without their continuing to be detained in a hospital;
- it is necessary that the Responsible Clinician should be able to exercise the power under section 17E(1) to recall the patient to hospital; and
- appropriate medical treatment is available for the patient.

26.7 In order to decide whether or not the grounds above are met the Act requires the Responsible Clinician to consider the risk of the patient’s condition deteriorating upon discharge from hospital. In considering this risk the Responsible Clinician is required to have regard to the patient’s history of mental disorder and any other
relevant factors for example the patient's refusal or neglect in receiving the medical treatment he or she needs.

### Considering the use of SCT

26.8 Careful consideration should be given to the most appropriate means of ensuring the delivery of effective patient care and supervision with the community for those patients not subject to special restrictions under Part 3 of the Act. These include:

- granting short-term or extended leave of absence under section 17 of the Act;
- transfer into guardianship (section 7 of the Act); and
- supervised community treatment.

#### Section 17 leave

26.9 Section 17 leave will ordinarily be used for short duration leave as part of the delivery of the patient’s care plan, and in preparation for discharge from hospital. Before granting longer term leave of over seven consecutive days, or where leave is extended so that the total leave granted exceeds seven consecutive days, the Responsible Clinician must consider whether SCT is the more appropriate way of managing the patient in the community.

26.10 Under section 17 of the Act the patient remains liable to be detained and subject to the treatment or assessment order for the remaining duration of that order. Further guidance is given in chapter 24 of this Code.

#### Guardianship

26.11 A patient who is liable to be detained in hospital may be transferred into guardianship if they meet the grounds for its use. Guardianship confers upon the guardian the ability to supervise the patient within the community. The patient is not liable to be detained and is not subject to recall to hospital. Guardianship is most appropriately used to enable health and social care agencies to provide a framework that ensures the welfare of eligible patients. Patients subject to Guardianship can have conditions placed upon them for example to reside in a particular place or to attend particular places as set out in their care plan. It would not however, normally be used where ensuring the delivery of medical treatment is the primary objective. Further guidance is given in chapter 6 of this Code.

#### Community treatment

26.12 The potential for the patient's deterioration in the community is a key factor in considering the appropriateness of making a CTO. In assessing the risk of deterioration the Responsible Clinician must consider:-
• the patient’s history of compliance with treatment and care. The potential for non compliance may be clear if the patient has a long history of mental disorder however the assessment of the potential for non compliance must be equally considered where no such history exists; and

• other relevant factors – such as the patient’s current mental state, the degree of recovery from their mental disorder, their insight into their mental disorder, their attitude to treatment, and any protective factors such as the support of family friends or supported accommodation.

26.13 Whilst deterioration is a significant factor it should not be the only factor considered; if the clinician considers there is little risk of deterioration a CTO can still be made if it is required to manage the risk of future harm to the patient or other people.

### Making a community treatment order

26.14 The Responsible Clinician is responsible for initiating the process of making a CTO. The decision to make the order is taken jointly with an Approved Mental Health Professional (AMHP). The AMHP may be a member of the multi-disciplinary team involved in the care of the patient but this is not a requirement.

26.15 In reaching their decision Responsible Clinician and AMHP should consider the Code’s guiding principles and whether the objectives of the proposed CTO could safely and effectively be achieved in a less restrictive way.

26.16 In order to make a CTO the Responsible Clinician must be satisfied that all of the criteria are met and must have the written agreement of an AMHP that they are met, and that it is appropriate to make the order. The AMHP should ensure that they consider the patient’s wider social circumstances including any cultural issues. For example, they should consider any support networks the patient may have, the potential impact on the patient’s family, employment and educational circumstances.

26.17 If the AMHP does not agree that a CTO should be made, or agree the suggested conditions, the SCT cannot proceed. It would not be appropriate for the Responsible Clinician to approach another AMHP in the absence of any change in circumstances. Where such disagreement occurs an alternative plan to deliver aftercare should be developed by the relevant professionals in consultation with those people listed at 26.20 below.

26.18 In all cases the AMHP must reach an independent professional view.

26.19 If a CTO is agreed to be the right option for the patient, it will be important that the arrangements for the clinical oversight of the patient’s care once discharged onto SCT are considered as soon as possible. If a different Responsible Clinician is to take over responsibility for the patient, clearly early liaison with that clinician, and the community team, will be essential.
Consultation

26.20 Consultation should be undertaken at all the stages of SCT. The people to be consulted include:-

- the patient who may be supported by an Independent Mental Health Advocate during the consultation process;
- the Nearest Relative (unless the patient objects or it is not reasonably practicable);
- 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 GP; and
- other relevant professionals.

26.21 Consultation is clearly vital when a CTO is first considered for a patient but should also take place on any review of the CTO, when a change in the conditions is envisaged and where it appears that the patient needs to be recalled to hospital, unless the need for recall is too urgent to allow prior consultation.

Conditions

26.22 The CTO must include, in writing, any conditions which the patient is required to abide by whilst the order is in force.

26.23 The Responsible Clinician and the AMHP must agree that the conditions to be set are necessary and appropriate to ensure:-

- that the patient receives medical treatment;
- the prevention of risk of harm to the patient’s health or safety; and
- the protection of other persons.

26.24 Conditions should include the requirement for the patient to make themselves available for medical examination:-

- where extension of the CTO is being considered; and
- where necessary to allow a SOAD to provide a Part 4A certificate authorising the patient’s treatment in the community.

26.25 Conditions should be the minimum necessary to achieve their purpose and be in keeping with the Code’s Guiding Principles.
26.26 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 (see chapter 32).

26.27 Conditions might include stipulating where the patient is to live, the arrangements for receiving treatment in the community and may cover matters such as the avoidance of the use of illegal drugs and or alcohol where their use has lead to relapse in their mental disorder. There would need to be clear justification for any other conditions relating to behaviour, but it may be appropriate, for example, to require a patient to try to avoid certain situations if that is directly relevant to his/her health or safety or the protection of others.

26.28 Following the decision to make the CTO, the Responsible Clinician should inform the patient, orally and in writing, of the reasons for making a CTO, the conditions to be applied, and of their right to appeal to a Mental Health Review Tribunal for discharge. Unless the patient objects, the Nearest Relative should be informed, where practicable, of the conditions to be applied and of their right to discharge the patient from SCT. For further guidance refer to chapter 17 of this Code.

26.29 The patient’s GP should be informed that the patient is to be made subject to a CTO, as well as other professionals and members of the voluntary sector who are directly involved in the patient’s care plan. A copy of the care plan should be attached to the CTO.

26.30 Upon commencement of the CTO the patient becomes a “community patient” and the treatment order they are subject to (e.g. section 3) does not end or expire but the Hospital Managers’ authority to detain is suspended.

26.31 The CTO should form a part of the Care Programme Approach/Unified Assessment Process care plan and review. Where a CTO is in force it will form a fundamental part of the care planning and delivery process.

26.32 Once discharged from hospital close contact with the patient and the monitoring of their mental health and wellbeing 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 local service configuration. The patient’s compliance with the conditions will be a key indicator of how SCT is working in practice. If the patient is not complying appropriate action will need to be taken - this may entail review of the conditions, or indicate a need to consider if the patient should be recalled to hospital.
Varying and suspending the CTO conditions

26.33 The Responsible Clinician has the power to vary or suspend any of the conditions. There is no requirement for the Responsible Clinician to obtain an AMHP’s agreement before doing so, but it would not be good practice to vary or suspend conditions which had recently been agreed with an AMHP unless a change of circumstances had occurred and there is an urgent need to vary, for example, the delivery of treatment or the place of residence. The Responsible Clinician should, where practicable, discuss these matters with an AMHP.

26.34 A variation of the conditions might be appropriate where the patient’s treatment needs or living circumstances have changed. For example, if a patient has been attending a clinic weekly to receive medication and it is agreed that the medication needs to be given fortnightly, the Responsible Clinician can vary the conditions to reflect this change.

26.35 The Responsible Clinician may also suspend any of the conditions at any stage, for example, to allow for the patient’s temporary absence (e.g. on holiday) or due to a change in the treatment regime.

26.36 The Responsible Clinician should always consider the patient’s specific cultural needs and background when negotiating or varying the conditions.

26.37 Whenever any changes are made to the conditions it will be important to ensure that the patient, and anyone else affected by the changes, knows that they have been varied, understands why, and how to comply with any new conditions.

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

26.38 Particular attention should be paid to carers and relatives when they raise a concern that the patient is not complying with the conditions and/or their mental health appears to be deteriorating. The community team needs to give due weight to those concerns and any requests made by the carers/relatives in deciding what action to take. It may prompt a review of how the CTO is working and consideration of whether it might be necessary to recall the patient to hospital. Local protocols should be developed to consider how concerns raised should be addressed by the relevant treatment and care services.

Continuing a CTO

26.39 Patients should not be subject to SCT for longer than necessary. Consideration of whether the patient continues to meet the grounds for continuation of the CTO should be held under constant review. If the patient no longer meets the grounds for SCT the Responsible Clinician should discharge the patient from SCT.

26.40 A CTO will initially apply for six months. It can be extended for a further six months, then for further periods of one year at a time.
Before the CTO can be extended, the Responsible Clinician must examine the patient in the two months preceding the expiry date. The Responsible Clinician must consult one or more people who have been professionally concerned with the patient’s treatment, and take their views into account.

The Responsible Clinician must apply exactly the same considerations as when the CTO was first made. They may only make a report to extend the CTO if the patient still meets the grounds for a CTO.

An AMHP must agree that the grounds continue to be met, and that it is appropriate to extend the CTO, for the extension to take place. If the CTO is to be extended a report must be completed by the Responsible Clinician and the AMHP and sent to the Hospital Managers, who should consider the report (refer to chapter 27).

Recalling a patient subject to SCT

The power of recall is intended to prevent relapse becoming critical and leading to the patient or other people being put at risk. This is achieved by ensuring that the patient receives treatment quickly increasing the likelihood that the patient’s condition can be stabilised and that they can resume life in the community as soon as is practicable.

The Responsible Clinician may recall a patient on SCT to hospital for treatment if the patient needs to receive treatment for mental disorder in hospital and there would be a risk of harm to the health or safety of the patient or to other persons if the patient were not recalled for that purpose. The grounds for recall (see section 17E) must be satisfied before the recall power can be used.

A patient may also be recalled to hospital if s/he breaks a condition relating to making themselves available for medical examination to allow consideration of extension of the CTO, or for a Part 4A certificate to be made by a SOAD.

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.

Each case should be considered on its merits but any action should be proportionate to the level of risk posed by the patient’s non-compliance. In some cases negotiation with the patient, carer or other interested parties may resolve the problem and avoid the need for recall. It might also be sufficient to monitor a patient who has failed to comply with a condition requiring attendance for treatment, before deciding if the lack of treatment means that recall is necessary.

For some patients, the risk arising from a failure to comply with treatment could mean that immediate recall will be appropriate, in order to prevent the risk from escalating.
26.50 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.

26.51 Recall to hospital for treatment should not become a regular or normal event for any patient on SCT. In circumstances where recall is being used frequently, the Responsible Clinician should consider reviewing the patient’s treatment and consider whether the use of community treatment remains appropriate.

26.52 The power of recall is exercisable by a notice in writing to the patient (Form [x] of Mental Health (Hospital, Guardianship, Community Treatment and Consent to Treatment (Wales) Regulations 2008). A copy of the recall form should be sent to the Hospital Managers.

26.53 The patient may be recalled to hospital even if s/he is in the hospital at the time that the decision to recall is made.

**The effect of recall under SCT**

26.54 On recall the patient can immediately be taken and conveyed to hospital. There may be some circumstances in which the Responsible Clinician thinks it appropriate to allow the patient to make their own way to the hospital, for example where they are accompanied by a family member. If the patient then fails to attend for admission, in spite of having been recalled, they are considered absent without leave and can be taken and conveyed to hospital.

26.55 Where a patient has been recalled the recall notice provides authority to the Hospital Managers to detain the patient in accordance with the Act. The nature and duration of the detention will be determined by the Responsible Clinician and AMHP considering the most appropriate course of action for the patient.

**Options following recall**

26.56 Once the power to recall the patient has been exercised the Responsible Clinician with the agreement of an AMHP may:-

- release the patient: this may happen at any time within the first 72 hours of the patient’s detention in hospital following recall, the patient will continue to remain on the CTO as before but a review of the conditions may be considered necessary; and

- revoke the CTO - where the patient requires treatment beyond 72 hours the Responsible Clinician and AMHP may decide to revoke the CTO, in which case the patient becomes subject to the treatment order that had been in effect prior to the patient being made subject to the CTO.

25 The period of 72 hours commences from the time when the patient’s detention in hospital (by virtue of the notice of recall under section 17E of the Act) begins (see section 17F(8)(a)).
26.57 If neither of these options has taken place within 72 hours after the patient was detained following recall, the patient must be released and the CTO will remain in force.

26.58 The Hospital Managers may transfer the patient to another hospital in accordance with the Regulation 23.

### Revoking the CTO

26.59 Before the CTO can be revoked, the Responsible Clinician and an AMHP must agree that the patient requires medical treatment as an inpatient and meets the grounds for detention as set out in section 3(2) of the Act.

26.60 If the CTO is revoked, the patient’s detention under their original treatment section of the Act will be re-instated from the date of revocation. A new detention period begins for the purposes of subsequent review and applications to the MHRT.

26.61 Even where a patient has not exercised his or her right to apply to the MHRT, the Hospital Managers must refer the case to the MHRT for review as soon as possible after the CTO is revoked (see chapter 10).

### Discharge from SCT

26.62 The need for the patient to remain on SCT should be kept under review. It would be unlawful to fail to discharge a patient from SCT if he or she no longer met the grounds for SCT.

26.63 The patient can be discharged from SCT in the following ways:-

- discharge by the Responsible Clinician at any time;
- by the Hospital Managers either following application by the patient’s Nearest Relative giving not less than 72 hours notice;
- by the Hospital Managers under section 23 of the Act;
- by the Mental Health Review Tribunal; and
- following the patient’s reception into guardianship.

The effect of discharge is to end the CTO and liability to detention.

### Professional and agency responsibilities relevant to SCT

26.64 The Responsible Clinician is responsible for:-

- giving appropriate consideration to SCT as an alternative to longer-term section leave, if that is proposed;
• determining the eligibility and suitability of a patient for SCT;
• examining the patient;
• consultation with the patient, Nearest Relative carer and other professionals;
• making the CTO in accordance with the statutory requirements;
• determining the conditions to be applied to a CTO;
• suspending or varying the CTO conditions;
• oversight of the patient’s care and treatment in the community;
• ensuring the patient receives medical treatment under Part 4A of the Act;
• revoking, with the involvement of an AMHP, the CTO if that becomes necessary;
• exercising the power of recall;
• extension of the CTO; and
• discharging a patient from SCT if the patient no longer meets the criteria.

26.65 The AMHP is responsible for:-

• assessing the eligibility and suitability of a patient for SCT;
• considering and agreeing the conditions with the Responsible Clinician;
• assessing the appropriate decisions with regard to extension of the CTO;
• considering the recall of a patient from the CTO, as requested by the Responsible Clinician; and
• assessing the appropriateness or otherwise of extending the CTO.

26.66 The Hospital Managers are responsible for:-

• ensuring the correct procedures are followed in placing patients on SCT;
• liaising with the Local Health Board and Local Social Services Authority to ensure correct aftercare services are in place in accordance with section 117 of the Act;
• exercising their power to detain a recalled patient;
• ensuring that detention after recall does not last for more than 72 hours unless the CTO is revoked;
• exercising their powers to transfer responsibility from their hospital for patients on SCT as necessary; and
• considering the discharge of SCT patients.

26.67 The Local Health Board and Local Social Services Authority are jointly responsible for ensuring the provision of statutory aftercare services in line with the requirements of section 117 of the Act.
27. The Hospital Managers' power of discharge (Section 23)

27.1 This chapter is concerned with the processes and good practice that should be adopted by the Hospital Managers (or those delegated to act on their behalf) in considering whether they should exercise their power of discharge.

### Background

27.2 Section 23 gives the Hospital Managers (see chapter 10) the power to discharge an unrestricted patient from detention or Supervised Community Treatment; discharge of a restricted patient requires the consent of the Secretary of State for Justice.

27.3 The power may be exercised on behalf of the Hospital Managers by three or more members of a committee or sub-committee formed for that purpose. It is useful to both patients and staff that any such committee is referred to in a way which clearly indicates that they are a committee formed solely for the purpose of considering whether Hospital Managers’ power of discharge should be exercised.

27.4 In the case of a Trust or Local Health Board the committee or sub-committee must not include any employee or officer of the Trust or Board concerned. The committee or sub-committee should include a Non Executive Director of the Trust or Board. In the case of an Independent Hospital it is desirable that the committee or sub-committee does not include people who are on the staff of the hospital or have a financial interest in it.

27.5 The Hospital Managers retain the final responsibility for the performance of their delegated duties, including considering whether or not patients should be discharged.

27.6 The Act does not define either the criteria or the procedure for reviewing a patient's detention. However the exercise of this power is subject to the general law and public law duties which arise from it. The Hospital Managers' conduct of reviews must abide by the rules of natural justice:-

- they must adopt and apply a procedure which is fair and reasonable;
- they must not make irrational decisions, that is, decisions which no body of Hospital Managers properly directing themselves as to the law and on the available information, could have made;
- they must act in good faith and without bias, affording each party the opportunity to adequately state their case; and
- they must not act unlawfully, that is, contrary to the provisions of the Act, any other legislation and any applicable regulations.
Review panels

27.7 The panel must have at least three members. The Board must ensure that all those appointed to this role are properly informed and experienced and receive suitable training.

27.8 For patients on section 17 leave to another hospital, the Hospital Managers of the original hospital should undertake any necessary hearings.

When to review

27.9 The Hospital Managers should ensure that all patients are aware that they may seek discharge by the Hospital Managers and of the distinction between this and their right to a Mental Health Review Tribunal hearing.

27.10 The Hospital Managers:

a. may undertake a review at any time at their discretion;

b. must review a patient's detention when the Responsible Clinician submits a report under section 20(3) renewing detention or section 20A(4) renewing supervised community treatment;

c. must consider holding a review when they receive a request from a patient; and

d. must consider holding a review when the Responsible Clinician makes a report under section 25(1) opposing a Nearest Relative's application for the patient's discharge.

27.11 It is desirable that the Hospital Managers consider a report made under s20(3) or s20A(4) and whether it is appropriate to exercise their discretion of discharge, before the current period of detention or community treatment ends. However the Responsible Clinician’s report provides authority for a patient’s continued detention or community treatment under the Act

27.12 A restricted patient is entitled to ask the Hospital Managers to consider whether they should conduct a review of his/her detention, although the Hospital Managers may not discharge the patient following any such a review without the consent of the Secretary of State for Justice.

27.13 In the cases covered by paragraph 27.10c and d above the patient, or the Nearest Relative, will be actively seeking discharge. In the case where the Responsible Clinician submits a report renewing detention or extending SCT, the Hospital Managers are under a statutory obligation to consider the renewal or extension even if the patient does not object to it. The Hospital Managers may adopt

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26 R v Managers of Warlingham Park Hospital Ex p B (1994) 22 BMLR 1, CA
procedures that differentiate "uncontested" renewals from reviews where detention is contested by the patient (see below).

| Criteria |

27.14 The Act does not define specific criteria to be applied by the Hospital Managers when considering the discharge of a patient who is detained, liable to be detained or liable to be recalled. The Hospital Managers should consider whether the grounds for admission or continued detention or community treatment under the Act are satisfied.

27.15 For a patient who is detained, or liable to be detained, the review panel should consider the following questions in the order stated:-

- Is the patient still suffering from mental disorder?
- If so, is the disorder of a nature or degree which makes treatment in a hospital appropriate?
- Is detention in hospital for treatment still necessary in the interests of the patient's health or safety, or for the protection of other people?
- Is appropriate medical treatment available for the patient?

27.16 For a patient who is subject to SCT, the review panel should consider the following questions in the order stated:-

- Is the patient still suffering from mental disorder?
- If so, is the disorder of a nature or degree which makes appropriate for them to receive medical treatment?
- If so, is it necessary in the interest of patient’s health and safety or for the protection of other people?
- Can such treatment be provided without being detained in hospital but subject to being liable recall?
- Is appropriate medical treatment available for the patient?

27.17 In cases where the Responsible Clinician has made a report under section 25(1), and the Nearest Relative has not applied to the Mental Health Review Tribunal for a review, the managers should not only consider the questions above but also the following question:-

- Would the patient, if discharged, be likely to act in a manner dangerous to other persons or to him or herself?27

27.18 This question focuses on the probability of dangerous acts, such as causing serious physical injury, not merely the patient's general need for safety and others' general need for protection: it provides a more stringent test for continuing detention.

27 R v Riverside Mental Health NHS Trust ex parte Huzzey (1998) 43 BMLR
If, on consideration of the report under section 25(1) and other evidence, the managers disagree with the Responsible Clinician and decide the answer to this question is "no", they should usually discharge the patient.

27.19 If three or more members of the review panel are satisfied from the evidence presented to them that the answer to any of these questions is "no", the patient should be discharged.

27.20 Hospital Managers may order the immediate discharge of a patient, or make a decision not to order the patient’s discharge, in line with their findings. They may also:-

a. adjourn the hearing, in order to seek further evidence and information; or
b. make recommendations relating to SCT or guardianship; or
c. order the deferred discharge of the patient (which must not be a date after the current authority for compulsion ends).

Recommendations made by the Hospital Managers in this regard are not enforceable, but should be considered by the Responsible Clinician. Hospital Managers may not order the discharge of a patient subject to certain conditions being achieved (for example, an aftercare package being prepared).

27.21 When exercising their discretion in respect of patients who are liable to be detained, both the Hospital Managers and the Responsible Clinician should always bear in mind that detention under the Act will be incompatible with Article 5 of the European Convention of Human Rights, and therefore unlawful under the Human Rights Act 1998 unless it complies with the so-called “Winterwerp” criteria, namely that:-

- except in emergency cases, a true mental disorder has been established by objective medical expertise (this does not necessarily mean the expertise of a medical practitioner);
- the mental disorder is of a kind or degree warranting compulsory confinement; and
- the validity of continued confinement depends on the persistence of such a disorder.

27.22 Scrupulous adherence to the requirements of the Act and the guidance in this Code should prevent any such breach.

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28 R (on the application of Tagoe-Thompson) v The Hospital Managers of the Park Royal Centre [2003] EWCA Civ 330
29 R (on the application of SR) v Huntercombe Maidenhead Hospital [2005] EWHC 2361
27.23 The review should be conducted so as to ensure that the case for discharging, or continuing compulsion, of the patient is properly considered against the above ground and in the light of all relevant evidence. The review panel needs to have before it sufficient information about the patient's past history of care and treatment, and details of any future plans. The main source of this will be the patient's Care Programme Approach documentation or care plan. It is essential that the panel is fully informed about any history of violence or self-harm, and that a risk assessment has been conducted and the findings are available to the Hospital Managers.

27.24 In advance of the hearing the review panel should receive written reports from the patient's Responsible Clinician and others who are directly involved in the patient's care such as other Approved Clinicians, the key worker, named nurse, care co-ordinator, social worker and clinical psychologist. The patient should receive copies of the reports unless the Hospital Managers are of the opinion that the information disclosed would adversely affect the health or wellbeing of the patient or others.

27.25 The patient's nearest or most concerned relatives and any informal carer should be informed of the review, if the patient consents. Relatives and carers may be invited to put their views to the panel in person. If the patient objects to this a suitable member of the professional care team should be asked to include the relatives' and/or carer's views in his or her report.

27.26 The report submitted by the Responsible Clinician should cover the history of the patient's care and treatment and details of his or her CPA or care plan, including all risk assessments. Where there is a report prepared by the Responsible Clinician under section 20, 20A or 21B (as the case may be) renewing detention the panel should also have a copy of this before them. This should be supplemented by a copy of the record by the professional consulted by the Responsible Clinician (under s20(5) and (5A)). Any report made under section 25(1) should also be made available to the Hospital Managers. The written reports should be considered by the panel alongside the documentation compiled under the CPA.

27.27 The procedure for the conduct of the hearing is for the Hospital Managers to decide, but generally it needs to balance informality against the rigour demanded by the importance of the task. Where a patient is being treated in the community, consideration should be given as to the best venue for a hearing. The patient's home should never be used for such a review; in most cases a community setting would be more appropriate than requiring the patient to attend a hospital setting.

27.28 Key points are:-

- the patient should be given a full opportunity, and any necessary help, to explain why he or she wishes to be discharged;
• the patient should be allowed to be accompanied by a friend or representative of his or her own choosing to help in putting his or her point of view to the panel. This may be an Independent Mental Health Advocate (IMHA);
• the Responsible Clinician and other professionals should be asked to give their views on whether the patient's continued detention or continued community treatment order is justified; and the factors on which those views are based; and
• the patient and the other parties to the review should be able to hear each other's statements to the panel and to put questions to each other. However the patient should always be offered the opportunity of speaking to the panel alone.

27.29 While the panel must give full weight to the views of all the professionals concerned in the patient's care its members will not, as a rule, be qualified to form clinical assessments of their own. If there is a divergence of views about whether the patient meets the grounds for continued detention, especially in relation to matters such as risk assessment, the panel should consider an adjournment to seek further professional advice.

27.30 In applying the criteria set out above in paragraphs 27.17 to 27.19, and deciding in the light of them whether or not to discharge the patient, the panel needs to consider very carefully the implications for the patient's subsequent care. The multi disciplinary team should consider whether a care planning meeting would be appropriate prior to any hearing. The presence or absence of adequate community care arrangements may be critical in deciding whether continued detention is necessary in the interests of the patient's health or safety or for the protection of others. If the panel conclude that the patient ought to be discharged but arrangements for aftercare need to be made, they may adjourn the panel, for a brief period, to enable a full aftercare planning meeting to take place. The managers should ensure that a full risk assessment has been carried out when considering discharge.

Uncontested renewals

27.31 If a patient's detention or community treatment order is renewed or extended under section 20, 20A or 21B (as appropriate), and the patient has indicated that he or she does not object to this, the review panel should meet to consider the papers and should interview the patient (if the patient wishes) and his or her Care Co-ordinator. If the panel then agree that the patient should not be discharged the review can be concluded and the outcome recorded in the patient's records.

Decision

27.32 The Hospital Managers' should fully record the evidence they considered in reaching their decision, the reasons for reaching their decision, and the decision itself.
27.33 At the time their decision is made this should be communicated, both orally and in writing\textsuperscript{30}, to the patient, to the Nearest Relative with the patient's consent, and to the professionals concerned. At least one of the members of the panel should see the patient to explain in person the reasons for the decision. Copies of the papers relating to the review, and the formal record of the decision, should be placed in the patient's records.

\textsuperscript{30} R (on the application of O) v West London Mental Health NHS Trust [2005] EWHC 604 (Admin)
28. After-Care

28.1 This chapter outlines the responsibilities of Local Health Boards (LHBs) and Local Social Services Authorities (LSSAs) in providing after-care for certain patients under section 117 of the Act.

| Entitlement to statutory after-care |

28.2 Section 117 of the Act requires LHBs and LSSAs, in collaboration with non-statutory agencies, to provide after-care for certain categories of detained patients. This section applies to patients who are detained under sections 3, 37, 45A, 47, or 48, and then cease to be detained and leave hospital.

28.3 The requirement also includes patients granted leave of absence under section 17 (if they would otherwise qualify when leaving hospital permanently) and patients commencing supervised community treatment (SCT). Section 117 states that after-care must be provided for such patients throughout the entire period that they are subject to SCT.

28.4 LHBs, LSSAs and NHS Trusts should establish jointly agreed policies on providing services under this section. The policy should include an appropriate form for recording the after-care arrangements for patients.

28.5 After-care is a vital component in qualifying patients treatment and care plans, which aims to enable patients to develop and enhance their skills in order to adjust to life outside hospital and to live their lives successfully at home in their communities. The planning of after-care therefore needs to start when the patient is admitted to hospital and for those patients to whom Care Programme Approach (CPA) applies should continue as part of the CPA planning and review process.

| After-care services |

28.6 After-care services are provided in order to meet an assessed need that arises from the patient’s mental disorder and is aimed at reducing the patient’s chance of being readmitted to hospital for treatment for that disorder. Services will therefore normally include treatment for mental disorder, social work, support in helping the patient with problems of employment, accommodation or family relationships, the provision of domiciliary services and the use of day centre and residential facilities. Administration of medication for mental disorder, and its subsequent monitoring, will often be a key component of a patient’s after-care plan.

28.7 Services provided under s117 can include those directly provided by primary and secondary health and social care services as well as those provided under contract by private and voluntary service providers.

Section 117 and CPA

28.8 The key elements of the Care Programme Approach are that there should be:-

- a multidisciplinary approach to community care provision, in particular where this follows admission;
- systematic planning, recording and review of the patient’s care and support;
- the involvement of users and carers in the creation and review of the care plan;
- the appointment of a care co-ordinator, to take responsibility for overseeing the delivery of the care plan;
- flexibility of service provision, responding to the person’s changing needs; and
- regular reviews of the patient’s care plan, progress monitoring and where necessary, agreed changes.

28.9 These objectives apply to adult patients receiving treatment and care from specialist mental health services, whether or not they are admitted to hospital and whether or not they are detained under the Act. They are embodied in the CPA policy guidance.  

28.10 Whilst the after-care of detained patients should be included in the general arrangements for delivering the CPA, because of the specific statutory obligation it is important that all patients who are entitled to section 117 are identified and records kept.

After-care planning

28.11 Before any decision is made to discharge, grant leave to, or place a patient onto SCT, the Responsible Clinician must ensure (in full consultation with other professionals involved), that all of the patient’s needs have been fully identified, assessed and that the after-care plan addresses them in full. Where a patient is being granted leave for only a short period a less comprehensive review may be sufficient, but the arrangements for the patient’s care should still be properly recorded (refer also chapter 24).

28.12 The Responsible Clinician is also responsible for ensuring that:-

- a full assessment is made of any potential risk(s) to the patient or other people and that plans, services and support are available to manage any risks;

32 Welsh Assembly Government (2003b)
in the case of patients under Part 3 of the Act, the circumstances of any victim and their families are taken into account; and

• consideration is given to whether the patient meets the criteria for guardianship (refer chapter 6).

**Involvement in preparation of the after-care plan**

28.13 Those who should be involved in the preparation of the after-care plan to meet the patient's after-care needs include:-

• the patient, if he or she wishes and/or a nominated representative;
• the patient's Responsible Clinician;
• the patient's key worker/care co-ordinator;
• a social worker/care manager specialising in mental health work;
• the GP and primary care team;
• a community psychiatric/mental health nurse;
• a representative of relevant voluntary organisations;
• in the case of a restricted patient, the probation service;
• subject to the patient's wishes, any informal carer who will be involved in looking after him or her outside hospital;
• subject to the patient's wishes, his or her Nearest Relative;
• a representative of housing authorities, if accommodation is an issue; and
• a donee of a Lasting Power of Attorney, if appropriate.

28.14 An independent advocate can support the patient in formulating any care-plan.

28.15 It is vital that those who are involved in making such decisions are empowered to make commitments on behalf of their agency's involvement. If approval for plans needs to be obtained from more senior officials (for example, for funding) it is important that this causes no delay to the implementation of the after-care plan.

28.16 For patients who are placed in services away from their home area, it is important that services from their home area remain engaged with their care. This may be achieved through attendance at care planning meetings, and other discussions.

**Considerations for after-care**

28.17 Those concerned must consider the following issues when preparing the after-care plan:-
a. the patient's own wishes and needs, and those of any dependants;

b. the views of any relevant relative, friend or supporter of the patient;

c. the need for agreement with all other authorities and agencies in the area where the patient is to live;

d. in the case of mentally disordered offenders, the circumstances of any victim and their families should be taken into account when deciding where the patient should live;

e. the patients' carer(s);

f. the involvement of other agencies, for example probation or voluntary organisations;

g. the development of a fully agreed after-care plan with the patient and others, based on a proper and thorough assessment and clearly identified needs, including:

- physical health care
- day time activities or employment
- appropriate accommodation
- out-patient treatment
- identified risks and safety issues
- any parenting or caring needs
- social, cultural or spiritual needs
- medical and psychological support
- counselling and personal support
- assistance in welfare rights and managing finances; and
- a contingency plan should the patient relapse and crisis contact details

h. liaison with, and appointment of, a CPA care co-ordinator, who will manage and review the after-care plan with inpatient staff whilst the patient is still in hospital and will work with the community team and services after discharge. Such a role will be to monitor the after-care plan’s implementation, liaise and co-ordinate where necessary and report to the senior officer in their agency any problems arising which cannot be resolved through local discussion; and

i. the identification of any unmet need.

28.18 The professionals concerned must establish an agreed outline of the patient's needs, taking into account his or her social and cultural background, and agree a time-scale for the implementation of the various aspects of the after-care plan.
All key professionals with specific responsibilities must be properly identified. Once plans are agreed it is essential that any changes are discussed with all others involved with the patient before being implemented. The plan should be recorded in writing.

28.19 The after-care plan should be regularly reviewed. It will be the responsibility of the care co-ordinator to arrange reviews of the plan until it is jointly agreed that the patient no longer requires aftercare services (see paragraph 28.21). The senior officer in the key worker's agency responsible for after-care arrangements should ensure that all aspects of the procedure are followed.

### Mental Health Review Tribunals and Hospital Managers’ hearings

28.20 LHBs and LSSAs have the power to make preparatory after-care plans prior to a patient leaving hospital. In view of this, some discussion of after-care needs should take place between the LSSA and other professionals prior to the patient appearing before the Mental Health Review Tribunal (MHRT) or Hospital Managers, so that suitable after-care arrangements can be implemented in the event of the patient being discharged. This will also allow the MHRT or the Hospital Managers to be informed of what after-care arrangements might be made.

### Ending the duty to provide after-care services

28.21 The duty to provide after-care services exists until the LHB and LSSA have jointly come to a decision that the patient no longer requires aftercare services. The decision should take into account the views of the patient, their family and carers. A patient should not be discharged from care under s117 solely on the grounds that:

- the patient has been discharged from the care of a consultant psychiatrist; or
- an arbitrary period has elapsed since the care was first provided; or
- although the patient still requires aftercare services, the provision of such services has been successful in that the patient is now well settled in the community or in a care home.

28.22 There is no statutory duty on a patient to accept aftercare services, and as such they can refuse these services. An unwillingness to accept services should not be equated with an absence of need to receive services.
29. Assessment, admission and discharge under Part 3 of the Act

29.1 This chapter provides guidance on the assessment of people subject to criminal proceedings prior to possible admission to hospital. It goes on to give guidance relating to the admission of such patients, and their discharge.

General matters

29.2 People subject to criminal proceedings have the same right to psychiatric assessment and treatment as any other person in Wales. A person who is in police or prison custody, and who is in need of medical treatment for mental disorder which can only be satisfactorily given in a hospital as defined by the Act, should be admitted to such a hospital. If criminal proceedings are discontinued it may be appropriate for the police to alert the relevant local social services authority to allow them to consider whether an application under Part 2 of the Act would be appropriate.

29.3 All professionals involved in the operation of Part 3 of the Act should remember:-

- that mentally disordered people in police or prison custody may be very vulnerable. The risk of suicide or other self-destructive behaviour should be of special concern; and
- that a prison health care centre is not a hospital within the meaning of the Act. The provisions of Part 4 of the Act do not apply and treatment cannot be given within a prison without the patient’s consent other than in circumstances defined within the Mental Capacity Act 2005 (refer to chapter 33).

29.4 Mental health professionals should be familiar with:-

- the guiding principles set out in chapter 1 of this Code;
- the relevant provisions of the Act;
- the professional responsibilities of other disciplines and authorities and agencies; and
- available facilities and services.

Assessment

Assessment by a doctor

29.5 A doctor who is asked to assess an accused person to provide evidence to the Court in relation to a possible admission under Part 3 of the Act should:-
• identify him or herself to the person being assessed, explain who has requested the report and the limits of confidentiality in relation to the report, including that the data and the opinion will be relevant to the type of disposal by the Court (which could be a prison sentence or hospital disposal) or to sentence length and any subsequent consideration of release under supervision; and

• request relevant pre-sentence reports, the case notes from the prison, if there is one, previous psychiatric reports, as well as relevant documentation regarding the alleged offence. If any of this information is not available, the report to the Court should clearly state this.

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

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

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

29.9 In cases where the doctor cannot state with confidence at the time of preparing the report whether detention in hospital for treatment is appropriate, he or she should consider recommending an interim hospital order under section 38 of the Act, so that the court can reach a conclusion on the most appropriate and effective disposal.

29.10 If the doctor has concluded that 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, he or she 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), together with relevant supporting information which the LHB will need in order to discharge their responsibilities.

Assessment by an Approved Mental Health Professional (AMHP)

29.11 If an AMHP is requested to undertake an assessment in prison or court with a view to making an application for admission under section 2 or section 3 or guardianship, he or she must be given as much notice as possible. Suitable facilities should be afforded for the assessment to take place. 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**

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

- the data on which the report is based;
- how this relates to the opinion given;
- where relevant, how the opinion may be related to any medical condition defence or other trial issue;
- factors relating to the presence of mental disorder that may affect the risk that the patient poses to him or herself, or to others, including risk of re-offending; and
- if detention in hospital is recommended, what, if any, special treatment or security is required and how this would be addressed.

29.13 The report should not comment on guilt or innocence.

29.14 Before passing a custodial sentence on an offender who is or appears to be suffering from a mental disorder the Court is bound by the requirement in section 157 of the Criminal Justice Act 2003 to consider any information before it which relates to the offender’s mental condition. Except where the offence is one for which the law requires the imposition of a mandatory life sentence, the court must, before passing sentence, consider the effect of a custodial sentence on the offender’s mental disorder and on the treatment which may be available for it.

29.15 In a report submitted to the court it may be appropriate to include recommendations on the disposal of the case, including any need for a further report in the event of conviction. In making recommendations for disposal the doctor should consider the longer term as well as immediate consequences. Factors to be taken into account 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; and
- whether, in the event of the Court concluding that a prison sentence is appropriate, the offender should initially be admitted to hospital by way of a hospital direction under section 45A.
29.16 The power of the Court to order admission to a named unit was introduced by the Crime (Sentences) Act 1997 to enable the Court or the Secretary of State for Justice to specify a level of security in which the patient needs to be detained. It applies only to restricted patients. A named hospital unit can be any part of a hospital which is treated as a separate unit. It will be for the Court to define what is meant in each case where it makes use of the power. Admission to a named unit will mean the Secretary of State’s consent will be required for any leave or transfer from the named unit, whether the leave or transfer is to another part of the same hospital or to another hospital.

29.17 The need to consider the longer term implications of a recommended disposal is particularly important where an extended or indeterminate sentence for public protection is indicated under the Criminal Justice Act 2003. Unless the conviction is for murder, either a hospital order under section 37 or a prison sentence with a hospital direction under section 45A is available to the Court. The decision rests with the Court. The making of a hospital direction and a limitation direction will mean that from the start of his or her sentence the offender will be managed in hospital as if he or she was a transferred prisoner (under section 47 and 49). Thereafter the Responsible Clinician will have the option of seeking the patient’s transfer to prison at any time before his or her release date if no further treatment is necessary or likely to be effective.

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

**Provision of information to Courts**

29.19 Section 39 requires Local Health Boards (LHBs) and Health Commission Wales (HCW) and Primary Care Trusts (PCTs) on request, to provide information to courts regarding the availability of hospital places where admission of defendants usually resident in their area is being considered.

29.20 Courts should ensure procedures are in place to request information from the above-named bodies.

29.21 LHBs and HCW should:-

- be able to provide in response to a request from a court under section 39 of the Act, or other proper requests, up-to-date and full information on the range of facilities that would be available for a potential patient from their area, including secure facilities;
- designate a named commissioning lead to respond to requests for information; and
- work together as necessary to provide information about low, medium and high secure facilities.
Where information is requested from a PCT, the Mental Health Act Code of Practice for England will apply.

29.22 Section 39A requires a local social services authority to inform the court if requested, whether it or any other person is willing to receive the offender into guardianship and how the guardian’s powers would be exercised.

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

**Transfer of prisoners to hospital**

29.24 The need for in-patient treatment for a prisoner should be identified and acted upon quickly and contact made immediately with the responsible LHB or HCW by the Head of Healthcare in the prison (or delegated member of the prison health care team). Reference should be made to Prison Service Instruction (PSI) 3/2006 for guidance on effective process. At no point should delays in identifying the responsible commissioner delay the transfer of the prisoner to an appropriate facility.

**Patients admitted from custody**

**Transfer and admission**

29.25 At the time of transfer the following documents should be made available to the Hospital Managers:-

- an up-to-date medical report from the prison health service including details of any medication;
- a report from the prison health care service covering the patient’s day-to-day care and management including risk factors; and
- any relevant pre-sentence reports prepared by the probation service, which should be provided by the court, prison or immigration detention centre as appropriate.

29.26 It is important that all information is made available to the patient’s Responsible Clinician and other professional staff concerned at the earliest opportunity.

**Information**

29.27 When a person is transferred from prison to hospital under sections 47 or 48 as a restricted patient, it is the responsibility of the Hospital Managers and the Responsible Clinician to ensure that the patient has received, and as far as possible understood, the letter from the Ministry of Justice explaining the roles of Hospital Managers and Responsible Clinicians in relation to restricted patients. Further guidance on providing information to patients is given in chapter 17 of this
Code, and the Welsh Assembly Government has prepared leaflets [x] and [x] to support this process.

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

29.28 For patients on remand or subject to a hospital or interim hospital order (under sections 35, 36, 37 and 38) it is the Court's responsibility to organise appropriate transport from the Court to the receiving hospital, having due regard to the health and safety of both the patient and escorting staff.

**Return to court**

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

**Return to prison**

29.30 Particular care should be taken when remitting to prison patients who have been in hospital under sections 45A, 47 or 48. In order to ensure continuity of care, they should not be returned to prison without a section 117 after-care planning meeting being held, to which appropriate staff from the receiving prison should be invited, as well as any relevant community staff.
30. Children and young people under the age of 18

30.1 This chapter provides guidance for all professional practitioners and those people who work with children and young people who suffer from mental disorders and for the managers of agencies that deliver services for children. This chapter of the Code clarifies the legal framework in relation to children and gives practical guidance on dealing with some common uncertainties. The term 'young people' as used in this chapter refers to children who are 16 or 17 years old.

30.2 This chapter is concerned with:-

- the guiding principles which, taken together with the first chapter of this Code, should inform decision making for all children whether or not they are subject to compulsion or detention;
- the consent to assessment, treatment and care that is given by or on behalf of children who use services, including their admission to hospital;
- assessing, caring for and treating children who are subject to compulsion, including their detention, using powers given by the Mental Health Act 1983; and
- choosing between the Mental Health Act 1983 and the Children Act 1989 as amended.

**Guiding principles and overarching matters**

**Guiding principles**

30.3 The following paragraphs [30.4 to 30.15] apply to all children, whether subject to compulsion under the Act, assessed and treated on the basis of their own or, if relevant, the consent of persons with parental responsibility, or admitted to hospital informally.

30.4 Chapter 1 of this Code establishes the Guiding Principles that inform decisions made with respect to using the Act and which apply to children and adults.

30.5 In addition to those general principles, there are particular principles in respect of 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 their plans for services and when 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 be respectful and protecting of children; and
• services should operate within the spirit and intentions as well as the fact of the law.

30.6 These principles mean that the guidance set out 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 having regard to their age and understanding;
• children should always be kept as fully informed as possible, and should receive clear and detailed information concerning their care and treatment;
• children have the right to share in making decisions about their care and treatment by expressing their views, if they have any;
• any intervention in the life of each child that is considered necessary by reason 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 each child that is considered necessary by reason 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; and
• 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 that they must be carried out having regard to the need to safeguard and promote the welfare of children.

30.7 Generally (including whenever use is made of compulsion using the Act), when assessing caring for and treating children who are under the age of 16, the following questions (among many others) should be asked:-

a. Who has parental responsibility for the child? It is essential that those people who are responsible for the care and treatment of each child are clear about who has parental responsibility and staff should always request copies of any court orders for reference in hospital departments and wards. These orders may include care orders, residence orders, contact orders, evidence of appointment as the child's guardian, parental
responsibility agreements or orders under section 4 of the Children Act and any order under wardship.

b. If 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 his or her own decisions in terms of emotional maturity, intellectual capacity, mental state, and, if the child is under 16 years of age, his or her competence? (see paragraphs 30.17 to 30.50 in this chapter, chapter 11 in this Code and chapter 12 of the Code of Practice to the Mental Capacity Act).

d. If a parent or other person with parental responsibility refuses consent to treatment, what are the reasons and on what grounds are they made? Should an application to the court to authorise treatment be considered (e.g. where the person with parental responsibility has a mental disorder).

e. Could the needs of the child be met if social services or education resources or placement were made available and to what extent have these authorities carefully considered all possible alternative suitable interventions including placements away from home?

Education

30.8 All 16 or 17 year old patients who wish to continue their education should not be denied access to learning as a result of receiving medical care and treatment. The duties on local authorities are clearly set out in the Education Act 1996 and include powers to make provision for 16-19 year olds who are unable to attend school for medical reasons.

Admission to appropriate services

30.9 Children who are admitted to hospital for treatment of mental disorder should, subject to their needs, be accommodated in an environment that is suitable for their age. This means that children 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.

30.10 If, exceptionally, this is not practicable, discrete accommodation in an adult ward, with facilities, security and staffing that are appropriate to the needs of the child might provide the most satisfactory solution. If possible, all those staff who are involved in the care and treatment of children should be child specialists. They must always have been vetted satisfactorily with the criminal records bureau. If it is not possible to have such a specialist in charge of the child’s treatment, arrangements should be made for the clinical staff who are caring for the child or to have access to a practitioner who is a specialist in child and adolescent mental healthcare (i.e. an experienced specialist practitioner who has been trained and practices in delivering the functions of Tiers 2, 3 and/or 4 in the CAMHS Strategic Framework for Wales).
30.11 In a small number of 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. Furthermore, it is also important to recognise that there is a clear difference between what is a suitable environment for a young person in an emergency situation and what is a suitable environment for a young person on a longer-term basis. In an emergency, such as when a patient is in crisis, the important thing is that the patient is in a safe environment. Once the initial emergency situation has subsided, the Hospital Managers must consider what is a suitable environment. They should take into account matters such as whether or not the child can mix with individuals of their own age, receive visitors of all ages, and have access to education. Hospital Managers should consider whether a patient should be transferred to more appropriate accommodation and, if so, for this to be arranged as soon as possible.

30.12 If a young patient’s presence on a ward with other children might have a detrimental effect on the other young patients, the Hospital Managers must ensure that the interests of other patients are protected. However, the needs of other patients should not override the need to provide accommodation in an environment that is suitable for their age (subject to their needs) for an individual patient aged under 18.

**Welfare of children who are admitted to hospital**

30.13 NHS Trusts and Local Health Boards, and the services for which they contract, are subject to section 11 of the Children Act 2004, which means that they must carry out their functions having regard to the need to safeguard and promote the welfare of children.

30.14 Local authorities should ensure that they arrange for visits to be made to:-

- children looked after by them, whether or not they are the subjects of care orders, who are in hospital; and
- those children who are accommodated or intended to be accommodated for three months or more by Local Health Boards, NHS Trusts, local education authorities or in residential care. This is in addition to their duty in respect of children in their care in hospitals in Wales as outlined by section 116 of the Children Act 1989.

30.15 Local authorities should take any other steps in relation to a patient, while that person is in hospital, as would be expected to be reasonably undertaken by his or her parent and in the child’s best interests. Local authorities have a duty to:-

- promote contact between children who are in need and their families, if they live away from home and to help them get back together, if considered safe and appropriate to do so; and
- to arrange for persons (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.
30.16 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 period. When alerted to such a situation, the local authority should consider whether visits should be arranged as outlined above.

**Consent to assessment and treatment (not under the Mental Health Act 1983)**

30.17 Whenever a child is offered assessment and treatment, including admission to a hospital for treatment for a mental disorder, but is not subject to compulsion using the authority of the Act, those persons with responsibility for assessing, admitting and treating that child must be satisfied that they have legal authority to do so. As in the case of an adult, the assessment, treatment or admittance to hospital of a child without proper authority could amount to a deprivation of liberty in violation of Article 5 of the European Convention on Human Rights.

30.18 In many cases, the child is competent to give consent themselves and this is sufficient authority although clinicians must be satisfied that the consent is given voluntarily by a child who is capacitous and/or competent to do so, depending on their age. This Code provides advice on matters relating to competence, capacity and consent in paragraphs 30.21 to 30.51.

30.19 However, it can be complicated to determine the authority for assessing, treating or admitting a child who needs treatment for mental disorder and which might involve depriving that child of his or her liberty in view of the different scenarios that can arise.

30.20 Children can be divided into four broad groups when considering matters concerning their consent to medical assessment, treatment and admission to hospital for mental disorder. Details of relevant paragraphs are listed below in order to assist the people who are using this guidance:

- under 16 years of age who are competent: see paragraphs 30.24 to 30.28;
- under 16 years of age who are not competent: see paragraphs 30.29 to 30.38;
- 16 or 17 years of age who have capacity: see paragraphs 30.39 to 30.46; and
- 16 or 17 years of age who lack capacity: see paragraphs 30.47 to 30.51.

**The competence of children who are under the age of 16**

30.21 The competence of each child who is under 16 to give consent is a matter for judgement in each particular case. That judgement must be based on certain core principles that relate to being capacitous with respect to the particular decisions that are to be made but, additionally, also turns on the age and understanding of each particular child and the nature of the particular decision to be made.
30.22 Legal precedent in the Gillick case\(^{33}\) established that a child who is under 16 years of age is *competent* to give valid consent to be treated if they have “sufficient understanding and intelligence to enable him or her to understand fully what is proposed”. In ascertaining whether a child is competent, a clinician should consider factors such as the child’s mental and emotional age, intellectual development and maturity, his or her ability to be able to appraise the nature, consequences and implications of the treatment that is being proposed. In effect, this requires the doctor to conclude that the child has the *capacity* to make the particular decision to have the proposed treatment *and* is of sufficient understanding and intelligence to be capable of making up his/her own mind. Thus, in respect of children who are under 16 years of age, their being competent includes being capacitous but also goes beyond that concept. Children who are assessed as being competent in the meaning of the word that is adopted in this Code are often referred to as “Gillick competent”. Hereafter, this Code simply refers to them as being competent.

30.23 Competence can be lost as well as gained. Therefore, the question of competence must be assessed each time a question arises. Competence must always be assessed in the particular context of each particular decision. Nonetheless it is important when assessing whether a child is to be regarded as competent that competence is a developmental concept and will not be lost or acquired on a day to day or week to week basis. In the case of mental disability, that disability must also be taken into account, particularly where it is fluctuating in its effect. This means that the legal position is that, ordinarily, children’s competence does not vary rapidly unless some event, events or circumstances affect their competence. These events might include accident and injury, illness, and mental disorder.

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

30.24 In most instances, decisions about assessment, treatment and hospital admissions of children occur on the basis of them being informal patients who are under the age of 16 years. The authority for assessment, treatment and admission is the consent of the child or a person with parental responsibility. A child may give consent to treatment if they are competent. While a person with parental responsibility may give consent for a competent child and that consent may be valid, clinicians are advised not to rely on that consent but to seek consent directly from the child.

30.25 Children who are competent are able to make their own decisions and clinicians are advised not to rely on the consent of a person with parental responsibility. As a result, the approach taken in these circumstances should be the same for children as for adults. To put it simply, their decisions to consent or to refuse the treatment proposed and/or to be admitted to hospital for treatment should not be over-ridden by a person with parental responsibility.

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

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\(^{33}\) *Gillick v West Norfolk and Wisbech AHA [1986] AC 112*
30.27 A competent child who is under 16 years of age can consent to treatment but their refusal can be overruled by a person with parental responsibility. Clinicians should avoid relying on parental consent in these circumstances.

30.28 However, if a child who is competent decides that they do not want to consent to being treated for mental disorder or to being admitted to hospital, depriving the child of their liberty by detaining them should only take place if it is within the terms of the compulsory provisions of the Mental Health Act (i.e. if they meet all the conditions for compulsion). In the rare cases in which the primary issue is not the provision of medical treatment for mental disorder, but deprivation of the child’s liberty for other reasons, it may be appropriate to use section 25 of the Children Act. Section 25 and the Mental Health Act are not straight alternatives. Each should be used where the needs of the child concerned would be best met by using that particular framework (see paragraphs 30.55 to 30.58).

**Children under 16 who lack competence**

30.29 If a child who is under 16 years old is not assessed as being competent, it is usually possible for a person with parental responsibility to consent to treatment on their behalf. Clinical practitioners should also be aware that a person with parental responsibility does not automatically have an absolute right to consent to every type of care or treatment that is proposed for a child. Some procedures, for example, although not unlawful, may require the prior sanction of the court.

30.30 A child’s views should be taken into account, even if they are not competent. How much weight the child’s views should be given will depend on the level of maturity of that child.

30.31 Consent for a child under 16 years of age who is not competent can be given by the person or persons with parental responsibility for the child although clinicians should involve the child in the decision making process and seek the child’s co-operation.

30.32 It may be appropriate to seek the assistance of the court in the following circumstances:

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

30.33 The first matter to consider is whether the primary purpose of the intervention is to provide medical treatment for mental disorder. If it is, the next matter to consider is whether the consent of a person with parental responsibility is given.
30.34 If consent regarding the assessment and/or treatment of a child (including how the child is to be kept safely in one place) is given by a person with parental responsibility, it will be safe to rely on that consent and treat and/or admit to hospital on that basis as an informal patient. If, in the opinion of the clinician, it is safe and correct to rely on the parent’s consent, it is appropriate to respect the wishes of the person with parental responsibility as being in the best interests of the child. It should be noted that it would also be possible to assess or treat on the basis of an order made by the court under its inherent jurisdiction or by way of an order made under section 8 of the Children Act. However, if use of the Mental Health Acts is justified to compel a child’s assessment, treatment and/or detention in hospital, obtaining a court order is unlikely to be necessary.

30.35 If consent of a person who has parental responsibility is not given, the Mental Health Act should be used so long as the child meets the grounds for detention under that Act.

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

30.37 In the cases in which the primary purpose of the intervention is not to provide medical treatment for mental disorder, but the intervention does require the restriction of liberty of the child, then the use of Section 25 of the Children Act should be considered. If section 25 is used to restrict the liberty of a non-competent child, treatment may be authorised on the basis of parental consent (where they are prepared to consent to treatment, but not to detention) or on the basis of a court order using its inherent jurisdiction.

**Children who are under 16 and who have fluctuating competency**

30.38 If a child has been considered to have been competent to make a decision, but, later, loses that competence, any views he expressed before losing competence should be taken into account and may act as parameters that limit the application of parental responsibility. If, for example, a child has an expressed willingness to receive one form of treatment, but not another while competent and he or she then loses competence, it might not be appropriate to give the treatment previously refused to the child as an informal patient even if a person with parental responsibility consents to it.

**16 and 17 year olds with capacity**

30.39 With certain exceptions, the Mental Capacity Act applies to any person who is aged 16 or over. Therefore, the mental capacity of a child of 16 or 17 years of age must be assessed in accordance with that Act and must be applied when any decisions in respect of that child are made (refer chapter 33 of this Code).
30.40 Section 8(1) of the Family Law Reform Act 1969 provides that the consent of a young person of 16 years "… to any surgical, medical or dental treatment which, in the absence of consent, would constitute a trespass to his person, [and the consent] shall be as effective as it would be if he were of full age; and where a minor has by virtue of this section given an effective consent to any treatment, it shall not be necessary to obtain any consent for it from his parent or guardian”.

30.41 Therefore, the assumption is that children who are aged 16 or 17 are able to make their own decisions about treatment and clinicians should not rely on the consent of a person with parental responsibility. As a result, the approach taken in these circumstances should be the same for these children as for adults. To put it simply, a child who is aged 16 or 17 years and is capacitous can make his or her own decision about their assessment and treatment and whether they are admitted to hospital as an informal patient. If a child of 16 or 17 who has capacity has given their consent that consent cannot be overridden by a person who has parental responsibility for them.

30.42 Although the child’s decision to agree to assessment, treatment and/or admission cannot be overridden by a person with parental responsibility for them, it is good practice to encourage the child to involve their parents or carers in the decision, if appropriate.

30.43 Thus, if a young person aged 16 or 17 who has the capacity to make a decision on their healthcare consents to being admitted for treatment, they should be treated as an informal patient in accordance with section 131 of the Mental Health Act even if a person with parental responsibility is refusing consent.

30.44 Also, the fact that a child has given consent to be admitted to hospital does not provide authority for that child to receive medical treatment while they are in hospital and clinicians must ensure that they have the proper authority in every case where treatment is proposed.

30.45 The law provides that if a child of 16 or 17 refuses treatment then their refusal can be overruled by a person with parental responsibility. However, if a child has refused consent, a clinician should only ever rely on the consent of a person with parental responsibility in exceptional circumstances. In such a case, if the relevant criteria are met, it may be appropriate for the child to be assessed, treated or admitted using powers provided by the Mental Health Act or for the matter to be referred to the court.

30.46 If a child aged 16 or 17 who has the capacity to make a decision on their healthcare decides that they do not want to consent to treatment for mental disorder, the young person cannot be treated unless they meet the conditions to be detained under the Mental Health Act even if a person with parental responsibility is prepared to consent. In the rare cases in which the primary issue is not the provision of medical treatment for mental disorder but the deprivation of the young person’s liberty, it may be appropriate to use section 25 of the Children Act. Section 25 and the Mental Health Act are not straight alternatives. Each should be used where the

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34 Section 8 of the Family Law Reform Act 1969 and section 131(3) of the Mental Health Act 1983
needs of the young person would be best met by using that particular framework (see paragraphs 33.88 to 33.91).

**16 and 17 year olds without capacity**

30.47 If a 16 or 17 year old is regarded as being unable to make a decision for him or herself in relation to a matter because of an impairment of, or a disturbance in, the functioning of his or her mind or brain, the provisions of the Mental Capacity Act apply unless the treatment amounts to a deprivation of liberty in which case, see below (paragraphs 33.50 to 33.51).

30.48 Any decision to treat or admit a young person who is 16 or 17 years old and who lacks capacity must be in their best interests and must take account of the principles set out in the Mental Capacity Act, as expanded by that Act’s Code of Practice as well as those principles established in chapter 1 of this Code.

30.49 For young people who lack capacity, the situation depends on whether or not the primary purpose of the intervention is to provide medical treatment for mental disorder.

30.50 If detention is required, but the primary purpose is not medical treatment for mental disorder (e.g. in the case of a child who has a learning disability and who is considered to require deprivation of liberty for their own safety or the safety of others), then an application order under section 25 of the Children Act should be considered in order to detain the child.

30.51 If compulsion and/or detention in hospital are required and the primary purpose is medical treatment for mental disorder, then the Mental Health Act should be used, so long as the conditions are met.

**Children and the Mental Health Act 1983**

30.52 The Mental Health Act 1983 applies to children as well as to adults. There is no minimum age limit for its application, including for admission to hospital, although only a person who has attained the age of 16 can be received into guardianship.

30.53 When a child is being assessed with a view to an application for detention under the Act, at least one of the people who are involved in the formal assessment of the child (i.e. one of the two registered medical practitioners or the Approved Mental Health Professional) should be a practitioner who is a specialist in child and adolescent mental healthcare. This should be an experienced specialist practitioner who has been trained and practices in delivering the functions of Tiers 2, 3 and/or 4 in the CAMHS Strategic Framework for Wales. When this is not possible, such a specialist in child and adolescent mental healthcare should be consulted as soon as possible thereafter. See chapter 2 for fuller information on the assessment process.

30.54 Guidance on the administration of ECT to children, including informal patients, is given in chapter 13 of this Code.
Choosing between the Mental Health Act 1983 and the Children Act 1989 (as amended)

30.55 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. It is essential that careful consideration is given to the environment that is most appropriate for each child.

30.56 In considering which legislative framework is appropriate to meet a child's needs, it is particularly important to identify the primary purpose of the proposed intervention. If the primary purpose of the intervention with a particular child 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.

30.57 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 that are available by using the Children Act 1989. Under section 25 of the latter Act, the court may make an order for a child to be detained in secure accommodation although such an order does not provide authority for a child to be given any medical treatment.

30.58 Therefore, professional and managerial staff who address these questions should:

- be aware of the relevant statutory provisions and have easy access to competent legal advice;
- keep in mind the importance of ensuring that the child's care and treatment is managed with clarity, consistency and within a recognisable framework; and
- attempt to select the option that reflects the predominant needs of each child at that time whether that be to provide specific mental healthcare and treatment or to achieve a measure of safety and protection. Either way, the least restrictive option that is consistent with the care and treatment objectives for each child should be sought.

Seeking the assistance of the court

30.59 In some circumstances, it may be appropriate to seek the assistance of the Court in determining whether the proposed care or treatment is in the child's best interests.
30.60 Cases may arise:–

- when care and treatment decisions need to be made if a child is neither 16 nor competent and the person with parental responsibility cannot be identified, or is incapacitated;
- if a person with parental responsibility is thought not to be acting in the best interests of the child, or if the matter is considered may be outside their responsibility as parent; and
- in some instances when a child is competent, but is refusing treatment.

30.61 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 that the inherent jurisdiction of the High Court be sought to override a child's refusal, where it considers it is in the child's best interests.\textsuperscript{35}

### Additional guidance

30.62 In addition to the Mental Health Act 1983 (as it is amended by the Mental Health Act 2007) and this Code of Practice, professionals should also have access and regard to the following key guidance:–

- Child and Adolescent Mental Health Services, Strategy Document, Everybody's Business; and

Full reference should also be made to:–

- the Mental Capacity Act 2005 and its Code of Practice; and
- the Children Act 1989 and guidance on it (particularly Volumes 1, 4, 6 and 7);

\textsuperscript{35} South Glamorgan CC v W & B [1993] 18 LR 57.
31. People with learning disabilities or autistic spectrum disorder

31.1 This chapter provides guidance to professionals working with people with learning disabilities or autistic spectrum disorder (ASD), who may require additional consideration over and above the guidance outlined elsewhere in this Code.

| Learning disability |

31.2 A learning disability is an impairment of intellectual function, which significantly affects development and leads to problems in understanding and using information, learning new skills and managing to live independently.

Assessment under the Mental Health Act

31.3 The assessment of a person with a learning disability requires special consideration to enable and ensure clear two-way communication. Anyone involved in the assessment, should understand that high-quality and skilled communication is essential and should take all necessary steps to ease any difficulties.

31.4 Professionals trained in the mental health care of people with learning disabilities, should be involved wherever practicable. In addition, the Approved Mental Health Professional (AMHP) involved in any formal assessment under the Act should have training and experience in working with people with learning disabilities.

31.5 Where the examiners or assessors have only limited expertise with this patient group, it is good practice wherever possible, to seek advice from the local specialist service who should provide details of alternatives to compulsory treatment and give advice on good communication. This however, should not be allowed to delay action which is considered immediately necessary.

31.6 It is desirable that during examination or assessment, people with learning disabilities have someone with them who they know well and with whom they have good communication, which could include an advocate, provided this does not compromise the confidentiality of the examination.

31.7 The potential of co-morbidity with mental illness and personality disorder should also be borne in mind, in order that the skills of clinicians and others with appropriate expertise can be brought into play at all points in the assessment, treatment and care pathway.

31.8 In certain cases confusion may occur with regard to hearing impairment and learning disabilities. In such cases contact with specialist hospital units for hearing impairment and mental health may help to prevent incorrect diagnosis.
The legal framework

31.9 Learning disability is defined in the Act as a “state of arrested or incomplete development of the mind which includes significant impairment of intelligence and social functioning” (section 1(4)). For most purposes, except for admission for assessment under section 2 of the Act, a learning disability by itself is not considered a mental disorder unless it is associated with abnormally aggressive or seriously irresponsible conduct on the part of the patient. Whilst “significant impairment” is not defined in the Act, an IQ of below 70 can feature in the diagnosis of a learning disability.

31.10 The identification of an individual with a learning disability, who may meet this definition, is a matter for clinical judgement and subject to the legal requirements. Those who assess the patient must be satisfied that he or she displays a number of characteristics, which are difficult to define in practice, however the following can be considered a general guidance to key factors in the definition of learning disability for the purposes of the Act:-

- **Arrested or incomplete development of mind** - this means that the features, which determine the learning disability were present prior to adulthood and permanently prevented the usual maturation of intellectual and social development. It excludes persons whose learning disability originates from accident, injury or illness occurring after the point which is 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, must make a judgment as to the presence of this particular characteristic on the basis of reliable and careful assessment; and

- **Significant impairment of social functioning** - the evidence of the degree and nature of social competence should be based on reliable and recent observations, preferably from a number of sources such as social workers, nurses and psychologists. Such evidence should include the results of one or more social functioning assessment tests.

31.11 Where consideration is being given to detention in hospital (other than admission for assessment) or reception into guardianship under the Act where the mental disorder is based on a learning disability alone, at least one of following features must also be associated with the learning disability:-

- **Abnormally aggressive behaviour** - any assessment of this category should be based on observations of behaviour which lead to a conclusion that the actions are outside the usual range of aggressive behaviour, and which cause actual damage and/or real distress occurring recently or persistently or with excessive severity; and

- **Seriously irresponsible conduct** - the assessment of this characteristic should be based on an observation of behaviour, which demonstrates a lack of responsibility, or a disregard of the consequences of action taken,
and where the results cause actual damage or real distress, either recently or persistently or with excessive severity.

31.12 Except where urgent action is required no patient with a learning disability should be diagnosed as meeting either of these additional conditions without having been assessed by a Consultant Psychiatrist with special experience in learning disabilities and having received a formal psychological assessment. This assessment should form part of a comprehensive appraisal by medical, nursing, social work and psychology professionals, with special experience in learning difficulties. Such an assessment should (where practical and appropriate), be carried out in consultation with a relative, friend or supporter (for example, an advocate) of the patient.

**Treatment and care**

31.13 All those involved in the examination, assessment, treatment or decision making in relation to people with learning disabilities should bear in mind that there are specific problems which such patients may encounter. These include:-

- an assumption by staff that they lack the capacity to make decisions for themselves and a tendency to be over-protective towards them;
- over reliance by professionals on family members, both for support and for decision-making. This may put families in the difficult position of having to make decisions on behalf of the patient where it may not be appropriate to do so;
- a lack of appreciation of the potential abilities of people with learning disabilities, including their potential to speak up for themselves;
- the potential to be denied full and inclusive access to the decision-making process, for example, not being included in meetings about them, not having information made accessible to them, and having decisions made in their absence;
- limited life experiences to draw on when making choices; and
- difficulties in understanding what is being explained to them and explaining their views. Moderate levels of anxiety may severely worsen this.

31.14 Those working under the Act with people with learning disabilities should also consider the following general points:-

- many people with learning disabilities are able to make their own decisions regarding medical treatment and other areas of their lives. They should be provided with the information and support necessary to do this;
- in law, capacity must be assumed unless there is evidence to the contrary;
- people with learning disabilities experience prejudice and discrimination in society. Care professionals therefore, should have specific skills and awareness of the issues which people with learning disabilities may face;
• the needs and wishes of the person with learning disabilities in relation to the role of their family should be afforded the same importance as any other patient;

• people with learning disabilities may have limited spoken language; Behaviour may replace language as a form of communication and it is therefore important to recognise behaviour which represents communication rather than a symptom of mental disorder (for example hitting out because they do not want to go to hospital);

• people with learning disabilities may have problems managing in environments they find new or frightening such as a hospital or clinical setting. Every effort therefore, should be made to adapt to their needs in order to maximise communication;

• information should be appropriate in format and content, for each patient with a learning disability, making it both relevant and as easy as possible for the patient to understand;

• the most appropriate method of communication for each person with learning disabilities (taking into account how they receive and understand information), should be identified as soon as possible. It is helpful to identify a specific person who will undertake this task;

• some people with learning disabilities may prefer to have communication through written material in simple language with images to assist. This can be reinforced verbally, by personal contact, or other means such as audio tape, CD or video. It can also be helpful to repeat information and keep a record of what information has been passed on and how;

• it is important to set aside sufficient time to allow for preparation of suitable information and for preparation before meeting. This should include anyone who is supporting the person with a learning disability as they will need time to understand the options and to present them in ways which will support communication; and

• that people with learning disabilities will need to be given information about their rights, in a form which they can understand. In the case of information about the Mental Health Review Tribunal it will need to be designed to help them understand its role. They may well need support to make an informed decision about whether and when to make an application.

### People with autism

31.15 The World Health Organisation define autism as follows:-

“the group of pervasive developmental disorders characterised by qualitative abnormalities in reciprocal social interactions and in patterns of communication and by a restricted, stereotyped, repetitive repertoire of interests and activities”.

206
31.16 The Act’s definition of mental disorder does include the full range of autistic spectrum disorders including those existing alongside a learning disability or any other kind of mental health problem. It is possible, although rare, for someone on the autistic spectrum to meet the conditions for treatment under the Act without having any other form of mental disorder.

31.17 The autistic spectrum covers disorders, which occur from early stages in development with the person showing marked deficiencies in social skills, having difficulties with transitions or changes and preferring a routine. They may be preoccupied with a particular subject of interest.

31.18 These disorders are developmental difficulties and not mental illnesses in themselves. They may however, be associated with mental illness such as anxiety and mood disorder. People can become frustrated when they and/or others fail to understand each other, or in particular settings, and this frustration can occasionally lead to seriously irresponsible or aggressive behaviour if not properly managed.

**General care and treatment**

31.19 Generally, the care and treatment of those with autistic spectrum disorders should follow those guidelines outlined above in respect of learning disability patients.

31.20 A person with an autistic spectrum disorder however, may have additional sensory and motor difficulties, which make them behave unusually and which could be interpreted as a mental illness but is in fact a coping mechanism. Eccentricity in anyone is not itself a reason for compulsion.

31.21 There can also be a repetitive element to behaviour, where someone appears to be making a choice, however their range of behaviour is very limited and potentially very harmful. Repetitive behaviour in itself does not constitute a mental disorder.

31.22 A person with an autistic spectrum disorder may show a marked difference between their intellectual and their emotional development, leading on occasion to aggressive or seriously irresponsible behaviour. They may be able to discuss an action intellectually and express consent to it, or confirm a desire to not do something, but not necessarily have the emotional maturity to carry out their intentions.

31.23 The therapeutic team should in such circumstances endeavour to help the person to understand their own behaviour and work with them to minimise it. When the person is unable however, to prevent themselves from causing severe harm to themselves or others, compulsion under the Act may become necessary.

31.24 People with social and communication disorders can become mentally ill and this mental illness may need compulsory treatment. Where possible a person brought to hospital under compulsion should be placed in a setting which can accommodate their social and communication needs as well as treat the mental disorder.
Further information

31.25 The draft *Autistic Spectrum Disorder (ASD) Strategic Action Plan for Wales* sets out how the Welsh Assembly Government expects people with ASD to be supported, and to ensure that support services provided by a range of organisations are delivered appropriately and in a co-ordinated fashion.
32. Victims

32.1 The victims of certain mentally disordered offenders detained in hospital have rights to make representations and receive information about such patients’ discharge (see below). This chapter provides guidance on these matters.

32.2 This chapter also provides guidance on the liaison with victims outside of these circumstances.

**Domestic Violence, Crime and Victims Act 2004**

32.3 The victims of certain mentally disordered offenders have rights to make representation and receive information about the patient’s discharge, as provided by the Domestic Violence, Crime and Victims Act 2004 (“the DVCV Act”). This applies where a person is convicted of a sexual or violent offence and the person is made subject to:

- a hospital order with or without a restriction order;
- a hospital and limitation direction; and
- a transfer direction with or without a restriction direction.

The provisions also apply where the person is made subject to a restriction order, limitation direction or restriction direction which subsequently expires or is lifted.

32.4 The definition of “victim” under the DVCV Act includes any person who appears to the local probation board to be, or to act for, the victim of an index offence. As a matter of practice this should be taken to include a victim’s family in a case where the offence has resulted in the victim’s death or incapacity, and in other cases where the victim’s age or personal circumstances make it sensible to approach a family member in the first place.

32.5 Under the DVCV Act, the victim of the offence has a right to make representations about any conditions to be attached to the patient’s discharge; and to receive information about the discharge.

32.6 Where the DVCV Act applies, following conviction of a mentally disordered offender for a violent or sexual offence, the local probation board will contact the victim(s) to see if they wish to make representations or receive information.

**Restricted patients**

32.7 The requirements in relation to restricted patients apply to cases where an order or direction is made on or after 1 July 2005.
32.8 The probation service (via the Victim Liaison Officer or VLO) are responsible for all contact with the victim. The DVCV Act requires the Secretary of State for Justice and the Mental Health Review Tribunal to notify the VLO of certain information, including if discharge is being considered. The Act does not place any statutory requirements on clinicians or Hospital Managers to disclose or forward information.

32.9 Victims may make representations about a patient’s conditions of discharge. Victims are entitled to receive information about whether the patient is to be subject to any conditions in the event of his or her conditional discharge; to receive details of any conditions which relate to contact with the victim or the victim's family; whether these conditions are to be varied; and, where the restriction order is to cease to have effect, to be notified of the date on which it ceases to have effect.

32.10 Where a patient is transferred to a different hospital, in the case of restricted patients, the Secretary of State for Justice may, if appropriate, notify the VLO so that the VLO may make contact with the new Responsible Clinician. VLOs may inform victims of the fact of transfer, on the understanding that they should not inform them of the name or location of the hospital.


### Unrestricted patients

32.12 The requirements in relation to unrestricted patients apply to cases where an order or direction is made on or after [commencement date].

32.13 As is the case with restricted patients, the VLO will take the initial steps, at the time of conviction, to establish (a) if the victim wishes to make representations as to whether the patient should be subject to conditions in the event of the patient’s discharge from hospital; and (b) whether the victim wishes to receive information about those conditions in the event of the patient’s discharge.

32.14 When the offender is detained in hospital under a hospital order, the VLO must notify the Hospital Managers of the hospital in which that patient is detained of the victim’s wish to receive information and make representations, and the name and address of the victim. They must also notify the victim of the name and address of the hospital. The communication from then on should be between Hospital Managers and the victim. Where a patient subsequently moves hospital the managers of the hospital where the patient was prior to transfer should take responsibility for ensuring that the victim and the managers of the new hospital have one another’s contact details.

32.15 If a victim of an unrestricted patient initially declines, but then subsequently expresses a wish to make representations or receive information under the DVCV Act, the probation board must find out whether the hospital order is still in force and, if it is, notify the Hospital Managers as set out above.
32.16 The Hospital Managers have a responsibility to inform the victim (if they have requested information):-

- if the patient’s discharge is being considered or if the patient is to be discharged; and
- whether the patient is to be subject to a community treatment order; and to inform the victim of any conditions relating to contact with the victim or the victim’s family made under the community treatment order. The victim should also be informed of any variation of the conditions and the date on which the community treatment order will cease.

32.17 In order that Hospital Managers are in a position to comply with these obligations, the Responsible Clinician and the Mental Health Review Tribunal must inform the Hospital Managers if the patient is to be discharged.

32.18 The Responsible Clinician must also inform the Hospital Managers whether he or she is to make a community treatment order and give the Managers information regarding the imposition or variation of any conditions to that order and the date that order will end.

32.19 Victims have the right to make representations about the conditions to be attached to a community treatment order. Hospital Managers must forward any such representations to the Responsible Clinician.

32.20 Under the DVCV Act, the probation board (in the context of restricted patients) and Hospital Manager (unrestricted patients) may also provide “such other information to the victim as [they consider] appropriate in all the circumstances of the case”; this is intended to allow them the discretion to give information which will reassure victims. It is not intended to require disclosure of any information which the Responsible Clinician would not otherwise disclose because of patient confidentiality.

32.21 There should be liaison between care teams and the VLO or Hospital Managers in each case where a victim decides that they wish to make representations or receive information under the DVCV Act.

32.22 It is for the clinical team and the VLO or Hospital Manager to decide the level of contact between them e.g. whether or not the VLO or a Hospital Manager (or officer acting on their behalf) should attend any meetings with the team about the case. It may be helpful for the team to know the views of any victim of the offence.

32.23 The requirements of the DVCV Act relate to provision of information about discharge and conditions of discharge or community treatment. The following guidance, on areas not covered by the DVCV Act, may be helpful regarding the disclosure of information to the VLO or Hospital Managers.
32.24 Where a patient detained under the Act is both competent and willing to agree to the disclosure to victims of specified information about his or her care, this should be encouraged to enable victims and victims’ families to be informed about progress. It can be important to a patient's rehabilitation that victims understand what has been achieved in terms of modifying offending behaviour.

32.25 Disclosure of such information also serves to reduce the danger of harmful confrontations after a discharge of which victims were unaware. Without prejudicing a patient's right to confidentiality, care teams should be ready to discuss with the patient the benefits of enabling some information to be given by professionals to victims, within the spirit of the Code of Practice for Victims of Crime (http://www.homeoffice.gov.uk/documents/victims-code-of-practice).

32.26 The patient's consent to the disclosure of such information must be freely given and he or she will need to understand the implications of agreeing to such disclosure. Care must be taken not to exert any pressure on the patients, which might bring into question the validity of the patient’s consent. If the patient has been convicted of a sexual or violent offence, the provisions of the DVCV Act may apply (see above).
33. The Mental Capacity Act 2005

33.1 This chapter provides guidance on the interface between the Mental Health Act and the Mental Capacity Act 2005.

33.2 Professionals and other paid workers who are involved in the care of people who lack capacity are under a duty to have regard of the Mental Capacity Act Code of Practice; this involves being aware of its contents and being able to show how the guidance within it has been followed. This chapter does not attempt to describe in detail the way in which the Mental Capacity Act works. For more detailed information, readers are advised to look at that Act and at the associated Code of Practice which contains a specific chapter on the interface between the two pieces of legislation.

33.3 A patient subject to detention, guardianship or supervised community treatment (SCT) under the Mental Health Act, should not automatically be considered as lacking capacity to take decisions about their own mental health care or any other matter.

33.4 Similarly, people who do lack capacity to make decisions do not cease to be protected by the Mental Capacity Act just because they happen to be subject to the Mental Health Act.

33.5 All those who are involved in treating or making decisions about patients who are (or who might be) subject to detention, guardianship or SCT under the Act need to be familiar with the key principles of the Mental Capacity Act. This includes:

- Approved Mental Health Professionals (AMHPs) need to be familiar with the Mental Capacity Act, in order to properly and appropriately evaluate possible alternatives to applications for admission and guardianship or to determine whether the making of a community treatment order is appropriate;
- Doctors making recommendations in support of applications similarly need to be familiar with the Mental Capacity Act in order to make appropriate recommendations;
- Responsible Clinicians need to be familiar with the Mental Capacity Act in order to properly and appropriately exercise their functions in relation to discharge, renewal and extension of compulsory measures. The same is true of Hospital Managers in relation to their powers of discharge; and
- Approved Clinicians in charge of patient’s treatment need to be familiar with the Mental Capacity Act in order to properly exercise their functions under Part 4 and 4A of the Mental Health Act.
33.6 All professional staff involved in the treatment of people with mental disorders need to understand what the limits and boundaries under the Mental Capacity Act. This is vital in order to ensure necessary and/or appropriate actions are taken in relation to the treatment or care of people who lack capacity to consent to it, either for mental disorder - where the Mental Health Act does not provide its own authority - or for other purposes.

### Defining capacity in the Mental Capacity Act

33.7 A person lacks capacity in relation to a matter if at the material time they are unable to make a decision for themselves in relation to the matter because of an impairment of, or a disturbance in the functioning of the mind or brain. It does not matter whether the impairment or disturbance is permanent or temporary.

33.8 A person is unable to take a decision for themselves if they are unable to:

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

33.9 In the main, the Mental Capacity Act applies to people subject to the Mental Health Act in the same way as it applies to anyone else, in relation to decisions about their property, affairs and their personal welfare.

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

33.10 Where treatment is regulated by Parts 4 or 4A of the Mental Health Act section 5 of the Mental Capacity Act may not be relied upon as an alternative legal basis on which to give or consent to the giving of such treatment.

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

33.12 Neither can the Mental Capacity Act provide an alternative authority for any treatment, which is regulated by section 57 of the Mental Health Act (e.g. neurosurgery for mental disorder). It therefore remains the case that such treatments can only be given to patients (whether informal or detained) after statutory certification that the patient has given valid consent and that the treatment should be given.
Roles and powers of attorneys, deputies and the Court of Protection

33.13 The fact that a person is subject to the Mental Health Act does not affect the validity of any Lasting Power of Attorney (LPA), the authority of an attorney or deputy (or the Court of Protection), to make decisions on their behalf. Similarly, it does not prevent such people creating new LPAs, provided they have the capacity to do so; it does not prevent the Court from appointing a deputy to take decisions for them, when they lack the capacity to make themselves.

33.14 Attorneys and deputies are therefore able to take any decisions in relation to the welfare, property or affairs of a person subject to the Mental Health Act that they are otherwise authorised to take, with two exceptions:-

- they will not be able to consent on the patient’s behalf to treatment which is regulated by Part 4 of the Mental Health 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 reside, nor make other decisions which conflict with those of a guardian.

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

33.16 Attorneys and deputies are able to exercise patients’ rights under the Mental Health Act on their behalf, if they have the relevant authority under the LPA or the order of the Court appointing them and the patients concerned lack the capacity to do so themselves. In particular the LPA may authorise personal welfare attorneys and deputies to exercise the patient’s various rights to apply to the Mental Health Review Tribunal (MHRT) or the Hospital Managers for discharge from detention, guardianship or supervised community treatment.

33.17 Attorneys and deputies may not exercise the rights of Nearest Relatives, unless they are themselves the Nearest Relative (because the rights belong to the Nearest Relative not the patient.) Where there is disagreement between a Nearest Relative and an attorney or deputy, it would be helpful for the two to discuss the issue, perhaps with the assistance of the patient’s clinicians or social worker/Approved Mental Health Professional. Ultimately an attorney or deputy must act in accordance with their authority and in what they believe to be the patient’s best interests.

33.18 It is good practice for clinicians and others involved in the assessment and/or treatment of patients under the Mental Health Act to try to find out if the person has an attorney or deputy, however it may not always be practicable.
33.19 To ensure that they are informed, and where relevant consulted about the patient's care, attorneys and deputies are advised to make themselves known either to the clinician responsible for the patient's care, or to the managers of the hospital at which the patient is detained. In the case of SCT patients, attorneys and deputies should make themselves known to the responsible hospital.

33.20 Attorneys and deputies may find it helpful to use hospitals’ Mental Health Act Administrators’ office as a useful first point of contact in relation to patients who are detained or subject to SCT.

**Independent Mental Capacity Act Advocates**

33.21 Under the Mental Capacity Act, NHS bodies or local authorities (as appropriate) are required to instruct Independent Mental Capacity Advocates (IMCAs) to represent people who are otherwise unbefriended, where the NHS body or local authority proposes:

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

An IMCA can also be instructed in cases of neglect or abuse of an adult, and where there are reviews being undertaken of accommodation arrangements.

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

33.23 A duty however to consult an IMCA, may arise in connection with serious medical treatment for physical disorder proposed for a patient who happens to be detained under the Mental Health Act. Similarly such a duty may arise in connection with accommodation being planned for other people who are to be accommodated as part of the after-care which the NHS and local social services authorities are required to provide under section 117 of the MHA.

**Deprivation of Liberty authorisations under the Mental Capacity Act 2005**

33.24 Where a person aged 16 or over lacks capacity to consent to admission and/or treatment for mental disorder, the Mental Capacity Act may offer an alternative which makes compulsory admission unnecessary. However, in the case of a person who needs to be detained in hospital for assessment or treatment of their mental disorder, the Mental Capacity Act will only offer an alternative if the patient satisfies the qualifying requirements that are set out in that Act.
33.25 A person can be detained under the Act and subject to a Deprivation of Liberty authorisation providing they meet the eligibility and other qualifying requirements. Further information about deprivation of liberty authorisations is in the Deprivation of Liberty Addendum to the Mental Capacity Act Code of Practice.
Bibliography

The following documents have been referred to in this Code of Practice:-

Welsh Assembly Government (2001a) *Adult Mental Health Services for Wales, Equity, Empowerment, Effectiveness, Efficiency* [Strategy Document]


Welsh Assembly Government (2003a) *The Strategy for Older People in Wales*

Welsh Assembly Government (2003b) *Mental Health Policy Guidance: The Care Programme Approach for Mental Health Service Users*


Welsh Assembly Government (2007a) *Statement on Policy and Practice for Adults with a Learning Disability*


Further guidance is also available in the following publications:-

Welsh Assembly Government ([year]) *Reference Guide to Consent to Examination and Treatment*
