Department of Health

Mental Health Act 1983: Code of Practice

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“Everyone including carers and families needs to know about the Code and all communication channels — from bottom to top and vice versa including sideways — should remain open for the benefit of all.”

Expert Reference Group carer

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Ministerial foreword

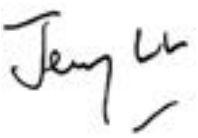
Since the last *Mental Health Act 1983: Code of Practice* was introduced in 2008 there have been substantial changes and updates in legislation, policy, case law, and professional practice. This revised Code reflects and embeds developments since then in areas including the use of restrictive interventions, seclusion, use of police powers to detain people in places of safety, and the use of community treatment orders.

We promised to improve mental health services, and to protect the most vulnerable in society. This Code reflects our personal commitment to ensuring this improvement and protection applies to all. We remain committed to ensuring that high quality care is always provided for patients who are subject to the Act. Care and treatment should always be a means to promote recovery, be of the shortest duration necessary, be the least restrictive option, and keep the patient and other people safe.

The Act affects the lives and liberty of many people, impacting upon them, their families and community. In 2013-14 there were more than 53,000 detentions in England under the Act. This reinforces how important it is to ensure that this document is as up to date, robust, and as accessible as possible. The Code safeguards patients' rights, ensures compliance with the law and must be considered by health and social care professionals. The Code is used by patients in hospital and those in the community, their families, carers and advocates. It is there to help make sure that anyone experiencing mental disorder and being treated under the Act gets the right care, treatment and support.

Each draft of the Code has been read and commented on by a wide range of people and organisations. We are particularly proud to say that this included our 'experts-by-experience' group of patients, former patients and carers, who worked with us from the very beginning. We'd like to thank everyone who shared their ideas and their practical experience to ensure that this document is as comprehensive, clear and compassionate as possible.

We are confident that we have succeeded in producing a revised Code which meets the needs of patients, families, carers and professionals, and presents information in a straightforward and accessible way for all who use it.



The Rt Hon Jeremy Hunt MP
Secretary of State for Health

The Rt Hon Norman Lamb MP
Minister of State for Care and Support

The views of service users and carers

You could ask almost anyone using mental health services, or their relative caring for them, what really matters to them and they would say the same:

'The one thing that makes a difference is knowing that your voice is being heard and that we feel listened to by others.' Expert Reference Group service user

Too many times in the past, people have tried to speak up about their concerns. They are ignored, their concerns are not acted upon and allowed to escalate until a person has the courage to acknowledge what they are saying, or blow the whistle, and awful failings and abuse are exposed, as in the case of Winterbourne View. The Code is designed to stimulate the best possible care, ensure patients' rights are protected, and prevent atrocities happening. We hope the Code will do just that.

There is no doubt that being in a mental health crisis yourself, or trying to support a distressed individual, is incredibly stressful. Knowing what your rights are can save a great deal of distress. The information needs to be straightforward and presented in a way that everyone understands, especially in acute situations.

The Expert Reference Group and Government officials have worked hard to make the Code more accessible and available to service users and carers, as well as professionals. Those of us who are service users, or support someone who is, know from personal experience what works well within mental health services, and what needs improving. Having the opportunity to share these views in the consultation for the revised Code was very important – it reassured us that decision-makers were listening.

'This Code of Practice has been co-produced by us all collectively. This is what real engagement is.' Expert Reference Group service user supporter

One of the most common themes has been the issue of practitioner training. We know that best practice, throughout all the different scenarios in mental healthcare, is detailed in the Code. These guidelines now need to be enforced, without exception, and for this to happen, training has to be consistent and robust across the board.

Finally we have one shared objective:

'Everyone including carers and families needs to know about the Code and all communication channels — from bottom to top and vice versa including sideways — should remain open for the benefit of all.' Expert Reference Group carer

Code of Practice Expert Reference Group
(nine service users and six carers with current or recent experience of care and treatment under the Mental Health Act 1983).

Acknowledgements

A great many people have contributed to the development and content of this Code of Practice – far too many to thank personally for their contributions, comments, suggestions, queries and observations.

Of especial importance are the contributions of the patients, former patients, carers and support workers on our expert reference group and the professionals on our steering group, who have worked with us since 2013 in identifying areas to address, and working through what additional guidance was required.

We are particularly grateful to the many patients, former patents, their relatives, carers, supporters and advocates who participated in consultation events, responded in writing during the consultation or entered our artwork completion to design the new front cover and design for the Code.

The artwork on the front cover is ‘Missed’ by Chris Ridge, the overall winner of our competition for artwork for the Code and this page includes ‘Seasons of the mind’ by Joanna Simms. ‘Missed’ and ‘Seasons of the mind’ both illustrate the benefits of art therapy for people with mental health problems.

‘Missed’
by Chris Ridge

‘Seasons of the mind’
by Joanna Simms.

Executive summary

This Code of Practice provides statutory guidance to registered medical practitioners, approved clinicians, managers and staff of providers, and approved mental health professionals on how they should carry out functions under the Mental Health Act ('the Act') in practice. It is statutory guidance for registered medical practitioners and other professionals in relation to the medical treatment of patients suffering from mental disorder.

All those for whom the Code is statutory guidance must ensure that they are familiar with its contents. Others for whom the Code is helpful in carrying out their duties should also be familiar with its requirements. The Code has been revised following extensive consultation, collaboration and engagement with service users, carers, professionals, the voluntary sector, providers, commissioners and statutory bodies.

The Introduction contains information about the purpose and status of the Code, the role of the Care Quality Commission, what to do if you think the Code is being inappropriately applied and information about safeguarding and whistleblowing. Chapters have been grouped into seven clusters relating to common themes and topics. Colour coding has been used so these groups can be recognised. Comprehensive cross-referencing, annexes and an index have been included to ensure that users can readily find related material.

The groupings are summarised below.

Using the Act: chapters 1 – 3

This group of chapters explains the five guiding principles that underpin the Act, provides guidance on the definition of mental disorder, and highlights equality and human rights considerations in relation to the Act. The five guiding principles should be considered when making all decisions in relation to care, support or treatment provided under the Act:

- Least restrictive option and maximising independence
- Empowerment and involvement
- Respect and dignity
- Purpose and effectiveness, and
- Efficiency and equity.

Protecting patients' rights and autonomy: chapters 4 – 12

Empowerment and involvement of patients and carers, and dignity and respect are principles underpinning the Act. This group of chapters addresses issues of particular importance when empowering patients, protecting their rights and autonomy, and ensuring they are treated with dignity and respect.

It gives guidance on people who can represent or may be interested in a patient's care and treatment, such as carers, nearest relatives, advocates, attorneys and deputies. It gives guidance on the Tribunal and its key role in decisions about detention, including duties on hospital managers and local authorities on informing a patient and their nearest relative of their rights to appeal to a Tribunal.

Assessment, transport and admission to hospital: chapters 13 – 18

It is essential that practitioners understand the legal framework that governs a patient's assessment and admission to hospital. In this group of chapters guidance is provided about applications for detention under the Act, including emergency detention and transporting a patient to a hospital and the roles and responsibilities of clinical commissioning groups and local authorities in relation to assessment and admission to hospital. The particular needs of patients with dementia are considered. Guidance is given on the Mental Capacity Act and the deprivation of liberty safeguards, including the circumstances when they should be used and when the Act should be used.

It may be necessary to remove people from public places or from private premises and guidance is given about police powers to do that and to transfer patients to places of safety and between different places of safety. Certain doctors, approved clinicians and nurses have 'holding powers' under the Act and guidance is given about the use of these powers and how they should be exercised and in what circumstances.

Additional considerations for specific patients: chapters 19 – 22

Certain groups of patients require consideration in addition to the general guidance that applies to all patients and is provided elsewhere in this Code. This group of chapters addresses the particular needs of children and young people under the age of 18 and the role of professionals and others responsible for their care. The key issues from the Act and the Mental Capacity Act which are relevant to people with learning disabilities or autistic spectrum conditions are identified and guidance for professionals is provided to ensure independence, dignity and respect.

Guidance is given on the assessment and appropriate medical treatment of people with personality disorders, and guidance is also given on the use of the Act to arrange treatment for people with mental disorders who come into contact with the criminal justice system (part 3 patients).

Care, support and treatment in hospital: chapters 23 – 26

These chapters address issues related to the care and treatment of patients. Guidance is given on the application of the appropriate medical treatment test including for patients with dementia, and the criteria for detention of a patient or a community treatment order (CTO).

Guidance is given on medical treatment for mental disorder under the Act, including on certain treatments which are subject to special rules and procedures under the Act, on treatment for patients on a CTO who are not recalled to hospital, and on the meaning of the 'clinician in charge of treatment' and the role of second opinion approved doctors.

Treatment must be appropriate to a patient's condition and take account of their wishes. All patients, including those who may present with behavioural disturbance, should receive treatment in a safe and therapeutic environment. Guidance is given for providers, professionals and practitioners on the particular issues related to managing disturbed behaviour which may present a risk to the patient or to others. Any restrictive interventions (eg restraint, seclusion and segregation) must be undertaken only in a manner that is compliant with human rights.

Leaving hospital: chapters 27 – 34

Patients may leave hospital under a variety of circumstances, including being fully discharged, on short-term leave or to receive care and treatment in the community under guardianship or a CTO.

This group of chapters gives guidance on the power to grant leave of absence, long-term leave, escorted leave, leave to reside in other hospitals and recall from leave, and short-term leave for restricted patients. Hospital managers should have policies outlining the actions necessary in cases where a patient is absent without leave and guidance is given about matters that should be covered by such polices.

CTOs may be used to allow suitable patients to leave hospital and to be treated in the community and guidance is given about the use of CTOs and patients for whom they are suitable. Guidance is also given about the purpose of guardianship and the responsibilities of local authorities. A choice may need to be made between guardianship, leave of absence or a CTO and guidance is given about how to make such a choice, and on renewal or extension and on discharge.

Clinical commissioning groups and local authorities have a duty to provide after-care to particular patients detained for hospital treatment. Guidance is given on this after-care duty and also on the care programme approach which is an overarching system for co-ordinating the care of people with mental disorders.

Professional responsibilities: chapters 35 – 40

Hospital managers, responsible clinicians and other professionals have specific responsibilities under the Act. This group of chapters provides guidance on responsibilities in relation to receiving and scrutinising documents, identifying a responsible clinician and the particular functions of hospital managers and their powers of discharge. Guidance is provided on the circumstances that may constitute a conflict of interests that may prevent an approved mental health professional from making an application for a patient's detention or guardianship, and a doctor from making a recommendation supporting the application.

Victims of serious violence and sexual offences have specific rights in relation to specific information about a part 3 patient and may also engage with the Victims Contact Scheme. Guidance is given on the Victims' Code and on the rights of victims and the obligations placed on professionals and on the Secretary of State for Justice.

Introduction

I This revised Code of Practice ('the Code') has been prepared in accordance with section 118 of the Mental Health Act 1983 ('the Act') by the Secretary of State for Health after consulting such bodies as appeared to him to be concerned, and laid before Parliament. The Code will come into force on 1 April 2015.

Purpose and legal status of the Code of Practice

II The Code provides statutory guidance to registered medical practitioners ('doctors'), approved clinicians, managers and staff of providers and approved mental health professionals (AMHPs) on how they should proceed when undertaking duties under the Act. These professionals should have detailed knowledge of the Code, including its purpose, function and scope.

III It gives statutory guidance to registered medical practitioners and other professionals in relation to the medical treatment of patients suffering from mental disorder.

IV The guidance given in the Code to local authorities and their staff is statutory guidance given under section 7 of the Local Authority Social Services Act 1970 (duty to exercise social services functions under guidance of Secretary of State).

Figure i: The Code: statutory guidance

Who this applies to	Context
• Registered medical practitioners ('doctors') • Approved clinicians, managers and staff of providers • Approved mental health professionals (AMHPs)	Given under section 118 of the Act in relation to the performance of their functions under the Act, including in relation to admission, guardianship and community patients
• Registered medical practitioners (doctors) and other professionals	Given under section 118 of the Act in relation to the medical treatment of patients suffering from disorder
• Local authorities and their staff	Given under section 7 of the Local Authority Social Services Act 1970 (duty to exercise social services functions under guidance of Secretary of State for Health)

V The people listed above to whom the Code is addressed must have regard to the Code. It is important that these persons have training on the Code and ensure that they are familiar with its requirements. As departures from the Code could give rise to legal challenge, reasons for any departure should be recorded clearly. Courts will scrutinise such reasons to ensure that there is sufficiently convincing justification in the circumstances.

VI The Code will not be statutory guidance, but will nonetheless be beneficial for others in carrying out their duties. This includes commissioners of health services, the police and ambulance services, and others in health and social services (including the independent and voluntary sectors) involved in commissioning or providing services to people who are, or may become, subject to compulsory measures under the Act. It is important that these persons have training on the Code and ensure that they are familiar with its requirements.

Figure ii: The Code: beneficial but not statutory guidance

Who this applies to	Context
• Commissioners of health services • The police • Ambulance services • Others in health and social services (including the independent and voluntary sectors) involved in commissioning or providing services to people who are, or may become, subject to compulsory measures under the Act. It is important that these persons have training on the Code and ensure that they are familiar with its requirements.	The Code is not statutory guidance, but is beneficial to these persons in carrying out their duties

VII The Code should assist the Care Quality Commission and others responsible for inspecting or monitoring the quality of such services, including commissioners, local authorities, general practitioners and the Tribunal. The Code will also be beneficial to managers and commissioners of immigration removal centres and people involved in visiting or dealing with care of detained patients.

VIII It is intended that the Code will be helpful to patients, their representatives, carers, families, friends, advocates and others who support them.

IX The Code describes legislative functions and duties and provides guidance. Whilst the whole of the Code should be followed, please note that where 'must' is used, it reflects legal obligations in legislation (including other legislation such as the Human Rights Act 1998) or case law, and must be followed. Where the Code uses the term 'should' then departures should be documented and recorded; paragraphs II to VI explains the status of this guidance. Where the Code gives guidance using the terms 'may', 'can' or 'could' then the guidance in the Code is to be followed wherever possible.

Figure iii: Terminology

Terminology	How it is to be understood	Exceptions
Must	Reflects legal obligations which it is essential to follow	No exceptions
Should	For those to whom this is statutory guidance see paragraphs II – V For those to whom it is not statutory guidance VI – VII	See paragraphs II – VII. Any exceptions should be documented and recorded including the reason for this. Patients, their families and carers, regulators, commissioners and other professionals may ask to see this
May/could/can	Reflects guidance to be followed wherever possible	Good practice but exceptions permissible

Scope of the Code

X The Code applies to the care and treatment of all patients in England who are subject to the exercise of powers and the discharge of duties under the Act, including patients who are detained, subject to community treatment orders (CTOs) or guardianship, or on leave under the Act.

XI The Act applies to England and Wales. Wales has its own Code that applies in Wales.[1]

Presentation

XII Throughout the Code, the Mental Health Act 1983 is referred to as 'the Act'. Where there is reference to sections of other Acts, the relevant Act is clearly indicated. Where the Code refers to 'the regulations' it means regulations made under the Act.

XIII The Code is intended to offer guidance on the operation of the Act and does not set out to explain each and every aspect of the Act and the regulations which should be read with it. The Code is divided into 40 chapters, plus four annexes and an index, which are grouped into seven common themes to help readers navigate to what is of most interest or relevance to them.

XIV To guide readers to more detailed information and explanation, references are given in the margins or footnotes to relevant legislation and to other reference material, including the Reference Guide,[2] which explains the relevant legislation. The Code should be read with these materials, especially the Reference Guide.

[1] Mental Health Act 1983: Code of Practice for Wales. Welsh Assembly Government. 2008. http://www.wales.nhs.uk/sites3/Documents/816/Mental%20Health%20Act%201983%20Code%20of%20Practice%20for%20Wales.pdf (The Welsh Government is currently reviewing this Code of Practice and is due to publish a revised version in 2015.)

[2] Reference Guide to the Mental Health Act 1983. Department of Health. 2015. https://www.gov.uk/government/publications/reference-guide-to-the-mental-health-act-1983

XV A list of relevant material is provided at the end of a chapter, where appropriate. References and links provided to other material or organisations are provided for information and assistance only; they do not form part of the Code and do not attract the same legal status.

XVI Flowcharts and tables are included to illustrate the types of decisions that may need to be made on particular issues. Annex D provides a written description of each of the flowcharts to assist those with visual impairments to access this material.

Reference Guide to the Act

XVII The *Reference Guide to the Mental Health Act 1983*[3] is intended as a source of reference for people who want to understand the main provisions of the Mental Health Act 1983 and regulations under the Act, as amended at 1 April 2015, including by the Mental Health Act 2007, Health and Social Care Acts 2008 and 2012 and Care Act 2014.

XVIII Guidance on the way the Act should be applied in practice is given in this Code. The two documents support one another and should be read together, as well as with other material available to assist people to understand their duties, rights and responsibilities under the Act.

XIX The Reference Guide is not a definitive statement of the law. It is not a substitute for consulting the Act itself or for taking legal advice.[4]

References to patients, children and young people and commissioners

XX The Code refers throughout to 'patients' when it means people who are, or appear to be, suffering from a mental disorder. This use of the term is not a recommendation that the term 'patient' should be used in practice in preference to other terms such as 'service users', 'clients', 'individuals' or similar terms. It is a reflection of the terminology used in the Act itself.

XXI When the Code refers to 'children' it means people under the age of 16. When it refers to 'young people' it means people aged 16 or 17.

XXII Where the Code refers to 'carers' it means a family member, friend or others who may be involved in the care of the patient. Where the term 'nearest relative' is used, it means the nearest relative as defined in the Act (see chapter 5), rather than the family member (including co-habiting families) who may be closest to the individual.

XXIII References to 'commissioners' mean NHS commissioners – clinical commissioning groups or the NHS Commissioning Board (NHS England) – and/or local authorities. The meaning of each reference depends on where commissioning responsibilities lie under the Act and other legislation (eg the National Health Service Act 2006 and regulations eg the Standing Rules that allocate CCGs and NHS Commissioning Board commissioning responsibilities, made under that Act).

[3] Reference Guide to the Mental Health Act 1983. Department of Health. 2015. https://www.gov.uk/government/publications/reference-guide-to-the-mental-health-act-1983

[4] Mental Health Act 1983. http://www.legislation.gov.uk/ukpga/1983/20/contents

The Care Quality Commission

XXIV The Care Quality Commission (CQC) makes sure health and social care services provide people with safe, effective, compassionate, high-quality care and encourage them to improve. CQC is responsible for the registration, inspection and monitoring of health and care providers, including mental health providers, under the Health and Social Care Act 2008. The CQC has specific duties in the Act to act as a general protection for patients by reviewing, and where appropriate, investigating the exercise of powers and the discharge of duties in relation to detention, community treatment orders (CTO) and guardianship under the Act. The CQC also has a duty to appoint second opinion appointed doctors. The CQC monitor, inspect and regulate services to make sure providers meet fundamental standards of quality and safety. CQC's findings are published, including performance ratings to help people choose care.

XXV A provider's exercise of powers and discharge of duties under the Act will inform CQC's health and social care inspections and its monitoring of the Act. Planned changes will also include a new ratings system (inadequate/requires improvement/good/outstanding). The Code will be the starting point for CQC's rating system and will help to identify a 'good' rating in the care and treatment of people subject to the Act. The integrated model of inspection will mean that a provider's exercise of powers and discharge of duties under the Act informs its final CQC rating following an inspection. Where the principles and guidance of the Code are not implemented, the CQC may use its regulatory powers to facilitate change and improvement in local services as a failure to apply the Act and its Code may show a breach of one of the registration requirements in the Health and Social Care Act 2008,[5] (Regulated Activities) Regulations 2014,[6] or Care Quality Commission (Registration) Regulations (2009).[7]

XXVI Providers and professionals should not use the Code in isolation. They will also need to consider relevant developments in professional practice, National Institute for Health and Care Excellence (NICE) and professional guidelines, legislation and case law to ensure they are consistently delivering the highest standards of care and professional practice. The Code refers to related material not included in the Code but these references are not exhaustive. The new introduction and guiding principles encourage commissioners of services, health and care providers and professionals to deliver a holistic, whole person approach to care that is reflective of clinical best practice and quality. CQC in its monitoring of services will seek to ensure that this takes place.

XXVII The United Kingdom (UK) ratified the United Nations Optional Protocol to the Convention against Torture (OPCAT) in 2003.[8] The protocol requires participating states to carry out regular reviews of places where people are deprived of their liberty to ensure that they are not being abused. Each state can choose how to establish their own National Preventive Mechanisms (NPM). The UK established its NPMs, including CQC's NPMs for detained patients, in 2009. The CQC visits places of detention in England as part of the UK's NPM.

[5] Health and Social Care Act 2008. http://www.legislation.gov.uk/ukpga/2008/14/contents
[6] Health and Social Care Act 2008 (Regulated Activities) Regulations. 2014. SI 2014/2936. http://www.legislation.gov.uk/uksi/2014/2936/contents/made
[7] Care Quality Commission (Registration) Regulations. 2009. http://www.legislation.gov.uk/uksi/2009/3112/contents/made
[8] United Nations Optional Protocol to the Convention Against Torture. 2003. SI 2009/3112. http://www.ohchr.org/EN/HRBodies/OPCAT/Pages/OPCATIndex.aspx

What to do if you think the Code is being inappropriately applied

XXVIII Everyone has a role in ensuring that the Act and the Code are complied with. The Serious Case Review into Winterbourne View Hospital and subsequent investigations and reports by the CQC illustrated that this was not always the case. In many instances opportunities for professionals across the health and social care system to spot and report abuse or neglect were missed allowing harm to continue unchecked.[9]

XXIX Commissioners, CQC inspectors, general practitioners and other health and social care practitioners and professional regulators all have an interest in identifying concerns about how the Act is being applied, whether it is being ignored and to stop abuse or neglect taking place. To minimise the chance of this happening all health and social care staff need to be trained in spotting the signs of potential abuse or neglect, listening to concerns raised by patients and should understand their role in responding, including having a working knowledge of local adult and children's safeguarding arrangements (see paragraphs XXXI – XXXIV). Such individuals should raise any concerns they may have, including, when appropriate, through locally agreed whistleblowing procedures or safeguarding arrangements (see paragraphs XXXI –XXXVI).

XXX Further guidance on information and support that should be provided to patients and carers to enable them to make complaints is provided in chapter 4, paragraphs 4.54 – 4.64.

Safeguarding

XXXI For adults, every local authority must establish a Safeguarding Adults Board (SAB) comprising the local authority, the local clinical commissioning group, the local police and whoever else the SAB considers appropriate, such as, housing providers and NHS-funded providers, including independent sector providers. The SAB's objective is to help and protect adults in its area who have needs for care and support (whether or not the local authority is meeting any of those needs) and are experiencing, or at risk of experiencing, abuse or neglect and unable to protect themselves because of their care and support needs. The SAB achieves its objective by assuring itself that local safeguarding arrangements are in place as to how relevant partners are to work together in order to safeguard adults. The SAB must publish a strategic plan each financial year which sets out its safeguarding strategy and what each member is to do to implement that strategy and an annual report at the end of each financial year on how this plan has been achieved and implemented. The SAB must carry out Adult Safeguarding Reviews to identify lessons learnt in any cases of serious abuse and neglect where there is concern as to how people with relevant functions worked together to safeguard the adult.

[9] Winterbourne View Hospital: A Serious Case Review. South Gloucestershire Safeguarding Adults Board. 2012. http://hosted.southglos.gov.uk/wv/report.pdf Transforming Care: a national response to Winterbourne View Hospital Department of Health Review. 2012. https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/213215/final-report.pdf

The SAB should have a strategic interest in quality of care issues across the locality and the ability to challenge individuals and organisations where there are concerns about any form of abuse or neglect in relation to adults with care and support needs.[10]

XXXII Where someone is concerned that an adult is at risk of or experiencing abuse they should refer to their local multi-agency safeguarding arrangements. These will be based on chapter 14 of the statutory guidance that underpins the Care Act 2014.[11] Practitioners should pay particular attention to the decision-making tree in that chapter that emphasises the dialogue with the adult in question and paying attention to their wishes.

XXXIII For children and young people under 18, the statutory guidance *Working Together to Safeguard Children 2013* sets out the legislative requirements and expectations on individual services to safeguard and promote the welfare of children. This includes Local Safeguarding Children Boards (LSCBs), which have a general objective to co-ordinate Board partners' activities relating to safeguarding and promoting the welfare of children within the area of the local authority concerned. Board partners must include representatives from the healthcare sector, as well as a wide range of other bodies. LSCBs have a range of functions, including to undertake serious case reviews in cases where abuse or neglect is known or suspected, and either the child has died, or the child has been seriously harmed and there is cause for concern about the way in which relevant agencies have worked together to safeguard the child.

XXXIV Anyone (including children, parents, other carers and professionals) who has a concern about a child's welfare should make a referral to the local authority children's social care department in which the child is located for treatment (whether in hospital or on a CTO). Within local authorities, children's social care should act as the principal point of contact for welfare concerns relating to children. Further guidance is available in *Working Together to Safeguard Children 2013.*

Whistleblowing

XXXV Each NHS commissioner, NHS-funded provider and local authority should have its own locally agreed whistleblowing policy and procedure, which are compliant with the whistleblowing statutory framework,[12] which follow best practice, and which should be publicised. To ensure better protection for patients, staff should be encouraged and supported to raise concerns about poor care in accordance with these policies and procedures, and these concerns should be listened to and, where appropriate, acted upon.

[10] Care and Support Statutory Guidance issued under the Care Act. Department of Health. 2014. https://www.gov.uk/government/publications/care-act-2014-statutory-guidance-for-implementation

[11] Care and Support Statutory Guidance issued under the Care Act. Department of Health. 2014. https://www.gov.uk/government/publications/care-act- 2014-statutory-guidance-for-implementation

[12] The relevant statutory provisions are contained within Part 4A ('Protected Disclosures'), section 48 ('Complaints to employment tribunals') and section 49 ('Remedies') of the Employment Rights Act 1996, as inserted by the Public Interest Disclosure Act 1998 and as subsequently amended, including amendments made by the Enterprise and Regulatory Reform Act 2013. http://www.legislation.gov.uk/ukpga/1996/18/contents

XXXVI For further support and advice, NHS-funded and local authority social care staff can contact the free, independent and confidential whistleblowing helpline.[13] The helpline provides a range of tools, resources, guidance, codes and standards that promote workforce development, including staff engagement and support to deliver high quality care. These resources encourage support for staff to be able to raise concerns early and for employers to act upon concerns raised.[14] The helpline also provides advice to staff who want to raise a concern but are unsure how to do so or what legal protections they have if they do so. It gives employers advice on best practice in implementing policies that are compliant with the whistleblowing statutory framework.

Related legislation

Mental Capacity Act 2005

XXXVII There are many references throughout this Code to the Mental Capacity Act 2005 (MCA).[15] The Code assumes that its readers are familiar with the main provisions of the MCA as it relates to the care and treatment of people with mental disorder who lack the capacity to take particular decisions for themselves.

XXXVIII It will be difficult for professionals involved in providing care for people with mental health problems to carry out their work (including their responsibilities under this Act) without an understanding of key concepts in the MCA.

XXXIX In particular, they will need to be familiar with the principles and main provisions of the MCA to understand when a person may lack capacity to make a particular decision, to know when decisions can be taken in the best interests of people who lack capacity to take those decisions themselves, and the steps to be taken before doing so. They will also need to be familiar with the concepts of advance decisions to refuse treatment, lasting powers of attorney and donees of such powers ('attorneys'), court-appointed deputies and independent mental capacity advocates (IMCAs).[16]

XL Professionals involved in deciding whether patients who lack capacity to decide whether or not to consent to their admission and treatment will also need to understand how deprivation of liberty should be authorised. Deprivation of liberty in hospitals and care homes may be authorised under the deprivation of liberty safeguards added to the MCA by the Mental Health Act 2007 and the procedures for doing so. The Court of Protection may authorise deprivation of liberty in other settings.

[13] At the time of publication, the free-phone helpline can be contacted on 08000 724 725 and operates weekdays between 08:00 and 18:00 with an out of hours answering service available weekends and public holidays. The email address is enquiries@wbhelpline.org.uk and the website address for more information is http://www.wbhelpline.org.uk

[14] Raising Concerns at Work. Whistleblowing Guidance for Workers and Employers in Health and Social Care. Whistleblowing Helpline. 2014. The Guidance is available at http://www.wbhelpline.org.uk/resources/rasing-concerns-at-work/

[15] Mental Capacity Act 2005. http://www.legislation.gov.uk/ukpga/2005/9/Contents

[16] Chapter 13 and guidance throughout this Code highlight these pieces of legislation and how they work together.

Care Act 2014

XLI In addition to the requirements of the Act, relevant professionals (particularly those involved in discharging or treating patients in the community) should also consider the general responsibilities of local authorities under Part 1 of the Care Act 2014[17] (eg duty to promote wellbeing, promote integration and co-operation duties), which applies to the care and support arranged or provided by local authorities to patients in the community, such as patients subject to CTOs, guardianship or leave from hospital.

XLII Professionals should consider the principles that the Care Act introduces about the centrality of the patient and a holistic approach to care and support. These are in line with the guiding principles proposed in this Code.

XLIII The Care Act requires local authorities, NHS commissioners and providers, and housing services to work together to provide truly person-centred care and support. It places a particular emphasis on managing people's needs to prevent them increasing. These duties are particularly important for people with mental illness who often require support from a number of agencies in order to promote their recovery and participate in society after leaving hospital or whilst on a CTO, guardianship or leave.

Related material

- Care Act 2014. http://www.legislation.gov.uk/ukpga/2014/23/contents/enacted
- Care and Support Statutory Guidance issued under the Care Act. Department of Health. 2014. https://www.gov.uk/government/publications/care-act-2014-statutory-guidance-for-implementation
- Mental Capacity Act 2005. http://www.legislation.gov.uk/ukpga/2005/9/contents
- Mental Capacity Act 2005. Code of Practice. Department for Constitutional Affairs (now Ministry of Justice). 2007. https://www.gov.uk/government/publications/mental-capacity-act-code-of-practice
- Reference Guide to the Mental Health Act 1983. Department of Health. 2015. https://www.gov.uk/government/publications/reference-guide-to-the-mental-health-act-1983
- Raising Concerns at Work. Whistleblowing Guidance for Workers and Employers in Health and Social Care. Whistleblowing Helpline. 2014. http://www.wbhelpline.org.uk/resources/raising-concerns-at-work/

[17] Care Act 2014. http://www.legislation.gov.uk/ukpga/2014/23/contents/enacted

Using the Act

This group of chapters explains the five guiding principles that underpin the Mental Health Act, provides guidance on the definition of mental disorder, and highlights equality and human rights considerations in relation to the Act.

All those for whom the Code is statutory guidance, and those for whom it is beneficial, should be familiar with these introductory chapters and should always consider the five guiding principles when making all decisions in relation to care, support or treatment provided under the Act.

Chapter 1 Guiding principles

Chapter 2 Mental disorder definition

Chapter 3 Human rights, equality and health inequalities

1 Guiding principles

1

Why read this chapter?

1.1 It is essential that all those undertaking functions under the Act understand the five sets of overarching principles which should always be considered when making decisions in relation to care, support or treatment provided under the Act. This chapter provides an explanation of the overarching principles and stresses that they should be considered when making decisions under the Act. Although all are of equal importance the weight given to each principle in reaching a particular decision will depend on context and the nature of the decision being made.

The five overarching principles are:

Least restrictive option and maximising independence
Where it is possible to treat a patient safely and lawfully without detaining them under the Act, the patient should not be detained. Wherever possible a patient's independence should be encouraged and supported with a focus on promoting recovery wherever possible.

Empowerment and involvement
Patients should be fully involved in decisions about care, support and treatment. The views of families, carers and others, if appropriate, should be fully considered when taking decisions. Where decisions are taken which are contradictory to views expressed, professionals should explain the reasons for this.

Respect and dignity
Patients, their families and carers should be treated with respect and dignity and listened to by professionals.

Purpose and effectiveness
Decisions about care and treatment should be appropriate to the patient, with clear therapeutic aims, promote recovery and should be performed to current national guidelines and/or current, available best practice guidelines.

Efficiency and equity
Providers, commissioners and other relevant organisations should work together to ensure that the quality of commissioning and provision of mental healthcare services are of high quality and are given equal priority to physical health and social care services. All relevant services should work together to facilitate timely, safe and supportive discharge from detention.

Least restrictive option and maximising independence

1.2 Where it is possible to treat a patient safely and lawfully without detaining them under the Act, the patient should not be detained.

1.3 Commissioners, providers and other relevant agencies should work together to prevent mental health crises and, where possible, reduce the use of detention through prevention and early intervention by commissioning a range of services that are accessible, responsive and as high quality as other health emergency services.

1.4 If the Act is used, detention should be used for the shortest time necessary in the least restrictive hospital setting available, and be delivered as close as reasonably possible to a location that the patient identifies they would like to be close to (eg their home or close to a family member or carer). In cases where the patient lacks capacity to make a decision about the location they would like to be close to, a best interests decision on the location should be taken. This will promote recovery and enable the patient to maintain contact with family, friends, and their community.

1.5 Any restrictions should be the minimum necessary to safely provide the care or treatment required having regard to whether the purpose for the restriction can be achieved in a way that is less restrictive of the person's rights and freedom of action.

1.6 Restrictions that apply to all patients in a particular setting (blanket or global restrictions) should be avoided. There may be settings where there will be restrictions on all patients that are necessary for their safety or for that of others. Any such restrictions should have a clear justification for the particular hospital, group or ward to which they apply. Blanket restrictions should never be for the convenience of the provider. Any such restrictions, should be agreed by hospital managers, be documented with the reasons for such restrictions clearly described and subject to governance procedures that exist in the relevant organisation.

Empowerment and involvement

1.7 Patients should be given the opportunity to be involved in planning, developing and reviewing their own care and treatment to help ensure that it is delivered in a way that is as appropriate and effective for them as possible. Wherever possible, care plans should be produced in consultation with the patient.

1.8 A patient's views, past and present wishes and feelings (whether expressed at the time or in advance), should be considered so far as they are reasonably ascertainable. Patients should be encouraged and supported to develop advance statements of wishes and feeling and express their views about future care and treatment when they are well.

1.9 The patient's choices and views should be fully recorded. Where a decision in the care plan is contrary to the wishes of the patient or others the reasons for this should be transparent, explained to them and fully documented.

1.10 Patients should be enabled to participate in decision-making as far as they are capable of doing so. Consideration should be given to what assistance or support a patient may need to participate in decision-making and any such assistance or support should be provided, to ensure maximum involvement possible. This includes being given sufficient information about their care and treatment in a format that is easily understandable to them.

1.11 Patients should be encouraged and supported in involving carers (unless there are particular reasons to the contrary). Professionals should fully consider their views when making decisions.

1.12 Patients should be informed of the support that an advocate can provide, including carers or, if they are eligible, an independent mental health advocate (IMHA) (or an independent mental capacity advocate (IMCA) where relevant). Local authorities should ensure that timely access to IMHAs is available and that IMHAs have appropriate training and skills to support the patient effectively including where a patient has particular needs.

Respect and dignity

1.13 Patients and carers should be treated with respect and dignity. Practitioners performing functions under the Act should respect the rights and dignity of patients and their carers, while also ensuring their safety and that of others.

1.14 People taking decisions under the Act must recognise and respect the diverse needs, values and circumstances of each patient, including their age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex and sexual orientation, and culture. There must be no unlawful discrimination.

Purpose and effectiveness

1.15 Care, support and treatment given under the Act should be given in accordance with up-to-date national guidance and/or current best practice from professional bodies, where this is available. Treatment should address an individual patient's needs, taking account of their circumstances and preferences where appropriate.

1.16 Patients should be offered treatment and care in environments that are safe for them, staff and any visitors and are supportive and, therapeutic. Practitioners should deliver a range of treatments which focus on positive clinical and personal outcomes, where appropriate. Care plans for detained patients should focus on maximising

recovery and ending detention as soon as possible. Commissioners, providers and professionals should consider the broad range of interventions and services needed to promote recovery not only in hospital but after a patient leaves hospital, including maintaining relationships, housing, opportunities for meaningful daytime activity and employment opportunities,

1.17 Physical healthcare needs should be assessed and addressed including promotion of healthy living and steps taken to reduce any potential side effects associated with treatments.

Efficiency and equity

1.18 Commissioners and providers, including their staff, should give equal priority to mental health as they do to physical health conditions.

1.19 Where patients are subject to compulsory detention, health and social care agencies should work together to deliver a programme of care that, as far as practicable, minimises the duration of detention, facilitates safe discharge from hospital and takes into account the patient's wishes.

1.20 Commissioners, providers and other relevant organisations should establish effective relationships to ensure efficient working with accountability defined through joint governance arrangements. Joint working should be used to minimise delay in care planning needed to facilitate discharge.

1.21 Commissioners, providers and other relevant organisations should ensure that their staff have sufficient skills, information and knowledge about the Act and provision of services to support all their patients. There should be clear mechanisms for accessing specialist support for those with additional needs.

Using the principles

1.22 All decisions must be lawful and informed by good professional practice. Lawfulness necessarily includes compliance with the Human Rights Act 1998 (HRA) and Equality Act 2010.

1.23 All five sets of principles are of equal importance, and should inform any decision made under the Act. The weight given to each principle in reaching a particular decision will need to be balanced in different ways according to the circumstances and nature of each particular decision. The guidance in the Code is based on these principles and reference is made to them throughout the Code.

1.24 Commissioners, providers, professionals and others providing care under the Act should document, and justify, any decision to depart from the Code or a particular guiding principle. The Care Quality Commission will look for evidence of this during their inspections and commissioners can use it as part of their contract monitoring.

2 Mental disorder definition

2

Why read this chapter?

2.1 This chapter provides guidance on the definition of mental disorder for the purposes of the Act. Mental disorder is defined in the Act as 'any disorder or disability of the mind'. Examples of clinically recognised disorders or disabilities are given and it is made clear that difference should not be confused with disorder.

2.2 Guidance is provided on dependence on alcohol or drugs and learning disabilities and autistic spectrum disorders.

2.3 The Act applies to personality disorders in exactly the same way as it applies to mental illness and other mental disorders.

Definition of mental disorder

2.4 Mental disorder is defined for the purposes of the Act as 'any disorder or disability of the mind'. Relevant professionals should determine whether a patient has a disorder or disability of the mind in accordance with good clinical practice and accepted standards of what constitutes such a disorder or disability.

2.5 Examples of clinically recognised conditions which could fall within this definition are given in the following figure.

Figure 1: Clinically recognised conditions which could fall within the Act's definition of mental disorder

- Affective disorders, such as depression and bipolar disorder
- Schizophrenia and delusional disorders
- Neurotic, stress-related and somatoform disorders, such as anxiety, phobic disorders, obsessive compulsive disorders, post-traumatic stress disorder and hypochondriacal disorders
- Organic mental disorders such as dementia and delirium (however caused)
- Personality and behavioural changes caused by brain injury or damage (however acquired)
- Personality disorders (see paragraphs 2.19 – 2.20 and chapter 21)
- Mental and behavioural disorders caused by psychoactive substance use (see paragraphs 2.9 – 2.13)
- Eating disorders, non-organic sleep disorders and non-organic sexual disorders
- Learning disabilities (see paragraphs 2.14 – 2.18 and chapter 20)
- Autistic spectrum disorders (including Asperger's syndrome) (see paragraphs 2.14 – 2.18 and chapter 20)
- Behavioural and emotional disorders of children and young people

(Note: this list is not exhaustive)

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

2.7 Care must always be taken to avoid diagnosing, or failing to diagnose, mental disorder on the basis of preconceptions about people or failure to appreciate cultural and social differences. What may be indicative of mental disorder in one person, given their background and individual circumstances, may be nothing of the sort in another person.

2.8 Difference should not be confused with disorder. No-one may be considered to be mentally disordered solely because of their political, religious or cultural beliefs, values or opinions, unless there are proper clinical grounds to believe that they are the symptoms or manifestations of a disability or disorder of the mind. The same is true of a person's involvement, or likely involvement, in illegal, anti-social or 'immoral' behaviour. Beliefs, behaviours or actions which do not result from a disorder or disability of the mind are not a basis for compulsory measures under the Act, even if they appear unusual or cause other people alarm, distress or danger.

Dependence on alcohol or drugs

2.9 Section 1(3) of the Act states that dependence on alcohol or drugs is not considered to be a disorder or disability of the mind for the purposes of the definition of mental disorder in the Act.

2.10 This means that there are no grounds under the Act for detaining a person in hospital (or using other compulsory measures) on the basis of alcohol or drug dependence alone. Drugs for these purposes may be taken to include solvents and similar substances with a psychoactive effect.

2.11 Alcohol or drug dependence may be accompanied by, or associated with, a mental disorder which does fall within the Act's definition. If the relevant criteria are met, it is therefore possible, for example, to detain people who are suffering from mental disorder, even though they are also dependent on alcohol or drugs. This is true even if the mental disorder in question results from the person's alcohol or drug dependence.

2.12 The Act does not exclude other disorders or disabilities of the mind related to the use of alcohol or drugs. These disorders – eg withdrawal state with delirium or associated psychotic disorder, acute intoxication, organic mental disorders associated with prolonged abuse of drugs or alcohol – remain mental disorders for the purposes of the Act.

2.13 Medical treatment for mental disorder under the Act (including treatment with consent) can include measures to address alcohol or drug dependence if that is an appropriate part of treating the mental disorder which is the primary focus of the treatment.

2

Learning disabilities and autistic spectrum disorders

2.14 Learning disabilities and autistic spectrum disorders are forms of mental disorder as defined in the Act.

2.15 Someone with a learning disability and no other form of mental disorder may not be detained for treatment or made subject to guardianship or a community treatment order (CTO) unless their learning disability is accompanied by abnormally aggressive or seriously irresponsible conduct on their part. Professionals should record their reasons for concluding that the individual's conduct is abnormally aggressive or seriously irresponsible, and why it relates to the person's learning disability and is not attributable to others factors such as an unmet physical health, social or emotional need (paragraphs 20.7 – 20.16).

2.16 This 'learning disability qualification' only applies to specific sections of the Act. In particular, it does not apply to detention for assessment under section 2 of the Act.

2.17 The learning disability qualification does not apply to autistic spectrum disorders (including Asperger's syndrome). It is possible for someone with an autistic spectrum disorder to meet the criteria for compulsory measures under the Act without having any other form of mental disorder, even if it is not associated with abnormally aggressive or seriously irresponsible behaviour. While experience suggests that this is likely to be necessary only very rarely, the possibility should never automatically be discounted.

2.18 For further guidance on particular issues relating to people with learning disabilities or autistic spectrum disorders (including further guidance on the learning disability qualification), see chapter 20.

Personality disorders

2.19 Apart from the learning disability qualification described above, the Act does not distinguish between different forms of mental disorder. The Act therefore applies to personality disorders (of all types) in exactly the same way as it applies to mental illness and other mental disorders.

2.20 No assumptions should be made about the suitability of using the Act – or indeed providing services without using the Act – in respect of personality disorders or the people who have them. The needs of the individual patient, the risks posed by their disorder and what can be done to address those needs and risks, both in the short and longer term (see chapter 21 for further guidance on personality disorders), should inform decisions.

3 Human rights, equality and health inequalities

Why read this chapter?

3.1 Individual chapters explain relevant human rights issues and give good practice guidance. This chapter builds on this to highlight specific examples of good practice in service delivery and professional practice in relation to the Act, which advance equality and protect human rights.

Human rights, equality and the duty to reduce inequalities

3.2 Commissioners and providers will need to consider the legislation and international conventions listed in figure 2.

Figure 2: Human rights, equality, NHS duties and relevant international conventions

• UN Declaration of Human Rights 1948	http://www.un.org/en/documents/udhr/
• UN Convention on the Rights of the Child	http://www.unicef.org.uk/Documents/Publication-pdfs/UNCRC_PRESS200910web.pdf http://www.unicef.org.uk/Documents/Publication-pdfs/UNCRC_summary.pdf http://www.unicef.org/crc/files/Rights_overview.pdf
• UN Convention on the Rights of Persons with Disabilities	http://www.un.org/disabilities/convention/conventionful
• United Nations Optional Protocol to the Convention against Torture (OPCAT) 2009	http://www2.ohchr.org/english/bodies/cat/opcat/docs/CAT.OP.SP.1.pdf
• European Convention on Human Rights (ECHR)	http://www.echr.coe.int/Documents/Convention_ENG.pdf
• Human Rights Act 1998	http://www.legislation.gov.uk/ukpga/1998/42
• Equality Act 2010 - Public Sector Equality Duty (PSED)	http://www.legislation.gov.uk/ukpga/2010/15 https://www.gov.uk/equality-act-2010-guidance#public-sector-equality-duty
• The duties in the National Health Service Act 2006	http://www.legislation.gov.uk/ukpga/2012/7 https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/138267/C2.-Factsheet-Tackling-inequalities-in-healthcare-270412.pdf

3

Human rights

3.3 Human rights legislation provides a framework for commissioners and providers to deliver the best possible outcomes for everyone who uses services. This means:

- putting human rights principles and standards into practice
- aiming to secure the full enjoyment of human rights for all, and
- ensuring rights are protected and secured.

3.4 Participation – enabling meaningful participation of key stakeholders in our policy development.

Accountability – ensuring clear accountability for human rights, through the system. Accountability requires strong governance including effective monitoring of human rights standards as well as effective remedies for human rights breaches. For this there must be appropriate laws, policies, institutions, administrative procedures and mechanisms of redress in order to ensure compliance with human rights legislation.

Non-discrimination and equality – working to eliminate discrimination by embedding equality through systems, processes and outputs. All forms of discrimination in the realisation of rights must be prohibited, prevented and eliminated. It also requires the prioritisation of those in the most marginalised situations who face the biggest barriers to realising their rights.

Empowerment – of all with knowledge, skills and commitment to realising human rights. Individuals and communities should know their rights. It also means that they should be fully supported to participate in the development of policy and practices which affect their lives and to claim rights where necessary.

Legality – expressly applying the Human Rights Act 1998 (HRA) and linking to international and European standards and bodies. A human rights-based approach requires the recognition of rights as legally enforceable entitlements and is linked in to national and international human rights law.

3.5 The HRA gives effect in the UK to certain rights and freedoms guaranteed under the European Convention on Human Rights. The HRA places a duty on public authorities to respect and protect people's human rights. A wide range of bodies carrying out public functions, including the delivery of public services by private and contracted-out providers, have legal obligations to respect and protect human rights.

3.6 In some instances, competing human rights will need to be considered, which may require finely balanced judgements. Such decisions and the reasons for them should be clearly documented. Decisions restricting a person's rights will need to be justifiable as necessary and proportionate in the circumstances of the specific case. Any restriction imposed should be kept to the minimum needed to meet the purpose and aim of the restriction.

Equality Act 2010

3.7 The Equality Act makes it unlawful to discriminate (directly or indirectly) against a person on the basis of a protected characteristic or combination of protected characteristics.[1] Protected characteristics under this Act include age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex and sexual orientation. The protected characteristic of disability includes a mental impairment that has a substantial and long-term adverse effect on the person's ability to carry out normal day-to-day activities.

Public sector equality duty (PSED)

3.8 Under the PSED (section 149) public authorities including NHS commissioners, NHS providers and local authorities must have due regard to the need to:

- eliminate unlawful discrimination, harassment and victimisation
- advance equality of opportunity between people who share a protected characteristic and those who do not, and
- foster good relations between people who share a protected characteristic and those who do not.

3.9 Complying with the PSED may involve treating persons with mental health problems more favourably than others in order to achieve equality of access to services and outcomes.

3.10 The protected characteristics for the purposes of the PSED are (i) age; (ii) disability; (iii) gender reassignment; (iv) marriage and civil partnership; (v) pregnancy and maternity; (vi) race; (vii) religion or belief; (viii) sex; and (ix) sexual orientation. However, the PSED only applies to marriage and civil partnership as regards the first aim of the need to eliminate unlawful discrimination.[2]

Reasonable adjustments

3.11 The Equality Act places a duty on providers of services to the public and those exercising public functions, including NHS services, to make reasonable adjustments (see figure 3) for people with an impairment (including mental impairment) that constitutes a disability under the Equality Act. Providers must take reasonable steps to avoid putting a person with a disability at a substantial disadvantage compared with those who are not disabled.

[1] Section 4 of the Equality Act 2010. Protected characteristics are also defined for the purpose of the section 149 public sector equality duty in that section. http://www.legislation.gov.uk/ukpga/2010/15 and https://www.gov.uk/equality-act-2010-guidance#publicsector-equality-duty

[2] For definitions of the protected characteristics see: http://www.legislation.gov.uk/ukpga/2010/15/pdfs/ukpga_20100015_en.pdf

3.12 The reasonable adjustments a person may need could be considered as part of a person-centred care planning process in all mental health service settings (see chapter 34). The duty applies where:

- a provision, criterion or practice puts disabled people at a substantial disadvantage compared with those who are not disabled
- a physical feature puts disabled people at a substantial disadvantage compared with people who are not disabled, and
- not providing an auxiliary aid puts disabled people at a substantial disadvantage compared with people who are not disabled.

3.13 Figure 3 includes examples of reasonable adjustments.

Figure 3: Examples of reasonable adjustments

- Assessment for detention is undertaken by professionals with the appropriate specialist skills to assess the person based on their individual needs, eg adjustments if the person has a learning disability, an autism spectrum disorder or is deaf.
- Ensuring the care environment is as accessible as possible, eg through appropriate signage and lighting.
- Ensuring information for patients is in a format accessible to the person, eg using pictures and big print, or providing translations into the person's first language.
- Ensuring there are adequate numbers of staff with the right skills and experience to communicate effectively with patients, eg staff who can use sign language or communicate in the person's first language.
- Providing specific or additional training for staff who work with people with learning disabilities or autism spectrum disorders.
- Ensuring meetings are accessible to people, eg providing materials in an appropriate format and holding the meeting in an accessible venue. The provision of an independent mental health advocate (IMHA) can support a patient to participate in decisions about their care and treatment.

Duty to reduce inequalities

3.14 NHS commissioners must, in the exercise of their functions, have due regard to the need to reduce health inequalities between patients with respect to (i) their ability to access health services and (ii) the outcomes achieved for them by the provision of health services.[3] The legal duties apply to the exercise of any functions, which includes decision made and policy developed. Both new policies and decisions and existing policies and decisions, when reviewed, come within the scope of the duty.

[3] In respect of the NHS Commissioning Board, section 13G of the National Health Service (NHS) Act 2006 and in respect of clinical commissioning groups, section 14T of the NHS Act.

Monitoring and compliance

3.15 Commissioners and providers should have in place a human rights and equality policy for service provision and practice in relation to the Act, which should be reviewed at Board (or equivalent) level at least annually. As a minimum the human rights and equality policy should:

- set out how the organisation complies with applicable human rights and equality legislation (and in relation to commissioners, the health inequalities legislation)
- ensure that there is robust monitoring of equalities so that the organisation can better understand how people with protected characteristics are affected by the Act. Information gathered should be made publicly available in a clear and transparent manner. Details of any action that will be taken in light of the information collected should also be made available. Consideration should be given to whether other bodies can assist in any action that is required eg the CQC
- set out how the organisation will review the environment and culture of wards and the hospital to ensure the organisation is providing therapeutic environments and patients are treated with dignity and respect, involved in discussions about their care and treatment and their culture and ethnicity are respected
- set out how the organisation will obtain qualitative evidence on patients' experiences and how it will ensure that the information is gathered at an appropriate time. This could include feedback on a patient's involvement in care planning and on their relationships with staff and other patients
- describe consideration given of the need for reasonable adjustments, and
- set out how staff will be provided with learning, development and training on human rights legislation and the Equality Act.

Related material

For definitions of the protected characteristics
http://www.legislation.gov.uk/ukpga/2010/15/pdfs/ukpga_20100015_en.pdf

This material does not form part of the Code. It is provided for assistance only.

3

Protecting patients' rights and autonomy

Empowerment and involvement of patients and carers, and dignity and respect are principles underpinning the Act. This group of chapters addresses issues of particular importance when empowering patients to be involved in matters relating to their care and treatment, protecting their rights and autonomy, and ensuring they are treated with dignity and respect.

Guidance is given on the information that must be given to patients, their nearest relatives and carers; the identification and appointment of acting nearest relative by the court, the role of independent mental health advocates; powers of attorneys and deputies; issues of patients' privacy, safety and dignity; advance decisions by patients to refuse treatment and other statements of views, wishes and feelings expressed in advance; confidentiality and information sharing by professionals and agencies; guidance on visiting patients in hospital including the particular circumstances of children and young people; and the role of the Tribunal and rights of the patient and nearest relative to apply to the Tribunal.

Chapter 4 Information for patients, nearest relatives, carers and others

Chapter 5 The nearest relative

Chapter 6 Independent mental health advocates

Chapter 7 Attorneys and deputies

Chapter 8 Privacy, safety and dignity

Chapter 9 Wishes expressed in advance

Chapter 10 Confidentiality and information sharing

Chapter 11 Visiting patients in hospital

Chapter 12 The Tribunal

4 Information for patients, nearest relatives, carers and others

Why read this chapter?

4.1 This chapter gives guidance on the information that must be given to patients, and their nearest relatives. It also gives guidance on communication with patients, their families and carers, and other people.

4.2 Effective communication is essential in ensuring appropriate care and respect for patients' rights, and those responsible for caring for patients should identify any communication difficulties and seek to address them. The Act requires hospital managers to take steps to ensure that patients who are detained or are the subject of a community treatment order (CTO) understand important information about how the Act applies to them.

Communication with patients

4.3 Effective communication is essential in ensuring appropriate care and respect for patients' rights. It is important that the language used is clear and unambiguous and that people giving information check that the information that has been communicated has been understood.

4.4 Everything possible should be done to overcome barriers to effective communication, which may be caused by any of a number of reasons. For example, a patient's first language may not be English. Patients may have difficulty in understanding technical terms and jargon or in maintaining attention for extended periods. They may have a hearing or visual impairment, have difficulty in reading or writing, or have a learning disability. A patient's cultural background may also be different from that of the person speaking to them. Children and young people will need to have information explained in a way they can understand and in a format that is appropriate to their age.

4.5 Those with responsibility for the care of patients need to identify how communication difficulties affect each patient so that they can assess the needs of each patient and address them in the most appropriate way. Hospitals and other organisations should make people with specialist expertise (eg in sign language or Makaton) available as required. Often carers and advocates can help with or advise on best ways of communicating with a patient. Carers' centres and similar services can advise carers on their rights and can also answer general questions on the Mental Health Act Code procedures and other issues.

4.6 Where an interpreter is needed, every effort should be made to identify an interpreter who is appropriate to the patient, given the patient's sex, religion or belief, dialect, cultural background and age. Interpreters need to be skilled and experienced in medical or health-related interpreting. Using the patient's relatives and friends as

intermediaries or interpreters is not good practice, and should only exceptionally be used, including when the patient is a child or a young person. Interpreters (both professional and non-professional) must respect the confidentiality of any personal information they learn about the patient through their involvement.

4.7 Independent mental health advocates (IMHAs) engaged by patients can be valuable in helping patients to understand the questions and information being presented to them and in helping patients to communicate their views to staff (see chapter 6).

4.8 Wherever possible, patients should be engaged in the processes of reaching decisions which affect their care and treatment under the Act. Consultation with patients involves helping them to understand the information relevant to decisions, their own role and the roles of others who are involved in taking decisions. Ideally decisions should be agreed with the patient. Where a decision is made that is contrary to the patient's wishes, that decision and the authority for it should be explained to the patient using a form of communication that the patient understands. Carers and advocates should be involved where the patient wishes or if the patient lacks capacity to understand.

Information for detained patients and patients on CTOs

4.9 The Act requires hospital managers to take steps to ensure that patients who are detained in hospital under the Act, or who are subject to a community treatment order, understand important information about how the Act applies to them. This must be done as soon as practicable after the start of the patient's detention or the CTO. This information must be given to patients subject to a CTO ('community patients') who are recalled to hospital at the time they are being recalled.

4.10 Information must be given to the patient both orally and in writing, including in accessible formats as appropriate (eg Braille, Moon, easy read) and in a language the patient understands. These are not alternatives. Those providing information to patients should ensure that all relevant information is communicated in a way that the patient understands.

4.11 It would not be sufficient to repeat what is already written on an information leaflet as a way of providing information orally.

4.12 Patients should be given all relevant information, including on complaints, advocacy, legal advice, safeguarding and the role of the Care Quality Commission (CQC). This information should be readily available to them throughout their detention or the period of the CTO.

4

Information about detention and CTOs

4.13 Patients must be informed:

- of the provisions of the Act under which they are detained or subject to a CTO and the effect of those provisions
- of the rights (if any) of their nearest relative to discharge them (and what can happen if their responsible clinician does not agree with that decision)
- for community patients, of the effect of the CTO, including the conditions which they are required to keep and the circumstances in which their responsible clinician may recall them to hospital, and
- that help is available to them from an IMHA, and how to obtain that help (chapter 6).

4.14 As part of this, they should be told:

- the reasons for their detention or CTO
- the maximum length of the current period of detention or CTO
- that their detention or CTO may be ended at any time if it is no longer required or the criteria for it are no longer met
- that they will not automatically be discharged when the current period of detention or CTO ends
- that their detention or CTO will not automatically be renewed or extended when the current period of detention or CTO ends
- the reasons for being recalled, and
- for patients subject to a CTO, the reasons for the revocation of a CTO.

4.15 Patients should also be told the essential legal and factual grounds for their detention or CTO. For the patient to be able to adequately and effectively challenge the grounds for their detention or their CTO, should they wish, they should be given the full facts rather than simply the broad reasons. This should be done promptly and clearly. They should be told they may seek legal advice, and assisted to do so if required.

4.16 In addition, a copy of the detention or CTO documentation should be made available to the patient as soon as practicable and as a priority, unless the hospital managers are of the opinion (based on the advice of the authors of the documents) that the information disclosed would adversely affect the health or wellbeing of the patient or others. It may be necessary to remove any personal information about third parties.

4.17 Where the section of the Act under which the patient is being detained changes, they must be provided with the above information to reflect the new situation. The same applies where a detained patient becomes subject to a CTO.

Information about recall to hospital whilst on CTO

4.18 Where a patient is to be recalled to hospital (see paragraphs 29.45 – 29.68), the responsible clinician should give (or arrange for the patient to be given) oral reasons for the decision before the recall. The patient may nominate another person who they wish to be notified of the decision.

4.19 Where a conditionally discharged patient is to be recalled to hospital, a brief verbal explanation of the Secretary of State's reasons for recall must be provided to the patient at the time of recall unless there are exceptional reasons why this is not possible, eg the patient is violent or too distressed. The Secretary of State's warrant will detail the reasons. The patient should also receive a full explanation of the reasons for his or her recall within 72 hours after admission, and both written and oral explanations should be provided. Further information is available at paragraphs 29.52 – 29.62.

Information about consent to treatment

4.20 Patients must be told what the Act says about treatment for their mental disorder. In particular they must be told:

- the circumstances (if any) in which they can be treated without their consent – and the circumstances in which they have the right to refuse treatment
- the role of second opinion appointed doctors (SOADs) and the circumstances in which they may be involved, and
- (where relevant) the rules on electro-convulsive therapy (ECT) and medication administered as part of ECT (see paragraphs 25.19 – 25.25).

Information about seeking a review of detention or CTOs

4.21 Patients must be informed of their rights to be considered for discharge, particularly:

- of the right of the responsible clinician and the hospital managers to discharge them (and, for restricted patients, that it is subject to the agreement of the Secretary of State for Justice)
- of their right to ask the hospital managers to discharge them
- that the hospital managers must consider discharging them when their detention is renewed or their CTO is extended
- of their rights to apply to the Tribunal
- of the rights (if any) of their nearest relative to apply to the Tribunal on their behalf
- about the role of the Tribunal, and
- how to apply to the Tribunal.

4.22 Hospital managers should ensure that patients are offered assistance to request a hospital managers' hearing or make an application to the Tribunal, and that the applications are transmitted to the Tribunal without delay. They should also be told:

- how to contact a suitably qualified legal representative (and should be given assistance to do so if required)
- that free legal aid may be available, and
- how to contact any other organisation which may be able to help them make an application to the Tribunal.

4.23 It is particularly important that patients are well-informed and supported to make an application to the Tribunal if they are on a CTO, do not otherwise have regular contact with their nearest relative or people who could help them make an application, or lack capacity. If a patient lacks capacity to decide whether to seek a review of detention or a CTO, an IMHA should be introduced to the patient so that the IMHA can explain what help they can offer.

4.24 Patients whose CTOs are revoked, and conditionally discharged patients recalled to hospital, should be told that their cases will be referred automatically to the Tribunal.

Information about the CQC

4.25 Patients must be informed about the role of the CQC and of their right to meet visitors appointed by the CQC in private. Patients should be told when the CQC is to visit their hospital and be reminded of the CQC's role.

4.26 Patients may make a complaint to the CQC, and must be informed of the process for this. Support should be made available to patients to do this, if required (see paragraphs 4.53 – 4.68).

Information about withholding of correspondence

4.27 Detained patients must be told that their letters for posting may be withheld if the person to whom it is addressed asks the hospital managers to do so. Patients in high security psychiatric hospitals must be told about the other circumstances in which their correspondence may be withheld, the procedures that will be followed and of their right to ask the CQC to review the decisions taken.

Keeping patients informed of their rights

4.28 Those with responsibility for patient care should ensure that patients are reminded from time to time of their rights and the effects of the Act. It may be necessary to give the same information on a number of different occasions or in different formats

and to check regularly that the patient has fully understood it. Information given to a patient who is unwell may need to be repeated when their condition has improved. It is helpful to ensure that patients are aware that an IMHA can help them to understand the information (see paragraph 6.12).

4.29 A fresh explanation of the patient's rights should be considered in particular where:

- the patient is considering applying to the Tribunal, or when the patient becomes eligible again to apply to the Tribunal
- the patient requests the hospital managers to consider discharging them, or such a request is refused
- the rules in the Act about their treatment change (eg because three months have passed since they were first given medication, or because they have regained capacity to consent to treatment) (see chapters 23, 24 and 25)
- any significant change in their treatment is being considered
- there is to be a care programme approach review (or its equivalent)
- renewal of their detention, or extension of their CTO is being considered
- a decision is taken to renew their detention or to extend their CTO
- a decision is taken to recall a community patient or revoke a CTO, or
- a decision is taken to recall a conditionally discharged patient to hospital.

4.30 When a detained patient or a community patient is discharged, or the authority for their detention or the CTO expires, this fact should be made clear to them. The patient should be given an explanation of what happens next, including any section 117 after-care or other services which are to be provided.

Information for nearest relatives

4.31 The Act requires hospital managers to take such steps as are practicable to give the patient's nearest relative a copy of any information given to the patient in writing, unless the patient requests otherwise. The information should be given to the nearest relative when the information is given to the patient, or within a reasonable time afterwards.

4.32 When a patient detained under the Act or subject to a CTO is given information, they should be told that the written information will also be supplied to their nearest relative, so that they can discuss their views about sharing this information and following this discussion, raise any concerns or object to the sharing of some or all of this information. There should be discussion with the patient at the earliest possible time as to what information they are happy to share and what they would like to be kept private.

4.33 The nearest relative must be told of the patient's discharge from detention or CTO (where practicable), unless either the patient or the nearest relative has requested that information about discharge should not be given. This includes discharge from detention onto a CTO. If practicable, the information should be given at least seven days in advance of the discharge.

4.34 In addition, regulations require nearest relatives to be informed of various other events, including the renewal of a patient's detention, extension of a CTO and transfer from one hospital to another.

4.35 These duties to inform nearest relatives are not absolute. In almost all cases, information is not to be shared if the patient objects.

4.36 In addition, occasionally there will be cases where these duties do not apply because disclosing information about the patient to the nearest relative cannot be considered practicable, on the grounds that it would have a detrimental impact on the patient that is disproportionate to any advantage to be gained from informing the nearest relative. This would therefore be a breach of the patient's right to privacy under article 8 of the European Convention on Human Rights (ECHR). The risk of this is greatest where the nearest relative is someone whom the patient would not have chosen themselves. Before disclosing information to nearest relatives without a patient's consent, the person concerned must consider whether the disclosure would be likely to:

- put the patient at risk of physical harm or financial or other exploitation
- cause the patient emotional distress or lead to a deterioration in their mental health, or
- have any other detrimental effect on their health or wellbeing and, if so, whether the advantages to the patient and the public interest of the disclosure outweigh the disadvantages to the patient, in the light of all the circumstances of the case.

Communication with other people nominated by the patient

4.37 Patients may want to nominate one or more people who they would wish to be involved in, or notified of, decisions related to their care and treatment.

4.38 Patients may nominate an IMHA, another independent advocate, or a legal professional. They may also nominate a carer or other informal supporter or advocate.

4.39 The involvement of such carers can have significant benefits for the care and treatment of the patient. It can provide reassurance to the patient, who may feel distrustful of professionals who are able to impose compulsory measures on them,

or are relatively unfamiliar and unknown to the patient. People who know the patient well can provide knowledge of the patient and perspectives that come from long-standing and intimate involvement with the patient prior to (and during) their involvement with mental health services. They can provide practical assistance in helping the patient to articulate information and views and may have knowledge of advance decisions or statements made by the patient (see chapter 9).

4.40 Professionals should normally agree to a patient's request to involve carers, relatives, friends or other informal supporters or advocates. They should tell the patient whenever such a request will not be, or has not been, granted. Where a patient's request is refused, it is good practice to record this in the patient's notes, giving reasons for the refusal. It may not always be appropriate to involve another person as requested by the patient, for example where:

- contacting and involving the person would result in a delay in making the decision in question that would not be in the patient's interests
- the involvement of the person is contrary to the interests of the patient, or
- that person has requested that they should not be involved.

4.41 Professionals should take steps to find out whether patients who lack capacity to take particular decisions for themselves have an attorney or deputy with authority to take the decision on their behalf. Where there is such a person, they act as the agent of the patient, and should be informed in the same way as the patient themselves about matters within the scope of their authority.

Involvement of carers

4.42 Carers are key partners with health and care services and local authorities in providing care, especially for relatives and friends who have mental disorders.[1] In many instances, especially when a patient is not in hospital, the patient's carers and wider family will provide more care and support than health and social care professionals. It is important for professionals to identify all individuals who provide care and support for patients, to ensure that health and care services assess those carers' needs and, where relevant, provide support to meet them. Local authorities also have duties in the Care Act 2014 to assess adult carers' current and future needs for support and, must meet eligible needs for support.[2] The Children and Families Act 2014 also places a duty on local authorities to assess needs for support of both parent carers of disabled children and young carers.[3]

[1] See Care Act 2014. http://www.legislation.gov.uk/ukpga/2014/23/contents/enacted

[2] These duties are expected to become operational on 1 April 2015.

[3] Children and Families Act 2014. http://www.legislation.gov.uk/ukpga/2014/6/contents/enacted

4.43 Unless there are good reasons to the contrary, patients should be encouraged to agree to their carers being involved in decisions under the Act and to them being kept informed. If patients lack capacity to consent to this, it may be appropriate to involve and inform carers if it is in the patient's interests – although that decision should always be made in the light of the specific circumstances of the case.

4.44 In order to ensure that carers can, where appropriate, participate fully in decision making, it is important that they have access to:

- practical and emotional help and support to assist them in participating, and
- timely access to comprehensive, up-to-date and accurate information.

4.45 Even if carers cannot be given detailed information about the patient's case, where appropriate, they should be offered general information in an appropriate form, which may help them understand the nature of mental disorder, the way it is treated, and the operation of the Act.

4.46 If carers request that the information they provide is kept confidential, this should be respected and recorded in the patient's notes. A carer should be asked to consent to such information being disclosed. Where a carer refuses to consent, professionals should discuss with the carer the benefits of sharing information in terms of patient care and how their concerns could be addressed.

4.47 Paragraph 4.44 applies equally to children, young people or individuals with a learning disability who are supporting parents who have mental disorder. In considering the kind and amount of information which young people (especially young carers) should receive about a parent's condition or treatment, the people giving the information will need to balance the interests of the child against the patient's right to privacy and their wishes and feelings. Any such information should be appropriate to the age and understanding of the young person.

Hospital managers' information policy

4.48 The formal duty to ensure that detained and community patients, and their nearest relatives, have been informed about their legal situation and rights falls to the hospital managers. In practice, it would usually be more appropriate for professionals working with the patient to provide them with the information. In order to fulfil their statutory duties hospital managers should have policies in place to ensure that:

- the correct information is given to patients and their nearest relatives
- information is given in accordance with the requirements of the legislation, at a suitable time and in an accessible format, where appropriate with the aid of assistive technologies and interpretative and advocacy services

- people who give the information have received adequate and appropriate training and guidance and, if relevant, have specialist skills in relation to people with learning disability, autism and/or children and young people
- a record is kept of the information given, including how, when, where and by whom it was given, and an assessment made of how well the information was understood by the recipient
- regular checks are made that information has been properly given to each patient and understood by them, and
- information must be provided in a format and/or language that the individual understands (eg Braille, easy read or Moon).

Information for informal hospital inpatients

4.49 Although the Act does not impose any duties to give information to informal patients, these patients should have their legal position and rights explained to them.

4.50 Informal patients should be provided with relevant information (eg about how to make a complaint and consent requirements for treatment).

4.51 Informal patients must be allowed to leave if they wish, unless they are to be detained under the Act. Both the patient and, where appropriate, their carer and advocate should be made aware of this right with information being provided in a format and language the patient understands. Local policies and arrangements about movement around the hospital and its grounds must be clearly explained to the patients concerned. Failure to do so could lead to a patient mistakenly believing that they are not allowed to leave hospital, which could result in an unlawful deprivation of their liberty and a breach of their human rights.

Information for those subject to guardianship

4.52 Responsible local authorities are required to take steps to ensure that guardianship patients understand their rights to apply to a Tribunal and the rights of their nearest relatives. The same information also must normally be given to nearest relatives. More generally, local authorities (and private guardians) should do what they can to ensure that patients understand why they are subject to guardianship and what it means for them.

4

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

4.53 A patient and persons supporting them (eg a patient's nearest relative, family, carer, advocate or legal representative), especially a patient lacking capacity, must be supported to make a complaint if they think the safeguards of the Act are not being appropriately applied or they have concerns about the care and treatment being provided.

4.54 Staff should be aware that it can be particularly difficult for patients and those supporting them to take forward complaints due to their mental ill-health and fear that this may impact on the quality of care and support they receive. All efforts must be made to support patients (especially those lacking capacity) and those supporting them to make complaints without any negative impact on the quality of care and support provided.

4.55 It is usually best for initial concerns to be raised locally. All providers should have clear complaints policies and procedures. Patients and those supporting them (including nearest relatives, family, carers and advocates) must be given information about how to make a complaint to the hospital. The information must be in formats that these individuals can understand.

4.56 Information about how to make a complaint to the service commissioner, CQC or Parliamentary and Health Ombudsmen should also be readily available.

4.57 CQC is likely to ask providers to detail the information provided to patients and those supporting them about how to make a complaint (see contact details below).

4.58 Patients can complain to the service provider, commissioner, local authority, CQC or the police depending upon what the complaint is about. The NHS complaints procedure sets out how complaints should be dealt with about NHS and local authority-funded services whilst the Act gives specific powers to make complaints about care under the Act and specifies certain criminal offences.

4.59 If the complaint is about service provision, a complaint may be made to the service provider or the commissioner. If not satisfied with the outcome, the complaint may be taken to the Parliamentary and Health Service Ombudsman.[4]

4.60 If the complaint is about care and treatment under the Act, the complaint can be made to the service provider, commissioner, or CQC. If not satisfied with the outcome, the complaint may be taken to the Parliamentary and Health Service Ombudsman or ultimately the Secretary of State for Health or Justice, as appropriate. This guidance focuses on care under the Act. Chapter 12 gives guidance on the applications that may be made to the Tribunal.

[4] The NHS Complaints Process for NHS commissioners, NHS-funded providers and local authorities is established by The Local Authority Social Services and National Health Service Complaints (England) Regulations. 2009. http://www.legislation.gov.uk/uksi/2009/309/pdfs/uksi_20090309_en.pdf

4.61 Every service provider should make reasonable efforts to raise awareness and understanding of the Act and Code among patients and carers and, particularly in relation to their rights under the Act.

4.62 Providers should ensure staff are trained appropriately to support patients who have additional needs to access information about complaints and resolution procedures. Every effort should be made to place copies of the Code in areas accessible to patients, and as appropriate their visitors.

4.63 Information about how to make a complaint to the service commissioner, the CQC or Parliamentary and Health Ombudsmen should also be readily available. This should be displayed on all mental health wards. Complaining to the commissioner may be the right option if the individual is not comfortable complaining directly to the service provider or, if the complaint is under the Act, directly to the CQC. Information should include specific information about the right of detained patients to complain to the CQC (contact details below), and the local support available if they wish to raise a concern or complaint. This should be available in alternative formats, eg easy read or Braille. The information should be explained to all patients, including those who lack capacity to make decisions about complaints, have problems communicating (eg they do not read or write), or whose first language is not English.

4.64 A patient and persons supporting them (eg a patient's nearest relative, carer, advocate or legal representative), especially a patient lacking capacity, should be supported to make a complaint if they think the safeguards of the Act are not being appropriately applied or they have concerns about the care and treatment being provided.

4.65 Staff should be aware that it can be particularly difficult for patients to take forward complaints due to their mental ill-health and fear that this may impact on the quality of care and support they receive. All efforts should be made to support patients (especially those lacking capacity), and those supporting them, to make complaints without any negative impact on the quality of care and support provided.

4.66 A qualifying patient (see paragraphs 6.8 – 6.11) may request the support of an independent mental health advocate (IMHA) in progressing a complaint. IMHAs are specialist advocates who are trained specifically to work within the framework of the Act and can enable patients to participate in decision-making. Patients should be encouraged to provide feedback on their general experiences, locally and to national bodies.

4.67 CQC is likely to ask providers to detail the information provided to patients and those supporting them about how to make a complaint (see contact details below).

4.68 Further information on what to do if you think the Act is not being appropriately applied, including additional advice if you are a health and social care professional, is available in the introduction at paragraphs XXVIII – XXX.

4

Related material

- Care Quality Commission (Additional Functions) Regulations 2011. http://www.cqc.org.uk
- The High Security Psychiatric Services (Arrangements for Safety and Security at Ashworth, Broadmoor and Rampton Hospitals) Directions 2011. https://www.gov.uk/government/publications/the-high-security-psychiatric-services-arrangements-for-safety-and-security-at-ashworth-broadmoor-and-rampton-hospitals-directions-2011
- Care Act 2014. http://www.legislation.gov.uk/ukpga/2014/23/contents/enacted
- Children and Families Act 2014. http://www.legislation.gov.uk/ukpga/2014/6/contents/enacted
- The Triangle of Care – carers included: a best practice guide in acute mental health care. Carers Trust and National Mental Health Development Unit. 2014. http://www.carers.org/news/mental-health-and-triangle-care

At the time of going to publication the contact details for CQC are:
Call CQC on: 03000 616161 and press '1' to speak to the mental health team.

Write to CQC at:
CQC Mental Health Act
Citygate
Gallowgate
Newcastle
NE1 4PA

Email CQC at: enquiries@cqc.org.uk
Or fill out a 'Tell us your experience' form on the CQC website: www.cqc.org.uk

This material does not form part of the Code. It is provided for assistance only.

5 The nearest relative

Why read this chapter?

5.1 This chapter gives guidance on the identification, appointment and displacement of nearest relatives under the Act. The 'nearest relative' for the purposes of the Act may not be the same person as the patient's 'next of kin'. This chapter gives guidance on what to do if there is no nearest relative and displacement of nearest relatives and appointment of acting nearest relative by the county court.

Identification of the nearest relative

5.2 Section 26 of the Act defines 'relative' and 'nearest relative' for the purposes of the Act. It is important to remember that the nearest relative for the purposes of the Act may not be the same person as the patient's 'next of kin'. The identity of the nearest relative may change with the passage of time – eg if the patient enters into a marriage or civil partnership. The nearest relative may be the patient's carer and it is important that they are recognised, particularly as they may have the most relevant information to share with professionals with regard to the patient's care and interests. If the nearest relative is not the carer, professionals should also involve the carer.

5.3 The Act includes additional provisions to identify the nearest relative of a child or young person. For example:

- if the child or young person is subject to a care order (or interim care order) under the Children Act 1989, the relevant local authority will be the nearest relative, save for where the young person is married or in a civil partnership, in which case their spouse or civil partner will be the nearest relative (section 27 of the Act)
- individuals who have been appointed as guardians (section 5 of the Children Act 1989) or special guardians (section 14A of the Children Act 1989) and those named in a child arrangements order as a person with whom the child or young person is to live (formerly known as a residence order)[1] (section 8 of the Children Act 1989) will be the child or young person's nearest relative (section 28 of the Act), and
- unmarried fathers will only be treated as the child or young person's 'father' for the purpose of section 26 of the Act if they have obtained 'parental responsibility'.[2] This may be acquired through a number of routes such as a parental responsibility agreement, subsequent marriage to the mother of the child or young person or by obtaining a child arrangements order as a person with whom the child or young person is to live (formerly known as a residence order). As from 1st December 2003, unmarried fathers can acquire parental responsibility for their children born after this date by registering themselves as the father on their child's birth certificate.

[1] Section 12 of the Children and Families Act 2014 amends section 8(1) of the Children Act 1989. http://www.legislation.gov.uk/ukpga/2014/6/section/12/enacted

[2] The section 26(2) requirement of parental responsibility only applies to patients under 18 who are not born to parents who are married or in a civil partnership.

5

5.4 Patients remanded to hospital under sections 35 and 36 of the Act, subject to interim hospital orders under section 38 or subject to special restrictions under part 3 of the Act (restricted patients – see chapter 22) do not have nearest relatives (as defined by the Act).

Delegation of nearest relative functions

5.5 A nearest relative is not obliged to act as such. They can authorise, in writing, another person to perform the functions of the nearest relative on their behalf. The procedure for doing this is set out in the Mental Health (Hospital, Guardianship and Treatment) (England) Regulations 2008.[3]

Where there is no nearest relative

5.6 Where an approved mental health professional (AMHP) discovers, when assessing a patient for possible detention or guardianship under the Act (or at any other time), that the patient appears to have no nearest relative, the AMHP should advise the patient of their right to apply to the county court for the appointment of a person to act as their nearest relative. If the patient lacks capacity to decide to apply themselves, the AMHP should apply to the county court.

Appointment of acting nearest relatives by the county court

Grounds for displacement and appointment

5.7 An acting nearest relative can be appointed by the county court on the grounds that:

- the nearest relative is incapable of acting as such because of illness or mental disorder
- the nearest relative has objected unreasonably to an application for admission for treatment or a guardianship application
- the nearest relative has exercised the power to discharge a patient without due regard to the welfare of the patient or the interests of the public
- the nearest relative is otherwise not a suitable person to act as such, or
- the patient has no nearest relative within the meaning of the Act, or it is not reasonably practicable to ascertain whether the patient has a nearest relative or who that nearest relative is.

[3] Mental Health (Hospital, Guardianship and Treatment) (England) Regulations. 2008. SI 2008/1184, regulation 24. http://www.legislation.gov.uk/uksi/2008/1184/contents/made

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

5.9 However, as an alternative to an order by the court, it may sometimes be enough for the actual nearest relative to delegate their role to someone else (see paragraph 5.5).

Who can make an application to the court?

5.10 An application to displace the nearest relative may be made by any of the following people:

- the patient (or if the patient lacks capacity to make the application, the patient's litigation friend, who could be an advocate or carer)
- any relative of the patient
- anyone with whom the person is residing (or was residing prior to admission), or
- an AMHP.

Applications to the court by AMHPs

5.11 AMHPs will need to consider making an application for displacement or appointment if:

- they believe that a patient should be detained in hospital under section 3 of the Act, or should become a guardianship patient, but the nearest relative objects, or
- they believe that the nearest relative is likely to discharge a patient from detention or guardianship unwisely.

5.12 They should also consider doing so if they think that:

- a patient has no identifiable nearest relative or their nearest relative is incapable of acting as such
- they have good reasons to think that a patient considers their nearest relative unsuitable and would like them to be replaced, and
- it would not be reasonable in the circumstances to expect a patient, or anyone else, to make an application.

5.13 AMHPs should bear in mind that some patients may wish to apply to displace their nearest relative but may be deterred from doing so by the need to apply to the county court.

5.14 It is entirely a matter for the court to decide what constitutes 'suitability' of a person to be a nearest relative. Factors which an AMHP might wish to consider when deciding whether to make an application to displace a nearest relative on those grounds, and when providing evidence in connection with an application, could include:

- any reason to think that the patient has suffered, or is suspected to have suffered, abuse at the hands of the nearest relative (or someone with whom the nearest relative is in a relationship), or is at risk of suffering such abuse
- whether the patient is afraid of the nearest relative or seriously distressed by the possibility of the nearest relative being involved in their life or their care, or
- whether the patient and nearest relative are unknown to each other, there is only a distant relationship, or their relationship has broken down irretrievably.

This is not an exhaustive list.

5.15 In all cases, the decision to make an application lies with the AMHP personally.

5.16 Before making an application for displacement, AMHPs should consider other ways of achieving the same end, including:

- whether the nearest relative will agree to delegate their role as the patient's nearest relative to someone else, or
- providing or arranging support to the patient (or someone else) to make an application themselves. This could include support from an independent mental health advocate (IMHA) (see chapter 6).

5.17 All local authorities should provide clear practical guidance to help the AMHP decide whether to make an application and how to proceed. Before producing such guidance, local authorities should consult with the county court. Local authorities should ensure that they have access to the necessary legal advice and support.

Making an application

5.18 People making an application to the county court will need to provide the court with the facts that will help it make a decision on the application. Exactly what will be required will depend on the type of application and the specific circumstances of the case.

5.19 When applying to displace a nearest relative, AMHPs should nominate someone to become the acting nearest relative in the event that application is successful. Wherever practicable, they should first consult the patient about the patient's own preferences and any concerns they have about the person the AMHP proposes to nominate. AMHPs should also seek the agreement of the proposed nominee prior to an application being made, although this is not a legal requirement.

5.20 Local authorities should provide clear practical guidance to help the AMHP decide whom it is appropriate to nominate when making an application to displace a nearest relative.

5.21 If the patient has any concerns that any information given to the court on their views on the suitability of the nearest relative may have implications for their own safety, an application can be made to the court seeking its permission not to make the current nearest relative a party to the proceedings. The reasons for the patient's concerns should be set out clearly in the application.

5.22 Hospital managers should provide support to detained patients to enable them to attend the court, if they wish, subject to the patient being granted leave under section 17 for this purpose.

5.23 If, exceptionally, the court decides to interview the patient (as the applicant), the court has the discretion to decide where and how this interview takes place and whether it should take place in the presence of, or separate from, other parties. The patient should be fully supported in this, including through the use of an advocate to support them.

5.24 If the court decides that the nearest relative should be displaced and finds the proposed replacement to be suitable, and the person is willing to act as nearest relative, the court will appoint them.

6 Independent mental health advocates

Why read this chapter?

6.1 Independent mental health advocates (IMHAs) provide an additional safeguard for patients who are subject to the Act. They support patients to exercise their rights and ensure they can participate in the decisions that are made about their care and treatment. They do not replace any other advocacy or support services and work in conjunction with other services. They help qualifying patients to obtain relevant information and to understand their position including their rights and aspects of their treatment.

6.2 This chapter explains the role of IMHAs under the Act and other people's responsibilities in making a patient aware of the help that an IMHA provides.

Purpose of IMHA services

6.3 IMHA services provide an additional safeguard for patients who are subject to the Act. IMHAs are specialist advocates who are trained specifically to work within the framework of the Act and enable patients to participate in decision-making, for example, by encouraging patients to express their views and supporting them to communicate their views. They are commissioned by the relevant local authority as identified under the Act.[1] IMHAs should be independent of any person who has been professionally involved in the patient's medical treatment.

6.4 IMHA services do not replace any other advocacy and support services that are available to patients, such as independent mental capacity advocates (IMCAs) or representatives for patients who lack capacity, but are intended to operate in harmony with those services.

6.5 The same advocate may be qualified to act as an IMHA and an IMCA though these are different roles. For detailed guidance on the functions of IMCAs see chapter 10 of the *Mental Capacity Act 2005: Code of Practice*.[2] For guidance on independent advocacy under the Care Act, see chapter 7 of Care and Support Statutory Guidance.[3]

[1] See section 130C(4A) of the Act.

[2] Care and Support Statutory Guidance issued under the Care Act 2014. Department of Health. 2014. https://www.gov.uk/government/publications/care-act- 2014-statutory-guidance-for-implementation

[3] Mental Capacity Act 2005: Code of Practice. Department for Constitutional Affairs (now Ministry of Justice). 2007. https://www.gov.uk/government/publications/mental-capacity-act-code-of-practice

Commissioning IMHA services

6.6 To ensure that IMHA services reflect the diversity of the local population and that they are as independent as possible, they are commissioned by local authorities, as follows:

- for detained patients, by the local authority for the area in which the hospital in which they are detained is located
- for community treatment order (CTO) patients, by the local authority for the area in which their responsible hospital is located
- for people subject to guardianship, by the local authority which is acting as the guardian or, if the patient has a private guardian, by the local authority for the area in which the private guardian lives.

6.7 Local authorities should ensure that IMHAs understand equality issues and that there are sufficient numbers of IMHAs with a specialised understanding of the specific needs of particular groups including the list below, and that IMHAs can communicate effectively with them:

- patients from minority cultural or ethnic backgrounds
- patients with physical impairments and/or sensory impairments, and/or
- patients with learning disabilities and/or autistic spectrum disorders.

Patients who are eligible for IMHA services (qualifying patients)

6.8 Patients are eligible for support from an IMHA, irrespective of their age, if they are:

- detained under the Act
- liable to be detained under the Act, even if not actually detained, including those who are currently on leave of absence from hospital or absent without leave, or those for whom an application or court order for admission has been completed (but not those listed in paragraph 6.9 below)
- conditionally discharged restricted patients
- subject to guardianship, or
- patients subject to community treatment orders (CTOs).

6.9 For these purposes, detention does not include being detained:

- on the basis of an emergency application (section 4) until the second medical recommendation is received (see chapter 15)
- under the 'holding powers' in section 5 (see chapter 18), or
- in a place of safety under section 135 or 136 (see chapter 16).

6.10 Other patients ('informal patients') are eligible if they are:

- being considered for a treatment to which section 57 applies ('a section 57 treatment') (see paragraphs 25.7 – 25.10 and for under 18s 19.79), or
- under 18 and being considered for electro-convulsive therapy (ECT) or any other treatment to which section 58A applies ('a section 58A treatment') (see paragraphs 19.80 – 19.88).

6.11 The Act calls patients who are eligible for the support of an IMHA 'qualifying patients'.

The role of IMHAs

6.12 The Act says that the support which IMHAs provide must include helping patients to obtain information about and understand the following:

- their rights under the Act
- the rights which other people (eg the nearest relative – see chapter 5) has in relation to them under the Act
- the particular parts of the Act which apply to them (eg the basis on which they are detained) and which therefore make them eligible for advocacy
- any conditions or restrictions to which they are subject (eg as condition of leave of absence from hospital (see chapter 27), as a condition of a CTO (see chapter 29), or as a condition of conditional discharge)
- any medical treatment that they are receiving or might be given
- the reasons for that treatment (or proposed treatment), and
- the legal authority for providing that treatment, and the safeguards and other requirements of the Act which would apply to that treatment.

6.13 The Act enables IMHAs to help patients to exercise their rights, which can include representing them and speaking on their behalf, eg by accompanying them to review meetings or hospital managers' hearings. IMHAs support patients in a range of other ways to ensure they can participate in the decisions that are made about their care and treatment, including by helping them to make applications to the Tribunal.

6.14 The involvement of an IMHA does not affect a patient's right (nor the right of their nearest relative) to seek advice from a lawyer. Nor does it affect any entitlement to legal aid. IMHAs may, if appropriate, help the patient to exercise their rights by assisting patients to access legal advice and supporting patients at Tribunal hearings.

Duty to inform patients about the availability of IMHA services

6.15 Certain people have a duty to take whatever steps are practicable to ensure that patients understand that help is available to them from IMHA services and how they can obtain that help, as set out in the following table. This must include giving the relevant information both orally and in writing.

6.16 If a patient lacks capacity to decide whether or not to obtain help from an IMHA, the hospital manager should ask an IMHA to attend the patient so that the IMHA can explain what they can offer to the patient directly.

Duty to provide patients with information about advocacy services

Figure 4: Providing patients with information about IMHAs

Type of patient	Steps to be taken by	As soon as practicable after
Detained patients	the managers of the hospital in which the patient is liable to be detained	the patient becomes liable to be detained
Guardianship patients	the responsible local authority	the patient becomes subject to guardianship
Community patients (subject to CTOs)	the managers of the responsible hospital	the patient becomes a community patient
Conditionally discharged patients	the patient's responsible clinician	the patient is conditionally discharged
Informal patients	the doctor or approved clinician who first discusses with the patient the possibility of them being given the section 57 or 58A treatment in question	that discussion (or during it)

6.17 The person responsible for taking steps identified in the table above should be aware that certain patients within each of the patient 'types' may need particular encouragement and assistance to seek the support of an IMHA. This would include people who lack or only have limited capacity (where an IMHA should be introduced to the patient), have sensory impairments, are from minority ethnic communities, or are under 18.

6.18 The relevant person must also take whatever steps are practicable to give a copy of the written information to the patient's nearest relative, unless the patient requests otherwise (and subject to the normal considerations about involving nearest relatives – see paragraphs 4.32 – 4.37).

6.19 Any information about independent mental health advocacy services should make clear that the service is for patients and is not an advocacy service for nearest relatives themselves.

6.20 The duty to give information to nearest relatives does not apply to informal patients, nor to patients detained in hospital under part 3 of the Act (although it does apply to those patients if they subsequently become community patients).

Seeking help from an IMHA

6.21 A qualifying patient may request the support of an IMHA at any time after they become a qualifying patient. Patients have the right to access the independent mental health advocacy service itself, rather than the services of a particular IMHA, though where possible it would normally be good practice for the same IMHA to remain involved while the person remains subject to the Act.

6.22 IMHAs must also comply with any reasonable request to visit and interview a qualifying patient, if the request is made by the patient's nearest relative, an approved mental health professional (AMHP) or the patient's responsible clinician (if they have one).

6.23 AMHPs and responsible clinicians should consider requesting an IMHA to visit a qualifying patient if they think that the patient might benefit from an IMHA's visit but is unable, or unlikely, for whatever reason to request an IMHA's help themselves. If a patient lacks capacity to decide whether to seek help from an IMHA, an IMHA should be introduced to the patient.

6.24 Before requesting an IMHA to visit a patient, they should, wherever practicable, first discuss the idea with the patient, and give the patient the opportunity to decide for themselves whether to request an IMHA's help. AMHPs and responsible clinicians should not request an IMHA to visit where they know, or strongly suspect, that the patient does not want an IMHA's help, or the help of the particular IMHA in question.

6.25 Patients may refuse to be interviewed and do not have to accept help from an IMHA if they do not want it. Equally, a patient may choose to end the support they are receiving from an IMHA at any time.

IMHAs' access to patients and professionals

6.26 Patients should have access to a telephone on which they can contact the IMHA service and talk to them in private.

6.27 Clinicians, hospital managers (and local authorities for guardianship patients) should ensure that IMHAs are able to:

- access wards and units on which patients are resident
- meet with the patients they are helping in private, unless the patient objects or it is otherwise inappropriate (for example where the risk is too great – see paragraphs 11.11 – 11.14), and
- attend meetings between patients and the professionals involved in their care and treatment when asked to do so by patients.

6.28 When instructed by a patient, the nearest relative, an AMHP or the responsible clinician, an IMHA has the right to meet the patient in private. IMHAs also have a right to visit and speak to any person who is currently professionally concerned with a patient's medical treatment, for the purpose of helping the patient as their IMHA.

6.29 Professionals should remember that the normal rules on patient confidentiality apply to conversations with IMHAs, even when the conversation is at the patient's request. IMHAs have a right of access to patients' records in certain cases (see paragraphs 6.30 – 6.38), but otherwise professionals should be careful not to share confidential information with IMHAs, unless the patient has consented to the disclosure or the disclosure is justified on the normal grounds (see chapter 10).

IMHAs' access to patients' records

6.30 Where the patient consents, IMHAs have a right to see any clinical or other records relating to the patient's detention or treatment in any hospital, or relating to any after-care services provided to the patient. An IMHA has a similar right to see any records relating to the patient held by a local authority.

6.31 Where the patient does not have the capacity (or in the case of a child, the competence) to consent to an IMHA having access to their records, the holder of the records must allow the IMHA access if they think that it is appropriate and that the records in question are relevant to the help to be provided by the IMHA.

6.32 When an IMHA seeks access to the records of a patient who does not have the capacity or the competence to consent, the person who holds the records should ask the IMHA to explain what information they think is relevant to the help they are providing to the patient and why they think it is appropriate for them to be able to see that information.

6.33 The Act does not define any further what it means by access being appropriate, so the record holder needs to consider all the facts of the case. But the starting point should always be what is in the patient's best interests and not (for example) what would be most convenient for the organisation which holds the records.

6.34 In deciding whether it is appropriate to allow the IMHA access, the holder of the records needs to consider whether disclosure of the confidential patient information contained in the records is justified.

6.35 The key consideration will therefore be whether the disclosure is in the patient's best interests. That decision should be taken in accordance with the Mental Capacity Act 2005 (MCA) (or, for children under 16, the common law).

6.36 Record holders should start from a general presumption that it is likely to be in the patient's interests to be represented by an IMHA who is knowledgeable about their case. But each decision must still be taken on its merits, and the record holder must, in particular, take into account what they know about the patient's wishes and feelings, including any written statements made in advance. (For further information on taking decisions in the best interests of people who lack capacity to make the decision themselves, please see the Code of Practice to the MCA.[2])

6.37 Records must not be disclosed if that would conflict with a decision made on the patient's behalf by the patient's attorney or deputy, or by the Court of Protection.

6.38 If the record holder thinks that disclosing the confidential patient information in the records to the IMHA would be in the patient's best interests, it is likely to be appropriate to allow the IMHA access to those records in all but the most exceptional cases.

Related material

- Mental Capacity Act 2005. http://www.legislation.gov.uk/ukpga/2005/9/contents
- Mental Capacity Act 2005. Code of Practice. Department for Constitutional Affairs (now Ministry of Justice). 2007. https://www.gov.uk/government/publications/mental-capacity-act-code-of-practice
- The Right to be Heard: review of independent mental health advocate services in England. University of Central Lancashire. 2012. http://www.uclan.ac.uk/research/environment/projects/the_right_to_be_heard.php
- Care and Support Statutory Guidance Issued under the Care Act 2014. Department of Health. 2014. https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/315993/Care-Act-Guidance.pdf

This material does not form part of the Code. It is provided for assistance only.

[2] Mental Capacity Act 2005. Code of Practice. Department for Constitutional Affairs (now Ministry of Justice). 2007. https://www.gov.uk/government/publications/mental-capacity-act-code-of-practice (Chapter 9).

7 Attorneys and deputies

Why read this chapter?

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

7.2 Attorney and deputies can take decisions in relation to the welfare, property or affairs of a person subject to the Act that they are otherwise authorised to take, subject to the exceptions outlined in this chapter.

Powers of attorneys and deputies

7.3 In general, the fact that a person is subject to the Act does not affect the validity of any lasting power of attorney (LPA), nor the scope of the authority of an attorney or deputy (or the Court of Protection) to make decisions on their behalf. Children and young people under 18 cannot create a lasting power of attorney or make an advanced decision.

7.4 Attorneys and deputies can take any decisions in relation to the welfare, property or affairs of a person subject to the 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 Act, including neurosurgery for mental disorder and other treatments under section 57 (see paragraphs 25.7 – 25.10 and under 18s 19.79), and
- they will not be able to take decisions about where a patient subject to guardianship is to live, nor take other decisions which conflict with decisions that a guardian has a legal right to make (see chapter 30).

7.5 Being subject to compulsory measures under the Act does not prevent people creating new LPAs under the MCA if they have the capacity to do so. Nor does it prevent the Court of Protection from appointing a deputy to take decisions for them which they lack the capacity to make themselves.

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

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7.7 Attorneys and deputies are able to exercise a patient's rights under the Act on their behalf, if they have the relevant authority under the LPA or the order of the court appointing them and the patient concerned lacks the capacity to do so themselves. In particular, personal welfare attorneys and deputies may be able to exercise the patient's various rights to apply to the Tribunal for discharge from detention, guardianship or a CTO.

7.8 It is good practice, where practicable, for clinicians and others involved in the assessment or treatment of patients under the Act to try to find out whether the person has an attorney or deputy and to establish effective means of communication to ensure that the attorney or deputy is informed and, where relevant, consulted about the patient's care. Information regarding the appointment of any registered LPA, attorney or deputy can be obtained through a search of the registers maintained by the Office of the Public Guardian.[1]

Relationship between the powers of attorneys and deputies and the role of nearest relatives

7.9 The rights of the nearest relative are not affected because a patient has an attorney or deputy.

7.10 Attorneys and deputies may not exercise the rights of the nearest relative, unless they are themselves the nearest relative (because the rights belong to the nearest relative, not the patient).

7.11 There may sometimes be a disagreement between a nearest relative and an attorney or deputy (eg over whether the attorney or deputy should exercise the patient's right to apply to the Tribunal, or whether the nearest relative should make a discharge order). If so, it may be helpful for the two to discuss the issue, perhaps with the assistance of one of the professionals involved in the patient's case. Ultimately they have different roles, and each must act as they think best. Specifically, an attorney or deputy must act in accordance with their authority and in the patient's best interests.

Related material

- Mental Capacity Act 2005. http://www.legislation.gov.uk/ukpga/2005/9/Contents
- Mental Capacity Act 2005. Code of Practice. Department for Constitutional Affairs (now Ministry of Justice). 2007. http://www.gov.uk/government/publications/mental-capacity-act-code-of-practice

This material does not form part of the Code. It is provided for assistance only.

[1] https://www.gov.uk/find-someones-attorney-or-deputy

8 Privacy, safety and dignity

Why read this chapter?

8.1 This chapter deals with privacy, safety and dignity in hospitals where patients are detained under the Act, including access to telephones and other mobile computing devices, access to the internet, and the use of searches.

8.2 Privacy, safety and dignity are important constituents of a therapeutic environment and hospital staff should respect a patient's privacy as far as possible, while maintaining safety. Patients should have every opportunity to maintain contact with family and friends by telephone, and hospitals should ensure they have policies for the use of mobile phones and computing devices.

8.3 Sleeping and bathroom areas should be segregated to protect the needs of patients of different genders and transgender patients. The nature of engagement with patients and of therapeutic environments and the structure and quality of life on a ward are important in encouraging patients to remain in the ward and minimising a culture of containment. The chapter also includes guidance on conducting personal and other searches, enhanced security, physical security and blanket locked door policy.[1]

Respect for privacy

8.4 Article 8 of the European Convention on Human Rights (ECHR) requires public authorities to respect a person's right to a private life. Article 8 has particular importance for people detained under the Act. Privacy, safety and dignity are important constituents of a therapeutic environment. Hospital staff should make conscious efforts to respect the privacy and dignity of patients as far as possible, while maintaining safety, including enabling a patient to wash and dress in private, and to send and receive mail, including in electronic formats, without restriction. Respecting patients' privacy encompasses the circumstances in which patients may meet or communicate with people of their choosing in private, including in their own rooms, and the protection of their private property.

[1] For patients in high security hospitals, this chapter should be read in conjunction with The High Security Psychiatric Services (Arrangements for Safety and Security) Directions 2013 and associated guidance. https://www.gov.uk/government/publications/high-security-psychiatric-services-directions

8

Blanket restrictions

8.5 In this chapter, the term 'blanket restrictions' refers to rules or policies that restrict a patient's liberty and other rights, which are routinely applied to all patients, or to classes of patients, or within a service, without individual risk assessments to justify their application. Blanket restrictions should be avoided unless they can be justified as necessary and proportionate responses to risks identified for particular individuals. The impact of a blanket restriction on each patient should be considered and documented in the patient's records.

8.6 Restrictions should never be introduced or applied in order to punish or humiliate, but only ever as a proportionate and measured response to an individually identified risk; they should be applied for no longer than can be shown to be necessary.

8.7 Blanket restrictions include restrictions concerning: access to the outside world, access to the internet, access to (or banning) mobile phones and chargers, incoming or outgoing mail, visiting hours, access to money or the ability to make personal purchases, or taking part in preferred activities. Such practices have no basis in national guidance or best practice; they promote neither independence nor recovery, and may breach a patient's human rights.

8.8 Within secure service settings some restrictions may form part of a broader package of physical, procedural and relational security measures associated with an individual's identified need for enhanced security in order to manage high levels of risk to other patients, staff and members of the public. The individual's need for such security measures should be justified to meet the admission criteria for any secure service. In any event, the application of security measures should be based on the needs of and identified risks for individual patients, and impose the least restriction possible. Where individual patients in secure services are assessed as not requiring certain security measures, consideration should be given to relaxing their application, where this will not compromise the overall security of the service. Where this is not possible, consideration should also be given as to whether the patient should more appropriately be managed in a service that operates under conditions of lesser security.

8.9 No form of blanket restriction should be implemented unless expressly authorised by the hospital managers on the basis of the organisation's policy and subject to local accountability and governance arrangements.

Blanket locked door policy

8.10 A blanket locked door policy which affects all patients in a hospital or on a ward could, depending on its implementation, amount to a restriction or a deprivation of liberty.

8.11 It is unlikely that there will be a deprivation of liberty if an informal patient, who has capacity to consent to being admitted and has done so, is informed of the locked door policy and consents to being informally admitted and remaining on the ward under these conditions. The patient should be told who they can speak to if they wish to leave and must be able to leave at any time they wish to, unless they are being detained using the holding powers under section 5 of the Act (chapter 18) or an application for detention (chapters 14 and 15).

8.12 A patient's article 8 rights should be protected by ensuring a locked door policy only imposes proportionate restrictions on their contact with family and friends which can be justified as being in the interests of the health and safety of the patient or others. The impact of a locked door policy on each patient should be considered and documented in the patient's records. The policy should conform to the 'empowerment and involvement' guiding principle (paragraphs 1.7 – 1.12).

8.13 Hospitals should not lock patients in clinical areas simply because of inadequate staffing levels. Local policies for locking clinical areas should be clearly displayed and explained to each patient on admission.

8.14 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.

8.15 Services should consider how to reduce the negative psychological and behavioural effects of having locked doors, whether or not patients are formally detained.

Private telephone calls and e-mail and internet access

8.16 Communication with family and friends is integral to a patient's care and hospitals should make every effort to support the patient in making and maintaining contact with family and friends by telephone, mobile, e-mail or social media. Providers should, however, provide patients access to a coin or card operated phone.

8.17 Mobile phones and other electronic devices commonly have functions including cameras and video and voice recording capability. There is therefore the potential for patients and visitors to use such equipment in a way that interferes with the confidentiality, dignity and privacy of other patients, staff and visitors. Staff should be mindful of enabling patients and visitors to maintain communication and contact while protecting others against the misuse of such technology.

8.18 When patients are admitted, staff should assess the risk and appropriateness of patients having access to mobile phones and other electronic devices and this should be detailed in the patient's care plan. Particular consideration should be given to people who are deaf who will have special communication needs. Patients should

be able to use such devices if deemed appropriate and safe for them to do so and access should only be limited or restricted in certain risk-assessed situations.

8.19 Hospital managers should have a policy for the possession and use of mobile phones and other mobile devices (such as laptops and tablets). These should be proportionate to risk and not seek to impose blanket restrictions on patients.

8.20 When drawing up their policy on the use of mobile phones and mobile devices, hospital managers should bear in mind the following points.

- Mobile phones and mobile computing devices provide a readily available means of communication with family and friends and are in widespread use. Most detained patients are therefore likely to have one. It is unlikely to be appropriate to impose a blanket restriction banning their use except in units specifically designed to provide enhanced levels of security in order to protect the public. Blanket restrictions may breach article 8.
- Different considerations will apply to different locations within the hospital. There may be valid reasons for banning or limiting the use of mobile phones or mobile computing devices in some parts of the premises to which detained patients have access or certain types of mobile phone or mobile computing device, eg because of the potential risk of interference with medical and other electronic equipment which could adversely affect the health of patients or because of the risk of intrusion into the privacy of other patients or others.
- Each patient should expect a peaceful environment, and that constant interruptions from ringing telephones have a potentially anti-therapeutic effect.
- It may be reasonable to require mobile phones and mobile computing devices to be switched off except where their use is permitted and to restrict their use to designated areas to which detained patients have access.
- Many mobile phones and mobile computing devices have cameras and give access to the internet and can be used as sound recorders. This creates a potential for the violation of the privacy and dignity of other patients, staff and visitors to the ward and may constitute a security risk. It would therefore be appropriate to stipulate the circumstances in which photographs, videos and sound recordings can be taken, eg only with specific permission from hospital staff and the patients involved.
- The difficulty in identifying when camera functions are being used may be an additional reason for restricting the areas in which mobile phones and computing devices may be used.
- It is important to ensure that the hospital's policy on the use of mobile phones and mobile computing devices can be enforced effectively, eg it may be appropriate in certain circumstances to confiscate mobile phones or mobile computing devices from patients who consistently refuse to comply with the rules.
- Any decision to prevent the use of cameras or to confiscate a mobile phone or mobile computing device should be fully documented and be subject to periodic review.

- There should be rules on when staff and visitors can bring mobile phones and mobile computing devices into a secure setting.
- The normal rules governing the use of the hospital's power supply to charge mobile phones or mobile computing devices may need to be varied for detained patients (given the restrictions with which such patients are faced).
- Staff should be fully informed of the hospital's policy, and steps should be taken to communicate it to all patients, carers, families and visitors, eg by displaying it clearly in each unit and providing it in a format and language that a patient can understand.
- The policy will need to be reviewed regularly, and updated where necessary, in the light of experience. It is good practice to involve patients, former patients and their carers in drawing up the policy.

8.21 Managers should develop policies on access by patients to e-mail and internet facilities by means of the hospital's IT infrastructure. This guidance should cover the availability of such facilities and rules prohibiting access to illegal or what would otherwise be considered inappropriate material, eg pornography, gambling or websites promoting violence, abuse or hate. Additionally, the guidance should cover the appropriate use of social media such as Skype. A blanket restriction on access to the internet could breach article 8 if it cannot be justified as necessary and proportionate. For further details about not applying blanket restrictions see paragraphs 8.5 – 8.9.

8.22 Managers should also develop guidance on the use of social media. As in paragraph 8.21 above, a blanket restriction on the use of social media could breach article 8 if it cannot be justified as necessary and proportionate. Staff should remind patients of confidentiality requirements, and the implications of breaching patient and staff confidentiality, and encourage patients to consider what they post on social media. Where wards contain coin-operated and card-operated telephones, hospital managers should ensure that patients are able use them without being overheard. Installing booths or hoods around them may help to provide the necessary level of privacy. Some patients may need help to make a phone call, but should still be given privacy during the call.

8.23 The principle that should underpin hospital or ward policies on all telephone use is that detained patients are not free to leave the premises but that their freedom to communicate with family and friends should be maintained as far as possible and restricted to the minimum extent necessary.

Private property

8.24 Hospitals should provide adequate storage in lockable facilities (with staff override) for the clothing and other personal possessions which patients may keep with them on the ward and for the secure central storage of anything of value or items

which may pose a risk to the patient or to others, eg razors. Information about arrangements for storage should be easily accessible to patients on the ward. Hospitals should compile an inventory of what has been allowed to be kept on the ward and what has been stored and give a copy to the patient. The inventory should be updated when necessary. Patients should always be able to access their private property on request if it is safe to do so.

Separate facilities for men and women

8.25 All sleeping and bathroom areas should be segregated, and patients should not have to walk through an area occupied by another sex to reach toilets or bathrooms. Separate male and female toilets and bathrooms should be provided, as should women-only day rooms. Women-only environments are important because of the increased risk of sexual and physical abuse and risk of trauma for women who have had prior experience of such abuse. Consideration should be given to the particular needs of transgender patients.[2]

8.26 A patient should not be admitted to mixed-sex accommodation. It may be acceptable, in a clinical emergency, to admit a patient temporarily to a single, ensuite room in the opposite-gender area of a ward. In such cases, a full risk-assessment should be carried out and the patient's safety, privacy and dignity maintained. Steps should be taken to rectify the situation as soon as possible. For more information see NHS guidance on eliminating the use of mixed-sex accommodation in relation to mental health patients. This includes information on temporary admissions in exceptional circumstances and the required reporting to the NHS Commissioning Board on mental health patients.[3]

Separate facilities for other reasons

8.27 Arrangements for the patient's accommodation should also consider the patient's history and personal circumstances, including:

- history and personal circumstances where known, including history of sexual or physical abuse and risks of trauma
- the particular needs of transgender patients
- cultural or religious preferences
- mothers and babies during and after pregnancy, or
- other health conditions (physical disabilities, learning disabilities or sensory impairments.

[2] Eliminating Mixed Sex Accommodation. Department of Health. 2009. PL/CNO/2009/2. https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/200215/CNO_note_dh_098893.pdf

[3] Eliminating Mixed Sex Accommodation. Department of Health. 2010. PL/CNO/2010/3. https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/215932/dh_121860.pdf

8.28 If, in an emergency, it is necessary to treat a patient in an environment that does not fully meet their needs, then senior management should be informed, steps should be taken to rectify the situation as soon as possible, and staff should protect the patient's privacy and dignity against intrusions – particularly in sleeping accommodation, toilets and bathrooms.

Personal and other searches

8.29 Hospital managers should ensure that there is an operational policy for searching patients detained under the Act, their belongings and surroundings and their visitors. When preparing the policy, hospital managers should consider the position of informal patients. The policy should be clearly displayed and communicated to patients in a format and language they understand.

8.30 The policy should be based on the following clear principles:

- the intention is to create and maintain a therapeutic environment in which treatment may take place and to ensure the security of the premises and the safety of patients, staff and the public
- the authority to conduct a search of a person or their property is controlled by law, and it is important that hospital staff are aware of whether they have legal authority to carry out any such search
- searching should be proportionate to the identified risk and should involve the minimum possible intrusion into the individual's privacy, and
- all searches will be undertaken with due regard to and respect for the person's dignity and privacy.

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

8.32 Patients, staff and visitors should be informed that there is a policy on searching. Information about searches should be provided in a variety of formats to meet patients' and visitors' needs and should be readily available.

Conducting personal and other searches

8.33 The consent of the person should always be sought before a personal search of them or a search of their possessions is attempted. If consent is given, the search should be carried out with regard to ensuring the maximum dignity and privacy of the person. Undertaking a personal search in a public area will only be justified in exceptional circumstances.

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

8.35 A person being searched or whose possessions are the subject of a search should be kept informed of what is happening and why. If they do not understand or are not fluent in English, the services of an interpreter should be sought, if practicable. The specific needs of people with impaired hearing or a learning disability and those of children and young people should be considered.

8.36 A personal search should be carried out by a member of the same sex, unless necessity dictates otherwise. The search should be carried out in a way that maintains the person's privacy and dignity and respects issues of gender, culture and faith. It is always advisable to have another member of the hospital staff present during a search, especially if it is not possible to conduct a same-sex search.

8.37 A comprehensive record of every search, including the reasons for it and details of any consequent risk assessment, should be made.

8.38 Staff involved in undertaking searches should receive appropriate instruction and refresher training.

8.39 In certain circumstances, it may be necessary to search a detained patient or their possessions without their consent.

8.40 If a detained patient refuses consent or lacks capacity to decide whether or not to consent to the search, their responsible clinician (or, failing that, another senior clinician with knowledge of the patient's case) should be contacted without delay in the first instance, if practicable, so that any clinical objection to searching by force may be raised. The patient should be kept separated and under close observation, while being informed of what is happening and why, in terms appropriate to their understanding. This is particularly important for individuals who may lack capacity to decide whether or not to consent to the search.[4] Searches should not be delayed if there is reason to think that the person is in possession of anything that may pose an immediate risk to their own safety or that of anyone else.

8.41 If a search is considered necessary, despite the patient's objections, and there is no clinical objection to one being conducted, the search should be carried out. If force has to be used, it should be the minimum necessary.

8.42 The policy should set out the steps to be taken to resolve any disagreement or dispute where there is a clinical objection to a search.

[4] Separation of a patient under close observation in order to await the arrival of the responsible clinician is different to seclusion (which is defined at paragraph 26.103).

8.43 Where a patient physically resists being personally searched, physical intervention should normally only proceed on the basis of a multi-disciplinary assessment, unless it is urgently required. A post-incident review should follow every search undertaken where consent has been withheld.

8.44 There should be support for patients and for staff who are affected by the process of searching. This may be particularly necessary where a personal search has had to proceed without consent or has involved physical intervention (see paragraphs 8.40 – 8.43 and chapter 26 on use of physical interventions).

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

8.46 The exercise of powers of search should be audited regularly and the outcomes reported to the hospital managers.

Hospital accommodation offering conditions of enhanced security

8.47 Some detained patients may be liable to present a particular danger to themselves or to others and therefore need to be accommodated in wards or units specifically designed to offer enhanced levels of physical security. For patients detained under part 3 of the Act, this may be a requirement of a court or of the Secretary of State for Justice, but in many cases the decision will lie primarily with the patient's responsible clinician.

8.48 When considering whether patients should be placed in, moved to or remain in such a ward or unit, responsible clinicians should, in consultation with the multi-disciplinary team, ensure that:

- they have carefully weighed the patient's individual circumstances and the degree of risk involved, and
- they have assessed the relative clinical considerations of placing the patient in an environment with enhanced physical security, in addition to or as opposed to providing care by way of intensive staffing.

8.49 Treatment in conditions of enhanced security should last for the minimum period necessary. Where responsible clinicians have taken the decision to transfer a patient within a hospital to a ward with enhanced security, they should ensure that arrangements are made to facilitate the patient's prompt return to a less secure ward when that enhanced security is no longer required.

8.50 Where responsible clinicians believe that patients no longer require conditions of enhanced security (or the current level of security), they should take steps to arrange their transfer to more appropriate accommodation. Where necessary, this may involve identifying another hospital that is willing and able to offer the patient suitable accommodation.

8.51 In the case of restricted patients, it will be necessary to seek the consent of the Secretary of State for Justice for a transfer to another hospital or, where the patient's detention is restricted to a particular unit, for a move within the same hospital.

8.52 Managers of hospitals offering accommodation with enhanced levels of security should ensure that:

- accommodation specifically designated for this purpose has adequate staffing levels, and
- written guidelines are drawn up, setting out the categories of patient for whom it is appropriate to use physically secure conditions and those for whom it is not appropriate.

Physical security in other hospital accommodation

8.53 Hospital managers will need to consider what arrangements should be put in place to protect the safety of patients who are not subject to enhanced security.

8.54 Patients admitted to acute wards, whether or not they are formally detained there, will have complex and specific needs. In such an environment, ward staff will need to balance competing priorities and interests when determining what safety measures are necessary. This should not amount to a blanket locked door policy (see paragraphs 8.10 – 8.15 above).

8.55 The intention should be to protect patients, in particular those who are at risk of suicide, self-harm, accidents or inflicting harm on others unless they are prevented from leaving the ward. Arrangements should also aim not to impose any unnecessary or disproportionate restrictions on patients or to make them feel as though they are subject to such restrictions. It may also be necessary to have in place arrangements for protecting patients and others from people whose mere presence on a ward may pose a risk to their health or safety.

8.56 It should be borne in mind that the nature of engagement with patients and of therapeutic interventions and the structure and quality of life on the ward are important factors in encouraging patients to remain in the ward and in minimising a culture of containment.

8.57 All patients should have regular access to outside space. Locking doors, placing staff on reception to control entry to particular areas, and the use of electronic swipe cards, electronic key fobs and other technological innovations of this sort are all methods that providers should consider to manage entry to and exit from clinical areas to ensure the safety of their patients and of others.

8.58 If providers are to manage entry to and exit from the ward effectively, they will need to have a policy for doing so. A written policy that sets out precisely what the ward arrangements are and how patients can exit from the ward, if they are legally free to leave, should be drawn up and given to all patients in the ward. The policy should be explained to patients on admission and to their visitors. In addition to producing the policy in English, providers may need to consider drawing it up it in other languages if these are in common use in the local area, as well as in accessible formats.

8.59 If managing entry and exit by means of locked external doors (or other physical barriers) is considered to be an appropriate way to maintain safety, the practice adopted should be reviewed regularly to ensure that there are clear benefits for patients and that it is not being used for the convenience of staff. It is never acceptable to lock patients and others in clinical areas simply because of inadequate staffing levels. In conjunction with clinical staff, managers should regularly review and evaluate the mix of patients (there may, for example, be some patients who ought to be in a more secure environment), staffing levels and the skills mix and training needs of staff.

Related material

- Using Mobile Phones in NHS Hospitals. Best practice guidance. Department of Health. 2009. http://webarchive.nationalarchives.gov.uk/20130107105354/http:/www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_092812.pdf
- Guidance on the High Security Psychiatric Services (arrangements for safety and security) Directions. 2013. https://www.gov.uk/government/publications/high-security-psychiatric-services-directions
- The High Security Psychiatric Services (Arrangements for Safety and Security) Directions. 2013. https://www.gov.uk/government/publications/high-security-psychiatric-services-directions
- Eliminating Mixed Sex Accommodation. Department of Health. 2009. PL/CNO/2009/2. https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/200215/CNO_note_dh_098893.pdf
- Eliminating Mixed Sex Accommodation. Department of Health. 2010. PL/CNO/2010/3. https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/215932/dh_121860.pdf

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9 Wishes expressed in advance

Why read this chapter?

9.1 This chapter gives guidance on statements by patients who are subject to compulsory measures under the Act about their preferences for what they would, or would not, like to happen if particular situations arise in future. Advance statements and decisions strengthen patients' participation in their treatment and recovery and help them to feel more empowered about what may happen to them should they lack mental capacity to make decisions about their care and treatment in the future.

9.2 Advance statements do not legally compel professionals to meet patients' stated preferences, though they should be taken into account when making decisions about care and treatment. Advance decisions to refuse treatment are legally binding. Such decisions must be recorded and documented. Advance decisions are concerned only with refusal of medical treatment and are made in advance by a person with the mental capacity to do so. The chapter details the circumstances when clinicians may lawfully treat a patent compulsorily under the Act.

Definitions

9.3 This chapter distinguishes between advance decisions to refuse medical treatment and other statements of views, wishes and feelings that patients make in advance.

9.4 An advance decision means a decision to refuse specified medical treatment made in advance by a person who has the mental capacity to do so. They are a way in which people can refuse medical treatment at a time in the future when they may lack the capacity to consent to or refuse that treatment.

9.5 Advance decisions are concerned only with refusal of medical treatment. Other advance expressions of views, wishes and feelings, often referred to as advance statements, may be about preferred medical treatment or other wishes and preferences not directly related to care, and may be about what the patient wants to happen as much as what they would prefer not to happen.

Advance decisions under the Mental Capacity Act

9.6 The Mental Capacity Act 2005 (MCA) says that people who have the capacity to do so, and who are at least 18 years old, may make an advance decision to refuse specified treatment which will have effect at a time when they no longer have capacity to refuse or consent to treatment. If a valid and applicable advance decision exists, it has the same effect as if the patient has capacity and makes a contemporaneous decision to refuse treatment.

9.7 Sometimes, the fact that a patient has made an advance decision refusing treatment for mental disorder will be one of the reasons why a decision is taken to detain them under the Act. That may be the only way to ensure they get the treatment they need.

9.8 In certain circumstances, described in chapter 24 the Act allows patients to be given medical treatment for their mental disorder without their consent and even though they have made a valid and applicable advance decision to refuse the treatment. This only applies to patients who are detained under the Act and to patients on community treatment orders (CTOs). Except in emergencies, it only applies to patients subject to CTOs ('community patients') if they have been recalled to hospital by their responsible clinician.

9.9 Even where clinicians may lawfully treat a patient compulsorily under the Act, they should, where practicable, try to comply with the patient's wishes as expressed in an advance decision. They should, for example, consider whether it is possible to use a different form of treatment not refused by the advance decision. If it is not, they should explain why to the patient.

9.10 Except where the Act means that they need not, clinicians must follow all other advance decisions made by their patients which they are satisfied are valid and applicable, even if the patients concerned are detained under the Act or on CTOs. By definition, this includes all valid and applicable advance decisions made by detained and community patients to refuse treatment which is not for mental disorder.

9.11 Clinicians must always start from the assumption that a person had the mental capacity at the time in question to make the advance decision. If a clinician is not satisfied that the person had capacity at the time they made the advance decision, or if there are genuine doubts about its validity or applicability, they can treat the person without fear of liability, so long as they comply with the other requirements of the MCA, including the requirement to act in the patient's best interests.

9.12 For more information on what constitutes an advance decision including specific additional requirements for the way advance decisions to refuse life-sustaining treatment must be documented, the effect they have and when they are valid and applicable, please refer to the MCA Code of Practice.[1]

[1] Mental Capacity Act 2005. Code of Practice. Department for Constitutional Affairs (now Ministry of Justice). 2007. https://www.gov.uk/government/publications/mental-capacity-act-code-of-practice

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Advance statements of wishes and feelings

9.13 There may be times when, because of their mental disorder, patients who are subject to compulsory measures under the Act are unable or unwilling to express their views, or participate as fully as they otherwise would, in decisions about their care or treatment under the Act. In such cases, patients' past wishes and feelings – so far as they are known – take on a greater significance.

9.14 Individuals with mental health conditions should be able to express their views and preferences about their care and treatment. Some patients will deliberately state their wishes in advance about a variety of issues, including their medical treatment, how families and carers should be involved, the steps that should be taken in emergencies and what should be done if particular situations occur. Such wishes should be given the same consideration as wishes expressed at any other time. Clinicians must consider advance statements when determining what is in the patient's best interests if the patient subsequently loses capacity.

9.15 Encouraging patients to set out their wishes in advance is often a helpful therapeutic tool, encouraging collaboration and trust between patients and professionals. It is a way in which effective use can be made of patients' expertise in the management of crises in their own conditions.

9.16 Whenever expressing a preference for their future treatment and care, patients should be encouraged to identify as precisely as possible the circumstances they have in mind. If they are saying that there are certain things that they do not want to happen – eg being given a particular type of treatment, or being restrained in a particular way – they should be encouraged to give their views on what should be done instead.

9.17 Patients should be made aware that expressing their preference for a particular form of treatment or care in advance like this does not legally compel professionals to meet that preference. However, professionals should make all practicable efforts to comply with these preferences and explain to patients why their preferences have not been followed.

9.18 Where patients express views to any of the professionals involved in their care about how they should be treated or ways they would not wish to be treated in future, the professional should record those views in the patient's notes. If the views are provided in a written form, they should be kept with the patient's notes.

9.19 Whether the patient or the professional records the patient's views, steps should be taken, unless the patient objects, to ensure that the information:

- is drawn to the attention of other professionals who ought to know about it, and
- it is included in care plans and other documentation which will help ensure that the patient's views are remembered and considered in situations where they are relevant in future.

9.20 Advance decisions to refuse treatment must be recorded and documented in the same way.

9.21 An advocate or carer should be invited to support a patient who may lack capacity to understand the wish they are expressing. If the professional to whom the wish is being expressed forms the opinion that the patient lacks capacity to understand this, the professional should record their opinion and their reasons for it, alongside the record of the patient's wish.

9.22 The fact that a patient has expressed their wishes about a particular matter in the past is not a substitute for seeking their views on it when the situation actually arises, even if they are no longer in a position to think about their views as clearly as they did when they expressed their wishes previously. Everyone has the right to change their mind. In particular, where patients have the mental capacity to express a clear wish in the present, that wish should always be assumed to have overtaken their previous wishes, even if it is significantly different.

9.23 Where patients lack the capacity to formulate and express their views on an issue on which they have given their views in advance, the professional should record whether they make a decision under the Act which is contrary to those previously expressed views. They should record their reasons for the decision, just as they would if they were going against wishes that a patient was expressing in the present.

Related material

- Mental Capacity Act 2005. http://www.legislation.gov.uk/ukpga/2005/9/Contents
- Mental Capacity Act 2005. Code of Practice. Department for Constitutional Affairs (now Ministry of Justice). 2007. https://www.gov.uk/government/publications/mental-capacity-act-code-of-practice

This material does not form part of the Code. It is provided for assistance only.

10 Confidentiality and information sharing

Why read this chapter?

10.1 This chapter deals with issues about confidentiality and information sharing which arise in connection with the Act.

10.2 The law on confidentiality is the same for patients subject to the Act as it is for any other patients, except where the Act says otherwise. Under the Act, there are some situations where confidential information about a patient is legally authorised to be disclosed, even if the patient does not consent. Guidance is given on the sharing of information by professionals and agencies to manage serious risks which certain patients pose to others.

Sharing information

10.3 Except where the Act itself says otherwise, the law on confidentiality is the same for patients subject to the Act as it is for any other patients. The box below gives a brief summary of the most fundamental points of the general law. These points are relevant to patients of all ages, although there are some additional considerations in relation to children and young people (see chapter 19).

Confidentiality – a brief summary

There will be specific considerations for healthcare professionals such as doctors and nurses to whom the common law duty of confidentiality applies. The duty arises when one person discloses information to another in circumstances where it is reasonable to expect that the information will be held in confidence. Certain situations, such as discussions with a health professional or social worker, are generally presumed to be confidential.

There are circumstances in which it is both justifiable and important to share otherwise confidential patient information with people outside the immediate team treating a patient.

Before considering such disclosure of confidential patient information, the individual's consent should normally be sought.

If a person lacks the capacity to consent to the disclosure, it may be acceptable and appropriate to disclose the information in the person's best interests. Healthcare professionals should use their professional judgement to determine what is in the patient's best interest. This should include consultation with colleagues, and the organisation's Caldicott Guardian[1] and take into account the patient's previously expressed wishes and views. It is also good practice for independent sector providers of NHS-funded services to have a Caldicott Guardian.

[1] A Caldicott Guardian is the senior person in the organisation responsible for protecting the confidentiality of patient and service-user information and enabling appropriate information-sharing. Each NHS commissioner, NHS provider and local authority with social services responsibilities is required to have a Caldicott Guardian. It is also good practice for independent sector providers of NHS-funded services to have a Caldicott Guardian.

Otherwise, confidential patient information should be disclosed outside the team only:

- with the patient's consent (where the patient has capacity to consent)
- if there is a specific legal obligation or authority to do so, or
- where there is an overriding public interest in disclosing the information.

The 'public interest' is not the same as what might be of interest to the public. Where confidential patient information is involved, public interest justifications for overriding confidentiality could include (but are not limited to) protecting other people from serious harm and preventing serious crime.

The common law does not normally permit disclosure of confidential patient information solely in the patient's own interests, if they have capacity to consent to the disclosure but refuse to do so.

A person's right to have their privacy respected is protected by article 8 of the European Convention on Human Rights (ECHR). The disclosure of confidential information may be a breach of that right unless it is a necessary and proportionate response to the situation.

10.4 Information sharing between professionals can contribute to and support the care and treatment of patients and help to protect people from harm. This includes information sharing as part of the care programme approach (CPA) (or its equivalent) or the Welsh Measure (see paragraphs 34.24 – 34.27 for information on the Welsh Measure).

10.5 A range of public agencies is involved in the provision of services to patients who are subject to compulsory measures under the Act, including housing and social services. Patients must be consulted about what information it may be helpful to share with these services and when. Professionals should be clear about how the sharing of such information could benefit the patient or help to prevent serious harm to others and whether there are any potential negative consequences. Advocates and advice services can support patients in helping them decide what information should be shared.

10.6 Sharing information with carers and other people with a valid interest in the care and wellbeing of the patient can contribute to and support their care and treatment. Where patients have capacity to agree and are willing to do so, carers and other people with a valid interest should be given information about the patient's progress to help them form and offer views about the patient's care and provide effective care and support to the patient, especially if the individual is a community patient, subject to guardianship, or on leave. A patient's agreement to such disclosure must be freely given. In the case of patients detained under part 3 of the Act, people with a valid interest may include victims and the families of victims (see chapter 40).

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Disclosure of confidential patient information for the purposes of the Act

10.7 The Act creates a number of situations where confidential information about patients is legally authorised to be disclosed, even if the patient does not consent. These include:

- reports to the Tribunal when a patient's case is to be considered
- reports to the Care Quality Commission (CQC) in relation to patients who have been treated on the basis of a certificate issued by a second opinion appointed doctor (SOAD), and
- reports to the Secretary of State for Justice on restricted patients.

10.8 The Act also gives certain people and bodies – including the CQC, SOADs and (in certain circumstances) independent mental health advocates (IMHAs) – the right to access records relating to patients.

10.9 In addition, where the Act allows steps to be taken in relation to patients without their consent, it is implicit that confidential patient information may be disclosed only to the extent that it is necessary to take those steps. For example, confidential patient information may be shared to the extent that it is necessary for:

- medical treatment which may be given without a patient's consent under the Act
- safely and securely transport a patient to hospital (or anywhere else) under the Act
- finding and returning a patient who has absconded from legal custody or who is absent without leave, or
- transferring responsibility for a patient who is subject to the Act from one set of people to another (eg where a detained patient is to be transferred from one hospital to another, or where responsibility for a patient is to be transferred between England and another jurisdiction).

10.10 Even though information may be disclosed in these cases, it is still necessary for people proposing to disclose the information to be confident that it is necessary in the circumstances, that the aim of disclosure cannot reasonably be achieved without it, and that any breach of the patient's confidentiality is a proportionate response given the purpose for which the disclosure is being considered. Care must also always be taken to ensure that any information disclosed is accurate.

Limitations on sharing information with carers

10.11 Simply asking for information from carers, relatives, friends or other people about a patient without that patient's consent need not involve any breach of confidentiality, provided the person requesting the information does not reveal any personal confidential information about the patient which the carer, relative, friend or other person being asked would not legitimately know.

10.12 Apart from information which must be given to nearest relatives, the Act does not create any exceptions to the general law about disclosing confidential patient information to carers, relatives or friends.

10.13 Carers cannot be told a patient's particular diagnosis or be given any other confidential personal information about the patient unless the patient consents or there is another basis on which to disclose it in accordance with the law. Carers, including young carers, should always be offered information which may help them understand the nature of mental disorder generally, the ways it is treated and the operation of the Act.

10.14 Carers, relatives, friends and other people have a right to expect that any personal information about themselves, or any information about the patient which they pass on to professionals in confidence, will be treated as confidential. Unless there is an overriding reason that makes it necessary and there is legal authority to do so, information they provide about patients should not be repeated to patients in a way that might reveal its source, unless the carer, relative, friend or other person was made aware that that could happen and had not objected to it.

Sharing information to manage risk

10.15 Although information may be disclosed only in line with the law, professionals and agencies may need to share information to manage any serious risks which certain patients pose to others.

10.16 Where the issue is the management of the risk of serious harm, the judgement required is normally a balance between the public interest in disclosure, including the need to prevent harm to others, and both the rights of the individual concerned and the public interest in maintaining trust in a confidential service.

10.17 Whether there is an overriding public interest in disclosing confidential patient information may vary according to the type of information. Even in cases where there is no overriding public interest in disclosing detailed clinical information about a patient's state of health there may, nonetheless, be an overriding public interest in sharing more limited information about the patient's current, and past status under the Act, if that will help ensure properly informed risk management by the relevant authorities, families and carers.

Recording disclosure without consent

10.18 Any decision to disclose confidential information about patients should be fully documented. The relevant facts should be recorded, with the reasons for the decision and the identity of all those involved in the decision-making. Reasons should be given by reference to the grounds on which the disclosure is to be justified.

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Information for victims of crimes

10.19 As set out in chapter 40, the victims of certain part 3 patients (mentally disordered offenders) detained in hospital have rights to make representations and receive information about that patient's discharge under the Domestic Violence, Crime and Victims Act 2004 (DVCVA).[2]

10.20 In other circumstances, professionals should encourage (but may not require) mentally disordered offender patients to agree to share information that will enable victims and victims' families to be informed about their progress. Among other benefits, disclosure of such information can sometimes serve to reduce the danger of harmful confrontations after a discharge of which victims were unaware.

10.21 Professionals should be ready to discuss with patients the benefits of enabling some information to be given by professionals to victims, within the spirit of the Code of Practice for Victims of Crime issued under the DVCVA.[3]

Related material

- Public Sector Data Sharing: guidance on the law. Ministry of Justice. 2012. http://www.justice.gov.uk/downloads/information-access-rights/data-sharing/annex-h-data-sharing.pdf
- Confidentiality: NHS code of practice. Department of Health. 2003. https://www.gov.uk/government/publications/confidentiality-nhs-code-of-practice
- Domestic Violence, Crime and Victims Act 2004. http://www.legislation.gov.uk/ukpga/2004/28/contents
- Mental Capacity Act 2005. http://www.legislation.gov.uk/ukpga/2005/9/contents
- Mental Capacity Act 2005. Code of Practice. Department for Constitutional Affairs (now Ministry of Justice). 2007. https://www.gov.uk/government/publications/mental-capacity-act-code-of-practice
- Data Protection Act 1998. http://www.legislation.gov.uk/ukpga/1998/29/contents
- Human Rights Act 1998. http://www.legislation.gov.uk/ukpga/1998/42/contents
- Information Sharing: guidance for practitioners and managers. Department of Health. 2008. https://www.gov.uk/government/publications/information-sharing-for-practitioners-and-managers
- Working Together to Safeguard Children: a guide to inter-agency working to safeguard and promote the welfare of children. Department for Education. 2013. https://www.gov.uk/government/publications/working-together-to-safeguard-children
- Information Sharing and Suicide Prevention: consensus statement. Department of Health. 2014. https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/271792/Consensus_statement_on_information_sharing.pdf

This material does not form part of the Code. It is provided for assistance only.

[2] Domestic Violence, Crime and Victims Act 2004. http://www.legislation.gov.uk/ukpga/2004/28/contents

[3] The code of practice for victims of crime and supporting public information materials. Ministry of Justice. 2013. https://www.gov.uk/government/publications/the-code-of-practice-for-victims-of-crime

11 Visiting patients in hospital

Why read this chapter?

11.1 This chapter covers visiting patients in hospital and circumstances where it may be necessary to consider the exclusion of visitors. It includes particular considerations for child visitors and how far an individual should be placed from their family and/or local community.

11.2 All patients have a right to maintain contact with family and friends and to be visited, subject to carefully limited exceptions. The Act gives certain people the right to visit patients in private and arrangements must be in place to enable this to happen. Hospital managers have the right, under certain circumstances to restrict or refuse visitors, or require them to leave.

11.3 All hospitals should have written policies and procedures concerning the arrangements for children and young people who visit patients and for visits to patients who are children or young people.[1]

Arrangements for visits to patients

11.4 All patients have the right to maintain contact with, and be visited by, anyone they wish to see, subject to carefully limited exceptions. The value of visits in maintaining links with family and community networks is recognised as a key element in a patient's care, treatment and recovery. Article 8 of the European Convention on Human Rights (ECHR) protects the right to a family life. In particular, every effort should be made to support parents to support their children. Patients should be able to see all their visitors in private, including in their own bedroom if the patient wishes.

11.5 Visits should be encouraged and made as comfortable and easy as possible for the visitor and the patient. Reasonable and flexible visiting times, access to refreshments and pleasant surroundings will all contribute to a sense of respect for the patient's entitlement to be visited.

11.6 In addition to visits, every effort should be made to assist the patient, where appropriate, to maintain contact with relatives, friends and advocates in other ways. It is good practice for patients to be placed in a hospital as close as reasonably practicable to their families, and patients should have readily accessible and appropriate daytime telephone and internet facilities (see chapter 8). Where a patient is placed out of area it is good practice to consider the needs of family and carers who have to travel in order to visit (see paragraph 14.85).

[1] For patients in high security hospitals, this chapter should be read in conjunction with The High Security Psychiatric Services (Arrangements for Safety and Security) Directions 2013, The High Security Psychiatric Services (Arrangements for Visits by Children) Directions 2013 and associated guidance. https://www.gov.uk/government/publications/high-security-psychiatric-services-directions

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People with a right to visit patients

11.7 The Act gives certain people the right to visit patients in private if they wish. This includes second opinion appointed doctors (SOADs), independent doctors or approved clinicians appointed to examine the patient in relation to an application or reference to the Tribunal, people visiting on behalf of the Care Quality Commission (CQC), and independent mental health advocates (IMHAs). These people should be given access to all areas where the patient lives or have access themselves.

11.8 Hospital managers must ensure that such visits can take place in private, if that is what the person concerned wants.

11.9 If there are particular concerns for the security of the visitor, they should be discussed with the visitor with a view to agreeing suitable security arrangements. For the safety of both visitors and patients, visitors should only be in clinical areas under supervision.

11.10 Hospital managers should also ensure that patients can communicate with their legal representatives in private, and should facilitate visits by those representatives when they request them.

Exclusion or restriction of visitors

11.11 There are circumstances where hospital managers may restrict visitors, refuse them entry or require them to leave. Managers should have a policy on the circumstances in which visits to patients may be restricted, to which both clinical staff and patients may refer, which should be clearly displayed on the ward.

11.12 There are two principal grounds which could justify the restriction or exclusion of a visitor: clinical grounds and security grounds.

11.13 The decision to prohibit a visit by any person whom the patient has requested to visit or has agreed to see should be regarded as a serious interference with the rights of the patient and a blanket restriction may be considered a breach of their article 8 rights. There may be circumstances when a visitor has to be excluded, but these instances should be exceptional and any decision should be taken only after other means to deal with the problem have been considered and (where appropriate) tried. Any such decision should be fully documented and include the reasons for the exclusion, and it should be made available for independent scrutiny by the CQC or service commissioner, and explained to the patient. Hospital managers should review the effect on the patient of any decision to restrict visits. These policies should be risk-based and not impose blanket restrictions, eg no visitors for the first four weeks after admission.

Restriction or exclusion on clinical grounds

11.14 From time to time, the patient's responsible clinician may decide, after assessment and discussion with the multi-disciplinary team, that some visits could be detrimental to the safety or wellbeing of the patient, the visitor, other patients or staff on the ward. In these circumstances, the responsible clinician may make special arrangements for the visit, impose reasonable conditions or if necessary exclude the visitor. In any of these cases, the reasons for the restriction should be recorded and explained to the patient and the visitor, both orally and in writing (subject to the normal considerations of patient confidentiality). Wherever possible, 24-hour notice should be given of this decision.

Restriction or exclusion on security grounds

11.15 The behaviour of a particular visitor may be disruptive, or may have been disruptive in the past, to the degree that exclusion from the hospital is necessary as a last resort. Examples of such behaviour include:

- incitement to abscond
- smuggling of illicit drugs or alcohol into the hospital or unit
- transfer of potential weapons
- unacceptable aggression, and
- attempts by members of the media to gain unauthorised access.

11.16 A decision to exclude a visitor on the grounds of their behaviour should be fully documented and explained to the patient orally and in writing. Where possible and appropriate, the reason for the decision should be communicated to the person being excluded (subject to the normal considerations of patient confidentiality and any overriding security concerns).

Monitoring by hospital managers

11.17 Hospital managers should regularly monitor the exclusion from the hospital of visitors to detained patients.

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

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Children and young people

11.19 All hospitals should have written policies and procedures regarding the arrangements for children and young people who visit patients in hospital and for visits to patients who are children or young people. Policies should be drawn up in consultation with local authorities and local safeguarding children boards.[2]

11.20 Local policies should ensure that the best interests and safety of the children and young people concerned are always considered and that visits by children and young people are not allowed if they are not in their best interests. Within that overarching framework, and subject to risk assessments, hospitals should do all they can to facilitate the maintenance of children and young people's contact with friends and family and offer privacy within which that can happen.

11.21 Information about visiting should be explained to children and young people in a way that they are able to understand. Environments that are friendly to children and young people should be provided.

11.22 Where a child or young person is being detained, it should not be assumed, because of their age, that they would welcome all visitors, and, like adults, their views should be sought.

Related material

- The High Security Psychiatric Services (Arrangements for Safety and Security) Directions. 2013. https://www.gov.uk/government/publications/high-security-psychiatric-services-directions
- The High Security Psychiatric Services (Arrangements for Visits by Children) Directions. 2013. https://www.gov.uk/government/publications/high-security-psychiatric-services-directions

This material does not form part of the Code. It is provided for assistance only.

[2] The Secretary of State for Health has issued directions which set out more detailed restrictions on the visits by children to patients in the high security psychiatric hospitals. Refer to The High Security Psychiatric Services (Arrangements for Visits by Children) Directions 2013 and the guidance re-issued https://www.gov.uk/government/publications/high-security-psychiatric-services-directions

12 The Tribunal

Why read this chapter?

12.1 This chapter provides guidance on the role of the Tribunal and related duties on hospital managers and others.

12.2 The Tribunal is an independent judicial body which reviews cases of detained and conditionally discharged patients and patients subject to community treatment orders under the Act. Hospital managers and the local authority have a duty to ensure that patients understand their rights to apply for a Tribunal hearing. Managers have duties to refer patients to the Tribunal. Guidance is given about the reports to be prepared for the Tribunal, medical examinations, withdrawing an application, and representation.[1]

Purpose of the Tribunal

12.3 The First-tier Tribunal (Mental Health) ('the Tribunal') is an independent judicial body. Its main purpose is to review the cases of detained and conditionally discharged patients and patients subject to community treatment orders (CTOs) under the Act ('community patients') and to direct the discharge of any patients where it thinks it appropriate. It also considers applications for discharge from guardianship.

12.4 The Tribunal provides a significant safeguard for patients who have had their liberty curtailed under the Act. Those giving evidence at hearings should do what they can to help enable tribunal hearings to be conducted in a professional manner, which includes having regard to the patient's wishes and feelings and medical condition and ensuring that the patient feels as comfortable as possible with the proceedings.

12.5 It is for those who believe that a patient should continue to be detained or remain a community patient to prove their case, not for the patient to disprove it. They will therefore need to present the Tribunal with sufficient evidence to support continuing liability to detention or a CTO. Clinical and social reports form the backbone of this evidence. Care should be given to ensure that all information is as up-to-date as possible to avoid adjournment. In order to support the Tribunal in making its decision, all information should be clear and concise.

[1] The First-tier Tribunal established under the Tribunals, Courts and Enforcement Act 2007. There is a right of appeal, on a point of law, from that Tribunal to the Upper Tribunal. http://www.legislation.gov.uk/ukpga/2007/15/contents

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

12.6 Hospital managers and the local authority are under a duty to take steps to ensure that patients understand their rights to apply for a Tribunal hearing. Hospital managers and the local authority should also advise patients of their entitlement to free legal advice and representation. They should do both whenever:

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

12.7 Unless the patient requests otherwise, and the patient should be asked, the information should normally also be given to their nearest relative (subject to the normal considerations about involving nearest relatives – see chapter 5).

12.8 Hospital managers and professionals should enable detained patients to be visited by their legal representatives at any reasonable time. This is particularly important where visits are necessary to discuss a Tribunal application. Where the patient consents, legal representatives and independent doctors should be given prompt access to the patient's medical records. Delays in providing access can hold up Tribunal proceedings and should be avoided.

12.9 In connection with an application (or a reference) to a Tribunal, an independent doctor or approved clinician authorised by (or on behalf of) a patient has a right to visit and examine the patient in private (see paragraph 12.23). Those doctors and approved clinicians also have a right to inspect any records relating to the patient's detention, treatment and (where relevant) after-care under section 117. Where nearest relatives have a right to apply to the Tribunal, they too may authorise independent doctors or approved clinicians in the same way. The patient's consent is not required for authorised doctors or approved clinicians to see their records, and they should be given prompt access to the records they wish to see.

Hospital managers' duty to refer cases to the Tribunal

12.10 Hospital managers have various duties to refer patients to the Tribunal (see paragraphs 37.39 – 37.43). They may also request the Secretary of State to refer a patient, and there are certain circumstances where they should always consider doing so (see paragraphs 37.44 – 37.46 and for children and young people, paragraphs 19.107 – 19.110).

Reports for the Tribunal

12.11 Responsible authorities (ie the managers of the relevant hospital or the local authority responsible for a guardianship patient) should be familiar with the Tribunal's rules and procedures. The rules place a statutory duty on the responsible authority to provide the Tribunal with a statement of relevant facts together with certain reports.

12.12 It is important that documents and information are provided in accordance with the Tribunal's rules and procedures in good time for any Tribunal hearing. Missing, out-of-date or inadequate reports can lead to adjournments or unnecessarily long hearings. Where responsible clinicians, social workers or other professionals are required to provide reports, they should do this promptly and within the statutory timescale. For more information refer to the Practice Direction First-tier Tribunal Health Education and Social Care Chamber: Statements and Reports in Mental Health Cases.[2]

12.13 In the case of a restricted patient, if the opinion of the responsible clinician or other professional changes from what was recorded in the original Tribunal report(s), it is vital that this is communicated in writing as soon as possible, prior to the hearing, to the Tribunal office and the Mental Health Unit of the Ministry of Justice to allow them the opportunity to prepare a supplementary statement. Information about the Tribunal can be found at: https://www.gov.uk/mental-health-tribunal

12.14 If a Tribunal panel feels that it needs more information on any report, it may request it, either in the form of a supplementary report or by questioning a witness at the hearing itself if the witness or their representative judge that it would not be detrimental to the patient's health or wellbeing.

12.15 In some circumstances, the Tribunal will not sit immediately after receiving the report. In these cases, the report writers should consider whether anything in the patient's circumstances have changed and should produce a concise update to the report. This is especially important if the patient's status changes – eg if a patient becomes a community patient or moves from detention under section 2 to section 3.

12.16 In those cases, the application will need to be considered under the new circumstances of the case, and the report will need to provide a justification for continued detention or liability to recall under the new circumstances. The Tribunal may ask the author of the reports to talk through their report, so it is good practice for the authors to re-familiarise themselves with the content of any report before the hearing. If the author of the report is unable to attend, it is important that anyone attending in their place should wherever possible also have a good knowledge of the patient's case.

[2] At the time of publication this was detailed in Annex E of Practice Direction. First-tier Tribunal, Health, Education and Social Care Chamber: statements and reports in mental health cases. Tribunals Judiciary. 2013. http://www.judiciary.gov.uk/wp-content/uploads/JCO/Documents/Practice+Directions/Tribunals/statements-in-mental-health-cases-hesc-28102013.pdf

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12.17 Hospital managers (or local authorities in guardianship cases) should ensure that the Tribunal is notified immediately of any events or changes that might have a bearing on Tribunal proceedings – eg where a patient is discharged or one of the parties is unavailable.

12.18 If the author of a report prepared for the Tribunal is aware of information they do not think the patient should see, they should follow the Tribunal's procedure for the submission of such information. Ultimately, it is for the Tribunal to decide what should be disclosed to the patient.

12.19 Reports should be sent to the Tribunal office, preferably by secure e-mail, otherwise by post.

12.20 The responsible authority must ensure that up-to-date reports prepared specifically for the Tribunal are provided in accordance with the Tribunal's rules and procedures. In practice, this will normally include a report completed by the patient's responsible clinician.

12.21 Where possible, reports should be written by the professionals with the best overall knowledge of the patient's situation.

12.22 The reports should be submitted in good time to enable all parties, including the Secretary of State in restricted cases, to fulfil their responsibilities.

Medical examination

12.23 In certain categories of case, a medical member of the Tribunal may be asked to examine the patient, sometime before the hearing. Hospital managers must ensure that the medical member can see patients who are in hospital in private, where this is safe and practicable, and make provision for the member and the Tribunal panel at the hearing to be able to examine the patient's medical records, if necessary. It is important that the patient is told of any visit in advance, so that they can be available when the medical member visits.

Withdrawing the application

12.24 A request to withdraw an application may be made by the applicant in accordance with the Tribunal rules. The Tribunal is not bound to agree, especially if the withdrawal is merely tactical or is sought within 48 hours of the hearing. The applicant may not withdraw a reference made by a hospital manager or the Secretary of State.

12.25 An application will be considered to be withdrawn if the patient is discharged. If this happens outside office hours, someone acting on behalf of the hospital managers (or the local authority, if it is a guardianship case) should contact the Tribunal office as soon as possible, to inform them. For detained patients, this could be done by a member of the ward staff.

Representation

12.26 Hospital managers (or local authorities, as the case may be) should inform patients of their right to present their own case to the Tribunal and their right to be represented by someone else (whether legally qualified or not) and of any free legal advice and representation available. Staff should be available to help patients make an application and prepare them for the Tribunal. This is especially important for community patients who may not have daily contact with professionals.

12.27 If a patient has not appointed a representative and they do not wish to present their own case, or the patient lacks capacity to decide whether they want a representative and the Tribunal considers it is in the patient's best interests to be represented, then the Tribunal can appoint a person before the hearing, or permit a person who has accompanied the patient to the hearing, to be a representative for the patient. A patient's family member, carer or advocate could be their representative.

The hearing

Attendance at hearings

12.28 Normally patients will be present throughout hearings. Patients and carers do not need to attend the Tribunal hearing, but professionals should encourage and support them to attend unless they judge that it would be detrimental to the patient's health or wellbeing.

12.29 A carer or advocate will only be able to present the patient's case if they are appointed, or given permission, by the Tribunal as a representative under the Tribunal's procedural rules (see paragraph 12.26 above). If the patient is not well enough to attend the hearing or speak on their own behalf then an advocate or carer should be given the opportunity to attend and speak on their behalf.

12.30 It is important that the patient's responsible clinician/s attend the Tribunal, supported by other staff involved in the patient's care, where appropriate, as their evidence is crucial for making the case for a patient's continued detention or CTO under the Act. 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 Tribunal and the Tribunal's decision and reasons.

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12.31 Responsible clinicians can attend the hearing solely as a witness or as the nominated representative of the responsible authority. As a representative of the responsible authority, the responsible clinician has the ability to call and cross-examine witnesses and to make submissions to the Tribunal. This may not always be desirable where it is envisaged that the responsible clinician will have to continue working closely with a patient.

12.32 Responsible authorities should therefore consider whether they want to send an additional person to represent their interests, allowing the responsible clinician to appear solely as a witness. Responsible clinicians should be clear in what capacity they are attending the Tribunal, as they may well be asked this by the panel.

12.33 It is important that other people who prepare reports submitted by the responsible authority attend the hearing to provide further up-to-date information about the patient, including (where relevant) their home circumstances and the aftercare available in the event of a decision to discharge the patient.

12.34 Increasingly, Tribunal hearings find it helpful to speak to a nurse, particularly a nurse who knows the patient. It is often helpful for a nurse who knows the patient to accompany them to the hearing.

12.35 Hospital managers should ensure that all professionals who attend Tribunal hearings are adequately prepared. They should provide patients and their carers with sufficient information to understand the matters the Tribunal is considering in a format and language that patients and their carers understand. This could include pictorial or video formats outlining what the patient can expect.

Accommodation for hearings

12.36 The managers of a hospital in which a Tribunal hearing is to be held should provide suitable accommodation for that purpose. The hearing room should be private, quiet, clean and adequately sized and furnished. It should not contain confidential information about other patients. If the room is used for other purposes, care should be taken to ensure that any equipment (such as a video camera or a two-way mirror) would not have a disturbing effect on the patient.

12.37 The patient should have access to a separate room in which to hold any private discussions that are necessary – eg with their representative – as should the Tribunal members, so that they can discuss their decision.

12.38 Where a patient is being treated in the community, the hospital managers should consider whether a hospital venue is appropriate. They may wish to discuss alternatives with the Tribunal office.

Interpretation

12.39 The Tribunal should ensure that Tribunal panel members understand equality issues and that there are sufficient numbers of panel members with a specialised understanding of the specific needs of particular groups including those listed below, and that panel members can communicate effectively with them:

- patients from minority cultural or ethnic backgrounds
- patients with physical impairments and/or sensory impairments, and/or
- patients with learning disabilities and/or autistic spectrum disorders.

12.40 It is important that patients and their representatives are able to understand and participate in the Tribunal hearing. This includes providing information in formats that they understand and, if required, providing interpretation services free of charge, including sign language. Hospital managers and local authorities should inform the Tribunal well in advance if they think any such services might be necessary.

Communication of the decision

12.41 The Tribunal will normally communicate its decision to all parties orally at the end of the hearing. Provided it is feasible to do so, and the patient wishes it, the Tribunal will speak to them personally. Otherwise, the decision will be given to the patient's representative (if they have one). If the patient is unrepresented, and it is not feasible to discuss matters with them after the hearing, the hospital managers or local authority should ensure that they are told the decision as soon as possible. All parties to the hearing should receive a written copy of the reasons for the decision.

Complaints

12.42 Complaints from users about the Tribunal should be sent to the Tribunal offices. The Tribunal has procedures in places to deal with complaints promptly. This information is available at: https://www.gov.uk/mental-health-tribunal

Further information on the Tribunal

12.43 The Tribunal itself publishes further information and guidance about its procedures and operations.

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Related material

- At the time of publication this was detailed in Annex E of Practice Direction. First-tier Tribunal, Health, Education and Social Care Chamber: statements and reports in mental health cases. Tribunals Judiciary. 2013. http://www.judiciary.gov.uk/wp-content/uploads/JCO/Documents/Practice+Directions/Tribunals/statements-in-mental-health-cases-hesc-28102013.pdf
- The Tribunal Procedure: First-tier Tribunal, Health, Education and Social Care Chamber Rules. 2008. http://www.legislation.gov.uk/uksi/2008/2699/contents/made

This material does not form part of the Code. It is provided for assistance only.

Assessment, transport and admission to hospital

It is essential that practitioners understand the legal framework that governs a patient's assessment and admission to hospital. In this group of chapters guidance is provided about applications for detention under the Act, including emergency detention and transporting patients to hospital and the roles and responsibilities of clinical commissioning groups and local authorities in relation to assessment and admission to hospital. Guidance is also given on the Mental Capacity Act and the Deprivation of Liberty Safeguards, including the circumstances when they should be used and when the Act should be used.

In some instances it may be necessary to remove people from public places or from private premises and guidance is given about police powers to do that and to transfer patients to places of safety and between different places of safety. Guidance is also given on the transport of patients between different locations. Certain doctors, approved clinicians and nurses have 'holding powers' under the Act and guidance is given about the use of these powers and how they should be exercised and in what circumstances.

Chapter 13 Mental capacity and deprivation of liberty

Chapter 14 Applications for detention in hospital

Chapter 15 Emergency applications for detention

Chapter 16 Police powers and places of safety

Chapter 17 Transport of patients

Chapter 18 Holding powers

13 Mental capacity and deprivation of liberty

Why read this chapter?

13.1 A sound understanding and application of the principles and provisions of the Mental Capacity Act (MCA) and the Deprivation of Liberty Safeguards (DoLS) and of the common law relating to consent, is essential to enable decision-makers to fulfil their legal responsibilities and to safeguard their patients' rights under the European Convention on Human Rights (ECHR).

13.2 Practitioners should be able to identify the legal framework that governs a patient's assessment and treatment and authorise any appropriate deprivation of a patient's liberty whether the MCA or Metal Health Act (the Act). The legal framework is not static and may change as the patient's circumstances and needs change.

Definitions and principles

13.3 Definitions for the purposes of this chapter:

- **Deprivation of liberty safeguards (DoLS)** – the framework of safeguards under the Mental Capacity Act 2005 (MCA), as amended by the Mental Health Act 2007, for people who need to be deprived of their liberty in their best interests for care or treatment to which they lack the capacity to consent themselves
- **DoLS authorisation** – an authorisation under Schedule A1 to the MCA given by a 'supervisory body' (a local authority or, in certain circumstances, the Welsh Ministers) which authorises a deprivation of liberty in a care home or hospital after completion of the statutory assessment process, which includes an assessment that the detention is in the best interests of the person, and
- **Court of Protection order** – a welfare order made by the Court of Protection that authorises a deprivation of liberty for an individual who lacks the capacity to decide whether or not to be accommodated in the relevant location, in their best interests.

13.4 Age and applicability of the MCA and DoLS:

- the MCA, in general, applies to individuals aged 16 years and over
- however, a DoLS authorisation can only be made in respect of an individual aged 18 or over. A Court of Protection order can be made in respect of individuals aged 16 or over, and
- a person must be 18 to make an advance decision to refuse treatment or create a lasting power of attorney (LPA) under the MCA.

13.5 This chapter describes:

- the MCA, including the definition of 'lack of capacity'
- the importance of the MCA in care planning
- acts that can be performed by professionals under the MCA on behalf of individuals who lack capacity
- treatment of individuals who lack capacity for physical conditions who are liable to be detained under the Act
- the authorisation of a deprivation of liberty by a DoLS authorisation or a Court of Protection order
- considerations when determining whether an individual is to be detained under the Act or deprived of their liberty under a DoLS authorisation or Court of Protection order (including a flowchart to aid decision-making)
- matters relevant to the MCA and Electro-Convulsive Therapy (ECT), and
- a case study that demonstrates decision making in relation to detention under the Act and deprivation of liberty under DoLS.

13.6 This chapter should be read in close reference to other chapters in this Code, particularly:

- Children and young people under the age of 18 (chapter 19)
- Applications for detention in hospital (chapter 14)
- Guardianship (chapter 30), and
- Wishes expressed in advance (chapter 9).

13.7 Further detailed information can be found in the:

- Mental Capacity Act 2005 Code of Practice (MCA Code of Practice)
- Deprivation of Liberty Safeguards: Code of Practice (DoLS Code of Practice), and
- Department of Health Guidance on Consent.[1]

13.8 In this chapter, references to 'the Act' refer to the Mental Health Act and MCA to the Mental Capacity Act.

What is the MCA?

13.9 The MCA empowers individuals to make their own decisions where possible and protects the rights of those who lack capacity. Where an individual lacks capacity to make a specific decision at a particular time, the MCA provides a legal framework for others to act and make that decision on their behalf, in their best interests, including where the decision is about care and/or treatment.

[1] Reference Guide to Consent for Examination or Treatment. Department of Health. 2009. https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/138296/dh_103653__1_.pdf

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13.10 The MCA applies to hundreds of thousands of people at any one time, and potentially to all adults at some point in their lives. The MCA places a strong emphasis on the need to support individuals to make their own decisions. Information should be explained in a manner best suited to the individual to aid the individual's understanding. All individuals should be encouraged to participate in decision making and professionals should carefully consider the individual's wishes at all times.

13.11 The MCA should be central to the approach professionals take to patients who lack capacity in all health and care settings (including psychiatric and general hospitals). The starting point should always be that the MCA should be applied wherever possible to individuals who lack capacity and are detained under the Act.

13.12 In some situations, the provision of treatment under the Act will limit the operation of aspects of the MCA. For example, if a patient's treatment is being regulated by part 4 of the Act, then the MCA cannot in general be used to authorise medical treatment for mental disorder. For such a patient, any advance decision by them under the MCA to refuse proposed medical treatment for mental disorder or any decision taken by their attorney under the MCA to refuse consent to proposed medical treatment, cannot prevent medical treatment for mental disorder being given under sections 58 and 63 of the Act.

13.13 An exception to this is electro-convulsive therapy (ECT). A person who has made a valid and applicable advance decision under the MCA, or for whom a decision has been taken by their attorney, to refuse ECT, cannot be given that treatment under section 58A of the Act although treatment can be given in specific emergency situations under section 62(1A).

13.14 At the heart of the MCA are five statutory principles.

Five statutory principles of the MCA

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

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

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

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

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

13.15 It is important for professionals to be aware that individuals with a mental disorder, including those liable to be detained under the Act, do not necessarily lack capacity. The assumption should always be that a patient subject to the Act has capacity, unless it is established otherwise in accordance with the MCA.

13.16 Healthcare providers have a legal duty to care for and treat patients who lack capacity in accordance with the MCA, when it applies. Failure to do so could result in enforcement action being taken by the Care Quality Commission (CQC).

How does the MCA define 'lack of capacity'?

13.17 A person lacks capacity in relation to a matter if, at the material time, the person is 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.

13.18 The above definition contains both a 'diagnostic test' and a 'functional test'. The diagnostic test determines whether the individual has an impairment of, or a disturbance in the functioning of, the mind or brain. The impairment or disturbance can be temporary or permanent, but if it is temporary, the decision-maker should justify why the decision cannot wait until the circumstances change.

13.19 The functional test determines whether the individual is unable to make the specific decision in question themselves because of the impairment or disturbance. The elements of the functional test are set out in section 3(1) of the MCA. The inability to make the decision must be because of the impairment or disturbance, as opposed to some other cause. Both tests must be satisfied for an individual to be deemed to lack capacity to make the specific decision in question at the material time.

13.20 A person is 'unable to make a decision' for themselves if they are unable to do any one of the following:

- understand information which is relevant to the decision to be made
- retain that information in their mind

- use or weigh that information as part of the decision-making process, or
- communicate their decision (whether by talking, sign language or any other means).

13.21 As capacity relates to specific matters and can change over time, capacity should be reassessed as appropriate over time and in respect of specific treatment decisions. Decision-makers should note that the MCA test of capacity should be used whenever assessing a patient's capacity to consent for the purposes of the Act (including, for instance, under section 58 of the Act).

13.22 Decision-makers should ensure that where a capacity assessment is undertaken, this is recorded in the individual's care and treatment record. As well as the outcome of the test, the following should be recorded:

- the specific decision for which capacity was assessed
- the salient points that the individual needs to understand and comprehend and the information that was presented to the individual in relation to the decision
- the steps taken to promote the individual's ability to decide themselves. How the information was given in the most effective way to communicate with the individual
- how the diagnostic test was assessed, and how the assessor reached their conclusions, and
- how the functional test was undertaken, and how the assessor reached their conclusions.

Care planning

13.23 The five statutory principles of the MCA form a vital part of developing a patient's care plan and should be integral to this process.

13.24 Professionals should seek to involve those who lack capacity in decisions about their care as much as they would involve those who have capacity. Care plans should be developed in collaboration with the patient as much as possible. Where professionals and patients disagree over elements of the care plan the emphasis should be on discussion and compromise where possible. Restrictions (including restraint) and the deprivation of liberty should only be considered when absolutely necessary and when all appropriate efforts at building consensus and agreement have failed.

13.25 Care planning, including planning for discharge, must adhere to the steps for determining what is in the person's best interests set out in section 4 of the MCA. This ensures participation by the person and consideration of their wishes, feelings, beliefs and values and consultation with specified others (eg carers, attorneys and people nominated by the person) about the person's best interests.

The Court of Protection

13.26 The Court of Protection is a specialist court set up by the MCA to deal with cases involving individuals lacking capacity. It operates on a 24-hour basis.

13.27 A Court of Protection order may be made under the MCA to authorise a deprivation of liberty. Such orders may also authorise care or treatment.

13.28 In certain cases, a Court of Protection order is the only way to authorise a deprivation of liberty under the MCA. This includes where:

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

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

Acts that can be performed under the MCA

13.30 The MCA recognises that situations will occur when carers, healthcare and social care staff will need to make decisions on behalf of individuals who lack capacity to make particular decisions themselves (including decisions that relate to care and/or treatment for mental and/or physical conditions).

13.31 The MCA can be relied upon to treat mental disorder where the patient lacks capacity to make the decision in question and such treatment is in the patient's best interests, provided that the treatment is not regulated by Part 4 of the Act.

13.32 The Act does not regulate the treatment of physical conditions that are unrelated to mental disorders.

13.33 Sections 5 and 6 of the MCA offer protection from legal liability for certain acts of restraint – provided those acts are reasonably believed to be in the best interests of the individual. In this context restraint means using or threatening to use force to make a person do something they are resisting, or may resist, or restricting the person's liberty of movement, whether or not the person resists.

13.34 In considering the use of restraint, decision-makers should carefully take into account the need to respect an individual's liberty and autonomy.[2] Section 6 of the MCA states that, in addition to needing to be in the best interests of the person who lacks capacity in respect of the relevant decision, acts of restraint will only be permitted if:

- the person taking action reasonably believes that restraint is necessary to prevent harm to the person who lacks capacity, and
- the amount or type of restraint used and the amount of time it lasts is a proportionate response to the likelihood and seriousness of that harm.

(More information on restraint and the MCA can be found from paragraph 6.40 onwards of the MCA Code of Practice.)

13.35 However, sections 5 and 6 of the MCA cannot be relied on if the overall care package, including any proposed measures of restraint and/or proposed restrictions on movement, will give rise to a 'deprivation of liberty'. A deprivation of liberty will engage article 5 of the ECHR and must be specifically authorised under the MCA by a DoLS authorisation or a Court of Protection order, or otherwise made lawful by way of detention under the Act.

13.36 It is important to note that if a potential deprivation of liberty is identified, the first step should always be to review the care plan to see if a less restrictive approach could be taken that would prevent that deprivation of liberty from arising.

Treatment for physical conditions (where the individual is liable to be detained under the Act)

13.37 The Act regulates medical treatment of mental disorder for individuals who are liable to be detained under the Act. This may include treatment of physical conditions that is intended to alleviate or prevent a worsening of symptoms or a manifestation of the mental disorder (eg a clozapine blood test) or where the treatment is otherwise part of, or ancillary to, treatment for mental disorder.

13.38 Where individuals liable to be detained under the Act have a physical condition unrelated to their mental disorder, consent to treat this physical condition must be sought from the individual. If the individual does not have the capacity to consent, treatment can be provided under the MCA as long as it is in their best interests.

13.39 If the individual is deprived of their liberty and the need for physical treatment is the only reason why the person needs to be detained in hospital, then the patient is not within the scope of the Mental Health Act (as the purpose of the deprivation of liberty is not to treat mental disorder) and a DoLS authorisation or a Court of Protection order should be sought.

[2] If a person is, or is likely to be, restrained within the meaning of section 6(4), of the MCA, the guidance on 'restrictive intervention' given in chapter 26 may apply.

Authorising deprivations of liberty under the MCA and the DoLS

13.40 The DoLS are part of the MCA and as such are rooted in the MCA's five statutory principles. The DoLS only apply to individuals who lack the capacity to consent to accommodation in a care home or hospital where care and/or treatment provided in that accommodation amounts (or is likely to amount) to a deprivation of liberty.

13.41 A DoLS authorisation does not in itself authorise care or treatment, only the deprivation of liberty that results from the implementation of the proposed care plan. Any necessary care or treatment should be provided in accordance with the MCA.

13.42 When considering whether to apply for a DoLS authorisation, decision-makers should first assess the capacity of the person to consent to the arrangements for their care or treatment, in accordance with the MCA.

13.43 Next, decision-makers should consider whether the circumstances of the proposed accommodation and treatment amount (or are likely to amount) to a deprivation of liberty. Consideration must also be given at this stage to whether the patient's care plan can be amended to avoid any potential deprivation of liberty.

13.44 The precise scope of the term 'deprivation of liberty' is not fixed. In its 19 March judgment P v Cheshire West and Chester Council and another and P and Q v Surrey County Council ('Cheshire West'),[3] the Supreme Court clarified that there is a deprivation of liberty in circumstances where a person is under continuous control and supervision, is not free to leave and lacks capacity to consent to these arrangements.

13.45 The Supreme Court also noted that factors which are not relevant in determining whether there is a deprivation of liberty include the person's compliance or lack of objection and the reason or purpose behind a particular placement. The relative normality of the placement (whatever the comparison made) is also not relevant.

13.46 A deprivation of liberty can occur in domestic settings where the state is responsible for such arrangements. In such cases, an order should be sought from the Court of Protection.

[3] P v Cheshire West and Chester Council and another and P and Q v Surrey County Council. 2014. WLR 2. https://www.supremecourt.uk/decided-cases/docs/UKSC_2012_0068_Judgment.pdf

13.47 The definition of a deprivation of liberty develops over time in accordance with the case law of the European Court of Human Rights and UK courts on article 5 of the ECHR. In order for decision-makers to be able to assess whether the situation they are faced with constitutes (or is likely to constitute) a deprivation of liberty, they should keep abreast of the latest case law developments.

13.48 The criteria that must be satisfied to obtain a DoLS authorisation is detailed in the box below.

DoLS authorisations

In general, a DoLS authorisation under Schedule A1 to the MCA is given by a 'supervisory body' (a local authority or, in certain circumstances, the Welsh Ministers), following a request from a 'managing authority' (the hospital or care home at which the individual is placed or is likely to be placed). Best practice would be for an authorisation to be in place at the time the deprivation of liberty occurs.

An authorisation will only be given if the individual concerned is assessed to meet all six of the qualifying requirements, on which detailed guidance is given in the DoLS Code of Practice. The six qualifying requirements are summarised below.

a. Age – is the individual aged 18 or over?

b. Mental health – does the individual have a mental disorder as defined by the Act? (It should be noted that the exclusion in the Act in respect of a learning disability is not relevant for the purposes of DoLS)

c. Mental capacity – does the individual lack capacity to decide whether or not they should be accommodated in the care home or hospital specified at the material time (ie the time of the assessment)?

d. Best interests:

(i) Is it in the best interest of the individual for them to be deprived of their liberty?

(ii) Is it necessary for them to be deprived of their liberty in order to prevent harm to themselves?

(iii) Is the deprivation of liberty a proportionate response to the likelihood of the individual suffering harm and the seriousness of that harm?

e. Eligibility – this qualifying requirement is met unless the person is ineligible to be deprived of their liberty by the MCA (Schedule 1A to the MCA sets out who is ineligible for this purpose)

f. No refusals – has the person made a valid and applicable advance decision to refuse some or all of the treatment in question or is there is a valid and conflicting decision by a donee or deputy? If so, they may not meet the qualifying criteria for DoLS.

Note 1: there is a different procedure in Schedule A1 of the MCA for an urgent DoLS authorisation. However, an urgent authorisation is generally only given if a request for a standard DoLS authorisation has been made, and therefore, there must be a reasonable expectation that the six qualifying requirements for a standard authorisation are likely to be met (For further information, see paragraph 6.1 of the DoLS Code of Practice).

Note 2: DoLS authorisations should be notified to the CQC.

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

13.49 If an individual:

a. is suffering from a mental disorder (within the meaning of the Act)

b. needs to be assessed and/or treated in a hospital[4] setting for that disorder or for physical conditions related to that disorder (and meets the criteria for an application for admission under sections 2 or 3 of the Act)

c. has a care treatment package that may or will amount to a deprivation of liberty

d. lacks capacity to consent to being accommodated in the relevant hospital for the purpose of treatment, and

e. does not object to being admitted to hospital, or to some or all the treatment they will receive there for mental disorder.

Then in principle a DoLS authorisation (or potentially a Court of Protection order) and detention under the Act would both be available (subject to the assessments required for a DoLS authorisation, including the eligibility assessment). This is the one situation where the option of using either the Act or DoLS exists. It is important to note that a person cannot be detained under the Act at the same time as being subject to a DoLS authorisation or a Court of Protection order.

13.50 Below is an options grid summarising the availability of the Act and of DoLS where a deprivation of liberty has been identified for a mental health patient, accommodated in hospital for the purpose of treatment for a mental disorder.

13.51 Whether a patient is objecting has to be considered in the round, taking into account all the circumstances, so far as they are reasonably ascertainable. The decision to be made is whether the patient objects, the reasonableness of that objection is not the issue. In many cases the patient will be perfectly able to state their objection. In other cases the relevant person will need to consider the patient's

[4] Detention under the Act can only occur in a hospital (as defined in section 145(2) of the Act) or a registered establishment (as defined in section 34(2) of the Act). Therefore if a person is to be accommodated and treated elsewhere then no question arises of detaining that person under the Act.

behaviour, wishes, feelings, views, beliefs and values, both present and past, so far as they can be ascertained. In deciding whether a patient objects to being admitted to hospital, or to some or all of the treatment they will receive there for mental disorder, decision-makers should err on the side of caution and, where in doubt, take the position that a patient is objecting.

Figure 5: Options grid summarising the availability of the Act and of DoLS

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

Important points for consideration

13.52 Figure 5 above reveals a number of important points in addition to those discussed earlier in this chapter.

13.53 First, a person who lacks capacity to consent to being accommodated in a hospital for care and/or treatment for mental disorder and who is likely to be deprived of their liberty should never be informally admitted to hospital (whether they are content to be admitted or not.[5]

13.54 Decision-makers should also consider whether an individual deprived of their liberty may regain capacity or may have fluctuating capacity. Such a situation is likely to indicate use of the Act to authorise a deprivation of liberty should be preferred over use of a DoLS authorisation or Court of Protection order.

13.55 An individual will be ineligible for a DoLS authorisation or a Court of Protection order if they fall within Schedule 1A to the MCA, which should be considered carefully.

[5] In an emergency situation, it should be noted that section 4B of the MCA allows for the deprivation of an individual's liberty for the purpose of life-sustaining treatment or doing any vital act while a decision is sought from the court. This section is not available in certain circumstances, for example, if the person is ineligible under Schedule 1A to the MCA. Section 4 of the Act also makes provision for admission in cases of emergency.

13.56 Individuals who are ineligible include the following:

- those persons detained in a hospital under sections 2, 3, 4, 35 – 38, 44, 45A, 47, 48 or 51 of the Act
- those persons liable to be detained under one of the above mentioned sections of the Act but who are not detained in a hospital under that regime; AND (i) proposed care and treatment in a hospital or care home would conflict with a requirement imposed on them in connection with their liability to detention under the Act (eg as a condition of a leave of absence) OR (ii) the relevant care and treatment consists in whole or in part of treatment for mental disorder in a hospital
- those persons on a community treatment order (CTO) under the Act AND (i) proposed care and treatment in a hospital or care home would conflict with a condition of their CTO OR (ii) the relevant care and treatment consists in whole or in part of treatment for mental disorder in a hospital
- those persons subject to guardianship under the Act AND (i) proposed detention or care and treatment would conflict with a requirement imposed on them by the guardianship regime (eg a requirement that they should reside elsewhere) OR (ii) it is proposed that the person will be detained in a hospital for treatment for mental disorder and they object, or are likely to object (and the person's attorney or deputy has not consented), and
- those persons who would meet the criteria for being detained under section 2 or 3 of the Act, but who is not liable to be detained under sections 4, 35–38, 44, 45A, 47, 48 or 51 or subject to a CTO or guardianship, AND it is proposed that the person will be detained in a hospital for treatment for mental disorder, AND the person objects to being accommodated in hospital for that treatment, or to being given some or all of that treatment (and the person's attorney or deputy has not consented where the person objects)

13.57 For those individuals detailed in paragraph 13.49 where both detention under the Act and a DoLS authorisation or a Court of Protection order are available, decision-makers should determine which regime is the more appropriate. The following paragraphs detail factors that should feature in this decision-making process.

13.58 The choice of legal regime should never be based on a general preference for one regime or the other, or because one regime is more familiar to the decision-maker than the other. Such considerations are not legally relevant and lead to arbitrary decision-making. In addition decision-makers should not proceed on the basis that one regime is generally less restrictive than the other. Both regimes are based on the need to impose as few restrictions on the liberty and autonomy of patients as possible. In the particular circumstances of an individual case, it may be apparent that one regime is likely to prove less restrictive. If so, this should be balanced against any potential benefits associated with the other regime.

13.59 Both regimes provide appropriate procedural safeguards to ensure the rights of the person concerned are protected during their detention. Decision-makers should not therefore proceed on the basis that one regime generally provides greater safeguards than the other. However, the nature of the safeguards provided under the two regimes are different and decision-makers will wish to exercise their professional judgement in determining which safeguards are more likely to best protect the interests of the patient in the particular circumstances of each individual case.

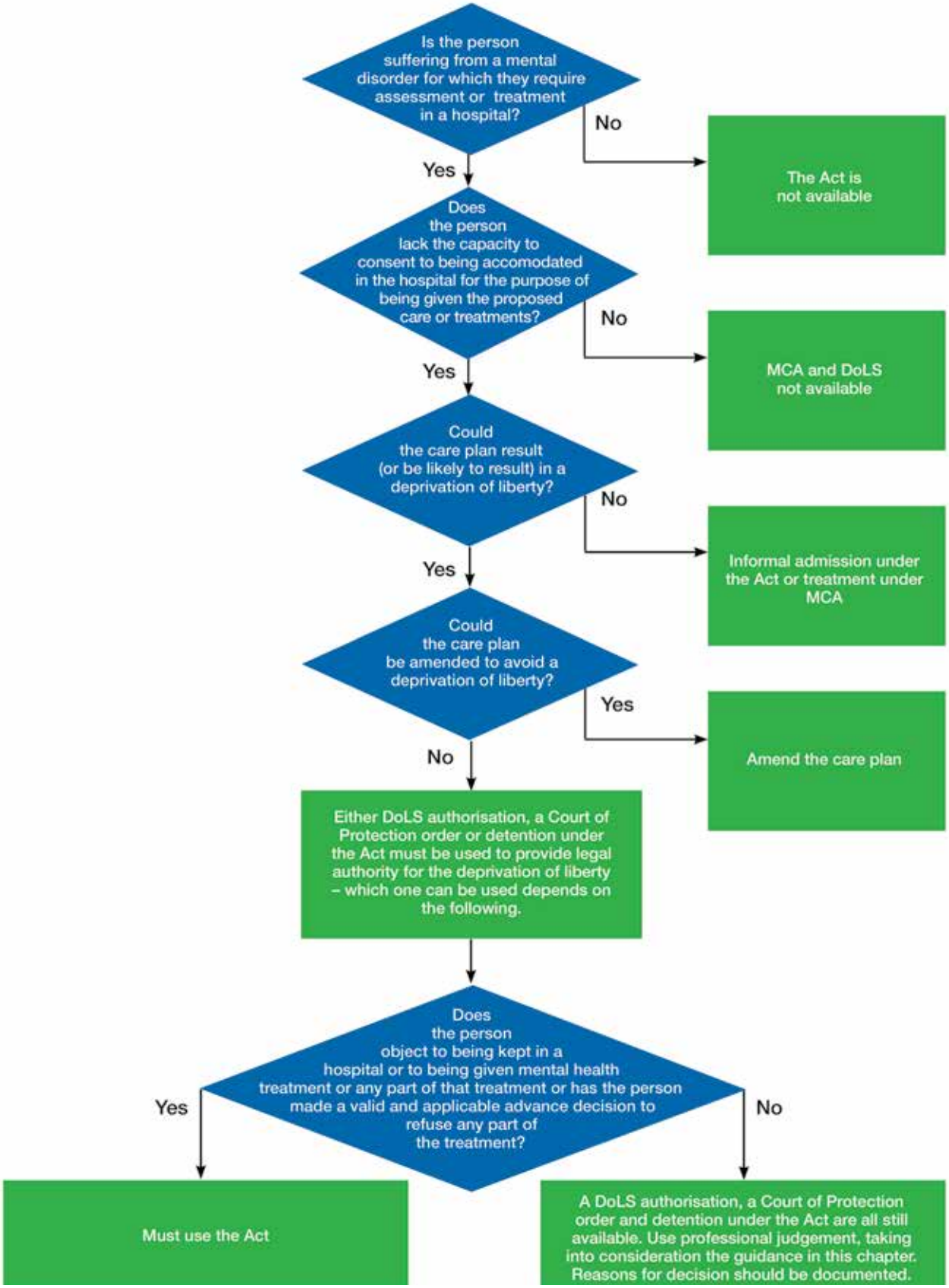
13.60 In the relatively small number of cases where detention under the Act and a DoLS authorisation or Court of Protection order are available, this Code of Practice does not seek to preferentially orientate the decision-maker in any given direction. Such a decision should always be made depending on the unique circumstances of each case. Clearly recording the reasons for the final decision made will be important. The most pressing concern should always be that if an individual lacks capacity to consent to the matter in question and is deprived of their liberty they should receive the safeguards afforded under either the Act or through a DoLS authorisation or a Court of Protection order.

13.61 Part 9 of the DoLS Code of Practice details steps to be taken if someone thinks a person is being deprived of their liberty without authorisation. These steps include raising the matter with the responsible person at the managing authority (the provider) and if necessary with the supervisory body (the local authority). Hospitals should have policies in place to deal with circumstances where disagreement results in an inability to take a decision as to whether the Act or DoLS should be used to give legal authorisation to a deprivation of liberty – to ensure that one is selected.

Deciding whether the Act and/or MCA will be available to be used

13.62 The flowchart opposite describes the key decision-making steps when determining whether the Act and/or the MCA including the DoLS will be available to be used. The flowchart does not replace careful consideration by decision-makers of all relevant circumstances in individual cases. Decision-makers should use their professional judgment within the framework of the legislation. Annex D provides a written description of figure 6.

Figure 6: Deciding whether the Act and/or MCA will be available to be used



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Electro-convulsive therapy (ECT)

13.63 ECT cannot be given to an individual who has the capacity to consent to that treatment but refuses to do so unless it is immediately necessary to save the patient's life or to prevent a serious deterioration in the patient's condition.[6]

13.64 Under the Act, ECT can only be given to individuals who lack capacity if approved by a second opinion appointed doctor (SOAD). See paragraphs 25.19 – 25.25 for further information on ECT.

13.65 If ECT is to be given to an individual who lacks capacity and is under a DoLS authorisation or Court of Protection order, consideration should be given to seeking an independent second medical opinion before treatment which could, in principle, be given under the MCA (remembering that a DoLS authorisation only authorises the deprivation of liberty, not the treatment).

13.66 It is worth noting that ECT is likely to be considered under the MCA to be 'serious medical treatment' and that as such, if appropriate, an independent mental capacity advocate (IMCA) may need to be appointed.

Complex cases

13.67 This guidance does not seek to provide definitive answers in complex cases. Every individual case is unique with a complex mix of factors that need to be considered. A patient's eligibility for detention under the Act or for a deprivation of liberty under a DoL authorisation or a Court of Protection order should always be considered.

13.68 In most cases, only one of the regimes will be available. However, in some cases, both will be available and must be considered. Decision-makers should exercise their professional judgement, taking legal advice where necessary, within the framework of the relevant legislation and guidance.

13.69 In the rare cases where neither the Act nor a DoLS authorisation nor a Court of Protection order is appropriate, then to avoid an unlawful deprivation of liberty it may be necessary to make an application to the High Court to use its inherent jurisdiction to authorise the deprivation of liberty.

13.70 A hypothetical case is considered below. This case is illustrative only and is not intended to provide a template for decision-making. The case does not form part of the Code.

[6] Sections 58A(1)(a) and (2) and 62(1)(a) and (b) and (1A) of the Act.

Case example

a. P is a 72 year old woman suffering from dementia. Following a sudden deterioration in the community it is proposed that P be taken to hospital to be assessed for her future care and treatment needs. P is assessed as lacking the capacity to decide whether or not to be taken to hospital to be assessed, so she is taken and admitted to hospital in her best interests under the protection of the MCA.

On arrival, the clinical team decide that P will need to be kept in hospital under continuous control and supervision to be assessed, and would not be free to leave. This would amount to a deprivation of liberty. An application to detain P for assessment is therefore made under section 2 of the Act to authorise the deprivation of liberty during the assessment.

b. The period of section 2 detention is reaching an end. During her assessment, P is given treatment for mental disorder. The clinical team decide that P will continue to need to be detained to receive treatment for mental disorder. P objects to staying in hospital to receive treatment and often says she will leave the hospital. In such an event, P would be prevented from leaving and the clinical team judge that a deprivation of liberty would arise. The clinical team determine that the criteria for detention under section 3 of the Act are satisfied and detain P under section 3. Treatment for mental disorder is provided.

c. When the course of treatment is finished, the clinical team decide that P no longer needs to be kept in a hospital for on-going treatment.

d. The clinical team considers (in consultation with P's family and other relevant individuals and with respect to P's previously stated views and beliefs) that it would not be in P's best interests to discharge her back into the community immediately because she lives alone and the clinical team does not believe she would be able to look after herself. The clinical team assess that P lacks capacity to decide whether to live in a care home (and lacks capacity to decide whether to remain in hospital).

e. The hospital contacts the local authority to arrange a place at a residential care home. The care home states that a place will not be available for two weeks. The hospital believes it is in P's best interests to remain in hospital until the care home is ready to receive her (again, consulting with family and relevant individuals and taking P's likely views and beliefs into consideration).

f. P's assigned mental health professional asks the clinical team where P will stay until she can be moved to the care home. The clinical team say P will remain on the ward with patients who, unlike P, are still detained under the Act. If P attempts to leave the ward, the clinical team say that she will be prevented from doing so – and so a deprivation of liberty could potentially occur. The clinical team assesses that P does not and is not likely to object to remaining on the ward.

g. The DoL best interests assessor (BIA) concludes that P meets the qualifying requirements for a DoL authorisation. The hospital applies to the local authority and receives a standard DoL authorisation covering P's remaining stay in hospital.

h. When P is moved to the care home, the care home reassesses P's situation and decides that P does not have capacity to decide whether to remain in the care home. The care home believes that it is in P's best interests to remain at the care home (she would not be allowed to go home if she requested to do so, as the care home still believes she would be unable to look after herself adequately). Therefore the care home (assessing that the situation represents a deprivation of liberty) requests a DoL authorisation from the local authority.

13

Explanation of important points in (a) to (h) above:

a. P lacks capacity and so the protection of section 5 and 6 of the MCA is available for P to be conveyed to hospital. P is detained under the Act when it is clear that that is required to authorise the deprivation of liberty required for P's assessment.

b. The proposed care plan involves a potential deprivation of liberty. Treatment is for a mental disorder. The DoLS and the Act are both potentially available at this point. However, P objects to the proposed stay in hospital so she is ineligible to be deprived of liberty by a DoL authorisation or Court of Protection order. As such she can only be detained under the Act.

c. P no longer needs to be detained in hospital for care and treatment for the mental disorder. As such, the Act is no longer available.

d. The clinical team reaches a best interests decision and correctly reassesses capacity for a significant new care decision.

e. It becomes clear that it will be in P's best interests to remain in hospital, pending the availability of an appropriate care home place.

f. A potential deprivation of liberty is identified – a legal regime must therefore be found to authorise that deprivation. The Act cannot be used as P does not meet the criteria for detention. The DoLS need to be used.

g. A standard DoL authorisation is received. (The clinical team might have felt it necessary to apply for an urgent authorisation together with the standard authorisation if the team determined that, after P's detention under the Act had finished, the need for P to be deprived of her liberty was so urgent that deprivation of liberty needed to begin before the request for a standard authorisation could be considered or granted by the local authority.)

h. P moves to a care home. The care home rightly re-assesses P's capacity and whether a deprivation of liberty could potentially occur. The care home applies for a DoL authorisation to authorise the detention. P cannot be detained under the Act at this stage because the Act does not apply to care homes. Care and treatment can be provided under the MCA.

Related material

- Mental Capacity Act 2005: Code of Practice. Department for Constitutional Affairs (now Ministry of Justice). 2007. https://www.gov.uk/government/publications/mental-capacity-act-code-of-practice
- Mental Capacity Act 2005: Deprivation of Liberty Safeguards – Code of Practice to supplement the main Mental Capacity Act 2005 Code of Practice. 2008. http://webarchive.nationalarchives.gov.uk/20130107105354/http:/www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_085476
- Reference Guide to Consent for Examination or Treatment. Department of Health. 2009. https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/138296/dh_103653__1_.pdf

This material does not form part of the Code. It is provided for assistance only.

14 Applications for detention in hospital

Why read this chapter?

14.1 This chapter gives guidance on making applications for detention in hospital under Part 2 of the Act.

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

Grounds for making an application for detention

14.3 An application for detention may only be made where the grounds in either section 2 or section 3 of the Act are met (see below).

Criteria for applications

14.4 A person can be detained for assessment under section 2 only if both the following criteria apply:

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

14.5 A person can be detained for treatment under section 3 only if all the following criteria apply:

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

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

14.7 Before it is decided that admission to hospital is necessary, consideration must be given to whether there are alternative means of providing the care and treatment which the patient requires. This includes consideration of whether there might be other effective forms of care or treatment which the patient would be willing to accept and of whether guardianship would be appropriate instead.

14.8 In all cases, consideration should be given to:

- the patient's wishes and view of their own needs
- the patient's age and physical health
- any past wishes or feelings expressed by the patient
- the patient's cultural background
- the patient's social and family circumstances
- the impact that any future deterioration or lack of improvement in the patient's condition would have on their children, other relatives or carers, especially those living with the patient, including an assessment of their ability and willingness to cope, and
- the effect on the patient, and those close to the patient, of a decision to admit or not to admit under the Act.

Factors to consider – the health or safety of the patient

14.9 Factors to be considered in deciding whether patients should be detained for their own health or safety include:

- the evidence suggesting that patients are at risk of:
  - suicide
  - self-harm
  - self-neglect or being unable to look after their own health or safety
  - jeopardising their own health or safety accidentally, recklessly or unintentionally, or
  - that their mental disorder is otherwise putting their health or safety at risk
- any evidence suggesting that the patient's mental health will deteriorate if they do not receive treatment, including the views of the patient or carers, relatives or close friends (especially those living with the patient) about the likely course of the disorder

- the patient's own skills and experience in managing their condition
- the patient's capacity to consent to or refuse admission and treatment (and the availability of the deprivation of liberty safeguards (DoLS))
- whether the patient objects to treatment for mental disorder – or is likely to
- the reliability of such evidence, including what is known of the history of the patient's mental disorder and the possibility of their condition improving
- the potential benefits of treatment, which should be weighed against any adverse effects that being detained might have on the patient's wellbeing, and
- whether other methods of managing the risk are available.

Factors to consider – protection of others

14.10 In considering whether detention is necessary for the protection of other people, the factors to consider are the nature of the risk to other people arising from the patient's mental disorder, the likelihood that harm will result and the severity of any potential harm, taking into account:

- that it is not always possible to differentiate risk of harm to the patient from the risk of harm to others
- the reliability of the available evidence, including any relevant details of the patient's clinical history and past behaviour, such as contact with other agencies and (where relevant) criminal convictions and cautions
- the willingness and ability of those who live with the patient and those who provide care and support to the patient to cope with and manage the risk
- whether other methods of managing the risk are available, and
- harm to other people including psychological as well as physical harm.

Alternatives to detention under the Act

14.11 In deciding whether it is necessary to detain patients, doctors and AMHPs must always consider the alternative ways of providing the treatment or care they need. Decision-makers should always consider whether there are less restrictive alternatives to detention under the Act, which may include:

- informal admission to hospital of a patient based on that person's consent (see chapter 19 for guidance on consent to informal admission for children and young people)

- treatment under the Mental Capacity Act (MCA) if the person lacks capacity to consent to admission and treatment. If a deprivation of liberty occurs, or is likely to occur, either the Act, a DoLS authorisation or a deprivation of liberty order by the Court of Protection must be in place (see chapter 13)
- management in the community – eg by a crisis and support team, in a crisis house or with a host family (see chapter 29 on community patients), or
- guardianship (see chapter 30 and 31).

14.12 In considering whether it is necessary for the person to be detained under the Act, decision-makers must consider whether the person has capacity to consent to or refuse admission and treatment. This should be assessed in accordance with the MCA, which makes clear that a person must be assumed to have capacity unless it is established that they do not.

14.13 Professionals must consider available alternatives, having regard to all the relevant circumstances, to identify the least restrictive way of best achieving the proposed assessment or treatment. This will include considering what is the person's best interests (if the person lacks capacity, this will be determined in accordance with the MCA).

Patients with capacity to give or to refuse consent to admission

14.14 When a patient needs to be in hospital, informal admission is usually appropriate when a patient who has the capacity to give or to refuse consent is consenting to admission. (See chapter 19 for guidance on when parents might consent to admission on behalf of children and young people.)

14.15 This should not be regarded as an absolute rule, especially if the reason for considering admission is that the patient presents a clear risk to themselves or others because of their mental disorder.

14.16 Compulsory admission should, in particular, be considered where a patient's current mental state, together with reliable evidence of past experience, indicates a strong likelihood that they will have a change of mind about informal admission, either before or after they are admitted, with a resulting risk to their health or safety or to the safety of other people.

14.17 The threat of detention must not be used to coerce a patient to consent to admission to hospital or to treatment (and is likely to invalidate any apparent consent).

14.18 If consideration is being given to the informal admission of a patient who is subject to Secretary of State for Justice restrictions, the Mental Health Casework Section (MHCS) of the Ministry of Justice should be contacted. Further advice is provided in chapter 22 and on the Ministry of Justice website.[1]

Patients who lack capacity to give or to refuse consent to admission or treatment

14.19 Where the criteria for detention under the Act are met, the situations where an application for detention should be made under the Act instead of relying on the DoLS include where:

- the patient has made a valid and applicable advance decision to refuse treatment which includes a necessary element of the treatment for which they are to be admitted to hospital (see chapter 9)
- the use of the DoLS would conflict with a decision of the person's attorney, deputy, guardian or the Court of Protection, or
- the patient is objecting to being admitted to (or remaining in) hospital for mental health treatment.[2]

14.20 In that last case, whether a patient is objecting has to be considered in the round, taking into account all the circumstances, so far as they are reasonably ascertainable. The decision to be made is whether the patient objects to treatment – the reasonableness of that objection is not the issue. In many cases the patient will be perfectly able to state their objection. In other cases doctors and AMHPs will need to consider the patient's behaviour, wishes, feelings, views, beliefs and values, both present and past, so far as they can be ascertained. If there is reason to think that a patient would object, if able to do so, then the patient should be taken to be objecting.

14.21 Even if providing appropriate care or treatment will not unavoidably involve a deprivation of liberty, in some cases it may be necessary to detain a patient under the Act rather than rely on the MCA. For example, where the patient:

- has, by means of a valid and applicable advance decision, refused a necessary element of the treatment required, or
- lacks capacity to make decisions on some elements of the care and treatment they need, but has capacity to decide about a vital element – eg admission to hospital – and has either already refused it or is likely to do so.

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[1] At the time of publication, contact details are available at www.justice.gov.uk/contacts/noms/mental-health-unit, and the Ministry of Justice switchboard is contactable on 020 3334 3555. For urgent queries out of office hours the telephone number (operated by the Home Office) is 020 7035 4848: select option 5.

[2] The patient would be ineligible to be deprived of their liberty under the MCA: see paragraphs 1, 2 (Case E), 5 and 12 of Schedule 1A to the MCA. This means they are ineligible to be deprived of their liberty under an authorisation under Schedule A1 (see section 4A(5) read with paragraphs 12(1)(e) and 17 of Schedule A1) or a Court of Protection order (see section 16A).

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14.22 Whether or not the DoLS could be used, other reasons why it may be necessary to detain a patient under the Act and not rely on the MCA alone include the following:

- the patient's lack of capacity to consent or refuse is fluctuating or temporary and the patient is not expected to consent to admission or treatment when they regain capacity. This may be particularly relevant to patients having acute psychotic, manic or depressive episodes
- a degree of restraint may need to be used which is justified by the risk to other people but which is not permissible under the MCA[3] because, exceptionally, it cannot be said to be proportionate to the risk to the patient personally, and
- there is some other specific identifiable risk that the person might not receive the treatment they need if the MCA is relied on and either the person or others might potentially suffer harm as a result.

14.23 Otherwise, if the MCA can be used safely and effectively to assess or treat a patient, it is likely to be difficult to demonstrate that the criteria for detaining the patient under the Act are met.

14.24 For further information on the DoLS, see chapter 13, the MCA Code of Practice and its supplementary DoLS Code.[4]

14.25 For the different considerations which apply to children and young people under the age of 18, see chapter 19.

Use of section 2 or section 3 of the Act

14.26 An application for detention can be made under either section 2 or section 3 of the Act.

14.27 Section 2 should only be used if:

- the full extent of the nature and degree of a patient's condition is unclear
- there is a need to carry out an initial in-patient assessment in order to formulate a treatment plan, or to reach a judgement about whether the patient will accept treatment on a voluntary basis following admission, or
- there is a need to carry out a new in-patient assessment in order to re-formulate a treatment plan, or to reach a judgement about whether the patient will accept treatment on a voluntary basis.

[3] Mental Capacity Act 2005: Code of Practice. Department for Constitutional Affairs (now Ministry of Justice). 2007. https://www.gov.uk/government/publications/mental-capacity-act-code-of-practice

[4] Mental Capacity Act 2005: Code of Practice. Department for Constitutional Affairs (now Ministry of Justice). 2007. https://www.gov.uk/government/publications/mental-capacity-act-code-of-practice

14.28 Section 3 should be used if:

- the patient is already detained under section 2 (detention under section 2 cannot be renewed by a new section 2 application), or
- the nature and current degree of the patient's mental disorder, the essential elements of the treatment plan to be followed and the likelihood of the patient accepting treatment as an informal patient are already sufficiently established to make it unnecessary to undertake a new assessment under section 2.

14.29 The rationale for decisions to use section 2 or section 3 should be clearly recorded.

The assessment process

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

14.31 An application must be supported by two medical recommendations given in accordance with the Act.

14.32 Doctors who are approached directly by a nearest relative about the possibility of an application being made should advise the nearest relative of their right to require a local authority to arrange for an AMHP to consider the patient's case.

Objective of the assessment

14.33 The objective of the assessment is to determine whether the criteria for detention are met and, if so, whether an application for detention should be made.

14.34 Because a proper assessment cannot be done without considering alternative means of providing care and treatment, AMHPs and doctors should, as far as possible in the circumstances, identify and liaise with services which may potentially be able to provide alternatives to admission to hospital, such as crisis and home treatment teams.

Responsibilities of local authorities

14.35 Local authorities are responsible for ensuring that sufficient AMHPs are available to carry out their roles under the Act, including assessing patients to decide whether an application for detention should be made. To fulfil their statutory duty, local authorities should have arrangements in place in their area to provide a 24-hour service that can respond to patients' needs.

14.36 Section 13 of the Act places a specific duty on local authorities to arrange for an AMHP to consider the case of any patient who is within their area if they have reason to believe that an application for detention in hospital may need to be made in respect of the patient. Local authorities must make such arrangements if asked to do so by (or on behalf of) the nearest relative.

14.37 If a patient is already detained under section 2 as the result of an application made by an AMHP, the local authority on whose behalf that AMHP was acting is responsible for arranging for an AMHP to consider the patient's case again if the local authority has reason to believe that an application under section 3 may be necessary. This applies even if the patient has been detained outside that local authority's area. These duties do not prevent any other local authority from arranging for an AMHP to consider a patient's case if that is more appropriate.

Setting up the assessment

14.38 Local arrangements should, as far as possible, ensure that assessments are carried out by the most appropriate AMHP and doctors in the particular circumstances.

14.39 Where a patient is known to belong to a group for which particular expertise is desirable (eg they are aged under 18 or have a learning disability), at least one of the professionals involved in their assessment should have expertise in working with people from that group, wherever possible.

14.40 If this is not possible, at least one of the professionals involved in the person's assessment should consult with one or more professionals who do have relevant expertise at the earliest opportunity and involve them as closely as the circumstances of the case allow.

14.41 Unless different arrangements have been agreed locally between the relevant authorities, AMHPs who assess patients for possible detention under the Act have overall responsibility for co-ordinating the process of assessment. In doing so, they should be sensitive to the patient's age, sex, gender identity, social, cultural or ethnic background, religion or belief, and/or sexual orientation (see chapter 3 for more information). They should also consider how any disability the patient has may affect the way the assessment needs to be carried out.

14.42 Given the importance of good communication, it is essential that those professionals who assess patients are able to communicate with the patient effectively and reliably to prevent potential misunderstandings. AMHPs should establish, as far as possible, whether patients have particular communication needs or difficulties and take steps to meet these, by arranging, for example a signer or a professional interpreter. AMHPs should also be in a position, where appropriate, to supply appropriate equipment to make communication easier with patients who have impaired hearing, but who do not have their own hearing aid.

14.43 See paragraphs 14.115 – 14.119 for specific guidance in relation to the assessment of people who are deaf and paragraphs 14.120 – 14.125 for people with dementia. For further guidance on specific issues that may arise when assessing people who have a learning disability or an autistic spectrum disorder, or who have a personality disorder, see chapter 20 and chapter 21 respectively.

14.44 Doctors and AMHPs undertaking assessments need to apply professional judgement and reach decisions independently of each other, but in a framework of co-operation and mutual support.

14.45 Unless there is good reason for undertaking separate assessments, patients should, where possible, be seen jointly by the AMHP and at least one of the two doctors involved in the assessment.

14.46 While it may not always be feasible for the patient to be examined by both doctors at the same time, they should both discuss the patient's case with the person considering making an application for the patient's detention.

14.47 Everyone involved in an assessment should be alert to the need to provide support to colleagues, especially where there is a risk of the patient causing physical harm. People carrying out assessments should be aware of circumstances in which the police should be asked to provide assistance, in accordance with arrangements agreed locally with the police (see paragraph 14.48), and how to use that assistance to maximise the safety of everyone involved in the assessment.[5]

14.48 Commissioners, providers, local authorities and the police should have joint locally agreed arrangements on the involvement of the police. These should include a joint risk assessment tool to help determine the level of risk and what (if any) police assistance may be required and how quickly it is needed. In cases where no warrant for the police to enter premises under section 135 is being applied for (see chapter 16), the risk assessment should indicate the reasons and why police assistance is nonetheless necessary.

The role of approved AMHPs

14.49 AMHPs may make an application for detention only if they:

- have interviewed the patient in a suitable manner
- are satisfied that the statutory criteria for detention are met, and
- are satisfied that, in all the circumstances of the case, detention in hospital is the most appropriate way of providing the care and medical treatment the patient needs.

[5] Local policies should already be in place between partner agencies in line with the Crisis Care Concordat. Mental Health Crisis Care Concordat: Improving outcomes for people experiencing mental health crisis. Department of Health and Concordat signatories. 2014. https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/281242/36353_Mental_Health_Crisis_accessible.pdf

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14.50 Once an AMHP has decided that an application should be made, they must then decide whether it is necessary or proper for them (rather than the nearest relative) to make the application. If, having considered any views expressed by the patient's relatives and all the other relevant circumstances, they decide that it is, the AMHP must make the application.

14.51 At the start of an assessment, AMHPs should identify themselves to the person being assessed, members of the family, carers or friends and the other professionals present. AMHPs should ensure that the purpose of the visit, their role and that of the other professionals is explained. They should carry documents with them at all times which identify them as AMHPs and which specify both the local authority which approved them and the local authority on whose behalf they are acting.

14.52 Although AMHPs act on behalf of a local authority, they cannot be told by the local authority or anyone else whether or not to make an application. They must exercise their own judgement, based on social and medical evidence, when deciding whether to apply for a patient to be detained under the Act. The role of AMHPs is to provide an independent decision about whether or not there are alternatives to detention under the Act, bringing a social perspective to bear on their decision, and taking account of the least restrictive option and maximising independence guiding principle.

14.53 If a patient wants someone else (eg a familiar person or an advocate) to be present during the assessment and any subsequent action that may be taken, then ordinarily AMHPs should assist in securing that person's attendance, unless the urgency of the case makes it inappropriate to do so. Patients may feel safer or more confident with a friend or other person they know well in attendance. Equally, an advocate can help to reassure patients. Some patients may already be receiving help from an advocate and, if this is the case, the advocate should also be present.

14.54 Patients should usually be given the opportunity of speaking to the AMHP alone. If an AMHP has reason to fear physical harm, they should insist that another professional is present.

14.55 It is not desirable for patients to be interviewed through a closed door or window, and this should be considered only where other people are at serious risk. Where direct access to the patient is not possible, but there is no immediate risk of physical danger to the patient or to anyone else, AMHPs should consider applying for a warrant under section 135 of the Act allowing the police to enter the premises (see chapter 16).

14.56 Where patients are subject to the short-term effects of alcohol or drugs (whether prescribed or self-administered) which make interviewing them difficult, the AMHP should either wait until the effects have abated before interviewing the patient or arrange to return later. If it is not realistic to wait because of the patient's disturbed behaviour and the urgency of the case, the assessment will have to be based on whatever information the AMHP can obtain from reliable sources. This should be made clear in the AMHP's record of the assessment.

The AMHP and the nearest relative

14.57 AMHPs are required by the Act to attempt to identify the patient's nearest relative as defined in section 26 of the Act (See chapter 5).

14.58 When AMHPs make an application for admission under section 2, they must take such steps as are practicable to inform the nearest relative and, if different, carer, that the application is to be (or has been) made and of the nearest relative's power to discharge the patient.

14.59 Before making an application for admission under section 3, AMHPs must consult the nearest relative, unless it is not reasonably practicable or would involve unreasonable delay.

14.60 Circumstances in which the nearest relative need not be informed or consulted include those where:

- it is not practicable for the AMHP to obtain sufficient information to establish the identity or location of the nearest relative or where to do so would require an excessive amount of investigation involving unreasonable delay, and
- consultation is not possible because of the nearest relative's own health or mental incapacity.

14.61 There may also be cases where, although physically possible, it would not be reasonably practicable to inform or consult the nearest relative because the detrimental impact of this on the patient would interfere with the patient's right to respect for their privacy and family life under article 8 of the European Convention on Human Rights to an extent that would not be justified and proportionate in the particular circumstances of the case. Detrimental impact may include cases where patients are likely to suffer emotional distress, deterioration in their mental health, physical harm, or financial or other exploitation as a result of the consultation. Consultation with the nearest relative that interferes with the patient's Article 8 rights may be justified to protect the patient's article 5 right to liberty.[6]

14.62 Consulting and notifying the nearest relative is a significant safeguard for patients. Therefore decisions not to do so on these grounds should not be taken lightly. AMHPs should consider all the circumstances of the case, including:

- the benefit to the patient of the involvement of their nearest relative, including to protect the patient's article 5 rights
- the patient's wishes including taking into account whether they have the capacity to decide whether they would want their nearest relative involved and any statement of their wishes they have made in advance. However, a patient's wishes will not be determinative of whether it is reasonably practicable to consult the nearest relative

[6] See TW v Enfield Borough Council. 2014. EWCA Civ 362. http://www.bailii.org/ew/cases/EWCA/Civ/2014/362.html

- any detrimental effect that involving the nearest relative would have on the patient's health and wellbeing, and
- whether there is any good reason to think that the patient's objection may be intended to prevent information relevant to the assessment being discovered.

14.63 If they do not consult or inform the nearest relative, AMHPs should record their reasons. Consultation must not be avoided purely because it is thought that the nearest relative might object to the application.

14.64 When consulting nearest relatives AMHPs should, where possible:

- ascertain the nearest relative's views about both the patient's needs and the nearest relative's own needs in relation to the patient
- inform the nearest relative of the reasons for considering an application for detention and what the effects of such an application would be, and
- inform the nearest relative of their role and rights under the Act.

14.65 If the nearest relative objects to an application being made for admission for treatment under section 3, the application cannot be made. If it is thought necessary to proceed with the application to ensure the patient's safety or that of others and the nearest relative cannot be persuaded to agree, the AMHP will need to consider applying to the county court for the nearest relative's displacement under section 29 of the Act (see paragraphs 5.7 and 5.11 – 5.24).

Consultation with other people

14.66 Although there are specific requirements to consult the nearest relative, it is important to recognise the value of involving other people in the decision-making process, particularly the patient's carers, family members and advocates, who are often able to provide a particular perspective on the patient's circumstances. In so far as the urgency of the case allows, AMHPs should consider consulting with other relevant relatives, carers or friends and should take their views into account.

14.67 Where patients are under 18, AMHPs should in particular consider consulting with the patient's parents (or other people who have parental responsibility for the patient – see chapter 19), assuming they are not the patient's nearest relative anyway.

14.68 In deciding whether it is appropriate to consult carers and other family members, AMHPs should consider:

- the patient's wishes
- the nature of the relationship between the patient and the person in question, including how long the relationship has existed, and
- whether the patient has referred to any hostility between them and the person in question, or there is other evidence of hostility, abuse or exploitation.

14.69 AMHPs should also consult wherever possible with other people who have been involved with the patient's care, including their care co-ordinator if they are supported on the care programme approach (see chapter 34). This could include people working for statutory, voluntary or independent services and other service providers who do not specialise in mental health services but have contact with the patient. For example, the patient may be known to services for older people or substance misuse services.

14.70 Some patients may have an attorney or deputy appointed under the MCA who has authority to make decisions about their personal welfare. Where such a person is known to exist, AMHPs should take reasonable steps to contact them and seek their opinion. Where attorneys or deputies have the power to consent or refuse treatment for mental disorder on the patient's behalf, they should also be given the opportunity to talk directly to the doctors assessing the patient, where practicable.

Medical examination by doctors as part of the assessment

14.71 A medical examination must involve:

- direct personal examination of the patient and their mental state, and
- consideration of all available relevant clinical information, including that in the possession of others, professional or non-professional.

14.72 If direct physical access to the patient is not immediately possible and it is not desirable to postpone the examination in order to negotiate access, consideration should be given to requesting that an AMHP apply for a warrant under section 135 of the Act (see paragraph 14.55 and chapter 16).

14.73 Where practicable, at least one of the medical recommendations must be provided by a doctor with previous acquaintance with the patient. Preferably, this should be a doctor who has personally treated the patient. It is sufficient for the doctor to have had some previous knowledge of the patient's case.

14.74 It is preferable that a doctor who does not have previous acquaintance with the patient be approved under section 12 of the Act. The Act requires that at least one of the doctors must be so approved.

14.75 Doctors must give reasons for the opinions stated in their recommendations. When giving a clinical description of the patient's mental disorder as part of these reasons, doctors should include a description of the patient's symptoms and behaviour, not merely a diagnostic classification.

14.76 When making recommendations for detention under section 3, doctors are required to state that appropriate medical treatment is available for the patient (see chapter 23). Preferably, they should know in advance of making the recommendation the name of the hospital to which the patient is to be admitted. If that is not possible, their recommendation may state that appropriate medical treatment will be available if the patient is admitted to one or more specific hospitals (or units within a hospital).

Commissioning and section 140 of the Act

14.77 If the doctors reach the opinion that the patient needs to be admitted to hospital, it is their responsibility to take the necessary steps to secure a suitable hospital bed; it is not the responsibility of the applicant. In some cases, it could be agreed locally between the local authority and the relevant NHS bodies and communicated to the AMHP that this will be done by any AMHP involved in the assessment.

14.78 Clinical commissioning groups (CCGs) are responsible for commissioning mental health services to meet the needs of their areas. Under section 140 of the Act, CCGs have a duty to notify local authorities in their areas of arrangements which are in force for the reception of patients in cases of special urgency or the provision of appropriate accommodation or facilities specifically designed for patients under the age of 18. The arrangements should include details of which providers in their area can receive patients in cases of special urgency and provide accommodation or facilities designed to be specifically suitable for patients under the age of 18. CCGs should provide a list of hospitals and their specialisms to local authorities which will help inform AMHPs as to where these hospitals are. This should in turn help inform AMHPs as to where beds are available in these circumstances if they are needed.

14.79 The NHS Commissioning Board (known as NHS England) is responsible for the commissioning of secure mental health services and other specialist services. NHS commissioners should work with providers to ensure that procedures are in place through which beds can be identified whenever required.

14.80 Local authorities, providers, NHS commissioners, police forces and ambulance services should ensure that they have in place a clear joint policy for the safe and appropriate admission of people in their local area agreed at board or board-equivalent level by each party and each party should appoint a named senior lead ('senior lead'). It is good practice for the parties to the local policy to meet regularly to discuss its effectiveness in the light of experience and review the policy where necessary, and to decide when information about specific cases can be shared between relevant parties for the purposes of protecting the person or others, in line with the law. Persons carrying out functions for these parties should understand the policies and their purpose, the roles and responsibilities of other agencies involved, and follow the local policy and receive the necessary training to be able to carry out fully their functions.[7]

[7] Local crisis care policies and agreements should already in place through the Mental Health Crisis Care Concordat: Improving outcomes for people experiencing mental health crisis. Department of Health and Concordat signatories. 2014. https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/281242/36353_Mental_ Health_Crisis_accessible.pd

14.81 In order to promote a patient's recovery, NHS commissioners and providers should work together to take steps, with appropriate input from section 12 doctors and AMHPs, to place individuals as close as is reasonably possible to a location that the patient identifies they would like to be close to (eg their home or close to a family member or carer). This should take account of any risk assessment undertaken, the availability of services which can meet the patient's individual needs, any assessment in respect of the likely duration of the patient's stay, and any other factors raised by the patient and their family. The location of the placement, and considerations relevant to that decision, should be monitored and reviewed regularly. Where secure care is needed further issues become relevant (see paragraph 14.82). This will help to facilitate effective discharge and after-care planning (see chapters 32 and 33).

14.82 For individuals who require low and medium secure mental health services, consideration should be given, through clinical and risk assessment, to the type of care required, especially where this includes specialist care. Steps should be taken to place individuals as close as is reasonably possible to a location that the patient identifies they would like to be close to that is suitable for their needs. If an individual is assessed as requiring high secure mental health services, they will be placed in a high security hospital according to the defined catchment areas of these hospitals. Rampton Hospital is the provider of national services for women, deaf people and people with learning disabilities who require high secure mental health services. Decisions regarding the location and type of facility where restricted patients are placed will be determined by appropriate clinical and risk assessment of the type of care required to meet the needs of the patient and to protect public safety.

14.83 In cases where the patient lacks capacity to make a decision about the location they would like to be close to, a best interests decision on the location should be taken.

14.84 Having regard to the empowerment and involvement principle, commissioners should ensure as far as is possible that carers are involved in the decision about where to locate an individual, and are informed of the reasons for the decision taken. Commissioners should have in place a policy so that the patient and/or the patient's carers are able to challenge a decision.[8]

14.85 When a patient's carer informs the commissioner of difficulties in visiting the patient because of the distance that they need to travel, the commissioner should consider whether they can provide any assistance to support the patient's carer to visit and maintain contact with the patient. The commissioner should inform the carer that they can request a carer's assessment from the local authority. CCGs should work with the relevant NHS Commissioning Board regional team under these circumstances to seek to move the patient closer to their preferred location.

[8] The Department of Health and NHS Commissioning Board (NHS England) will work together to develop guidance for commissioners as to what should be included in such a policy.

14.86 Local recording and reporting mechanisms should be in place to ensure the details of any delays in placing patients, and the impacts on patients, their carers, provider staff and other professionals are reported to commissioning and local authority senior leads. These details should feed into local demand planning. AMHPs should be supported by their local authority in these circumstances and should not be expected by commissioners and providers to address the delay themselves. In the meantime, commissioners should, in partnership with providers, ensure that alternative arrangements to meet the person's needs pending the availability of a bed are accessible, eg crisis houses, and should communicate those arrangements to the local authority. The local authority should ensure that AMHPs are aware of these arrangements.

Action when it is decided to make an application

14.87 Most compulsory admissions require prompt action. Applicants have up to 14 days (depending on when the patient was last examined by a doctor as part of the assessment) in which to decide whether to make the application, starting with the day they personally last saw the patient. There may be cases where AMHPs conclude that they should delay taking a final decision in order to see whether the patient's condition changes, or whether successful alternatives to detention can be put in place in the interim.

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

14.89 Applications for detention must be addressed to the managers of the hospital where the patient is to be detained. An application must state a specific hospital. An application cannot, for example, be made to a multi-site provider without specifying which of the provider's sites the patient is to be admitted to. Providers should identify a bed manager or other single point of contact who will be responsible for finding a suitable bed as soon as possible and telling the applicant the name of the site at which it is situated. Effective systems of bed management including discharge planning, possible alternatives to admission and demand planning should be in place. The bed manager should work closely with commissioners to proactively identify local need, and with assessing doctors and AMHPs to secure a bed. AMHPs should be adequately supported by their local authority in establishing working partnerships with other local agencies listed at paragraph 14.80.

14.90 Where units under the management of different bodies exist on the same site (or even in the same building), they will be separate hospitals for the purposes of the Act, because one hospital cannot be under the control of two sets of managers. Where there is potential for confusion, the respective hospital managers should ensure that there are distinct names for the units. In collaboration with local authorities, they should take steps to ensure that information is available to AMHPs who are likely to be making relevant applications to enable them effectively to distinguish the different hospitals on the site and to describe them correctly in applications.

14.91 Once an application has been completed, the patient should be transported to hospital as soon as possible, if they are not already in the hospital. However, patients should not be moved until it is known that the hospital is willing to accept them.

14.92 A properly completed application supported by the necessary medical recommendations provides the applicant with the authority to transport the patient to hospital even if the patient does not wish to go. That authority lasts for 14 days from the date when the patient was last examined by one of the doctors with a view to making a recommendation to support the application. See chapter 17 for further guidance on transport.

14.93 The AMHP should provide an outline report for the hospital at the time the patient is first admitted or detained, giving reasons for the application and any practical matters about the patient's circumstances which the hospital should know. Where possible, the report should include the name and telephone number of the AMHP or a care co-ordinator who can give further information. Local authorities should use a standard form on which AMHPs can make this outline report.

14.94 Where it is not realistic for the AMHP to accompany the patient to the hospital, it is acceptable for them to provide the information outlined above by telephone, fax or other electronic means compatible with transferring confidential information. If providing the information by telephone, the AMHP should ensure that a written report is sent to the admitting hospital as soon as possible.

14.95 An outline report does not take the place of the full report which AMHPs are expected to complete for their employer (or the local authority on whose behalf they are acting – if different).

14.96 If the patient is a restricted patient, the AMHP should ensure that the MHCS of the Ministry of Justice is notified of the detention as soon as possible. This information should be left during office hours, although a duty officer is available at all times for urgent queries.[9]

[9] At the time of publication, contact details are available at www.justice.gov.uk/contacts/noms/mental-health-unit, and the Ministry of Justice switchboard is contactable on 020 3334 3555. For urgent queries out of office hours the telephone number (operated by the Home Office) is 020 7035 4848: select option 5.

14.97 If the patient is a looked after child under the Children Act 1989, AMHPs should inform the local authority's children's services as soon as possible. If this patient is placed out of the area of the local authority that looks after the child ('responsible authority'), AMHPs should inform the children's services in both the responsible authority and the local authority in which the child is placed.

14.98 An application cannot be used to admit a patient to any hospital other than the one stated in the application (although once admitted a patient may be transferred to another hospital – see paragraphs 37.16 – 37.27).

14.99 In exceptional circumstances, if patients are transported to a hospital which has agreed to accept them, but there is no longer a bed available, the managers and staff of that hospital should assist in finding a suitable alternative for the patient. This may involve making a new application to a different hospital. If the application is under section 3, new medical recommendations will be required, unless the original recommendations already state that appropriate medical treatment is available in the proposed new hospital. The hospital to which the original application was made should assist in securing new medical recommendations if they are needed. A situation of this sort should be considered a serious failure and should be recorded and investigated accordingly.

Communicating the outcome of the assessment

14.100 Having decided whether or not to make an application for admission, AMHPs should inform the patient, giving their reasons. Subject to the normal considerations of patient confidentiality, AMHPs should also give their decision and the reasons for it to:

- the patient's nearest relative
- the doctors involved in the assessment
- the patient's care co-ordinator (if they have one), and
- the patient's GP, if they were not one of the doctors involved in the assessment.

14.101 An AMHP should, when informing the nearest relative that they not do intend to make an application, advise the nearest relative of their right to do so instead. If the nearest relative wishes to pursue this, the AMHP should suggest that they consult with the doctors to see if they would be prepared to provide recommendations.

14.102 Where the AMHP has considered a patient's case at the request of the nearest relative, the reasons for not applying for the patient's admission must be given to the nearest relative in writing. Such a letter should contain, as far as possible, sufficient details to enable the nearest relative to understand the decision while at the same time preserving the patient's right to confidentiality.

Action when it is decided not to apply for admission

14.103 There is no obligation on an AMHP or nearest relative to make an application for admission just because the statutory criteria are met.

14.104 Where AMHPs decide not to apply for a patient's detention they should record the reasons for their decision. The decision should be supported, where necessary, by an alternative framework of care or treatment (or both). AMHPs should decide how to pursue any actions which their assessment indicates are necessary to meet the needs of the patient. That might include, for example, referring the patient to social, health or other services.

14.105 The steps to be taken to put in place any new arrangements for the patient's care and treatment, and any plans for reviewing them, should be recorded in writing and copies made available to all those who need them (subject to the normal considerations of patient confidentiality).

14.106 It is particularly important that the patient's care co-ordinator (where they require support under the care programme approach (CPA) – see chapter 34) is fully involved in decisions about meeting the patient's needs.

14.107 Arrangements should be made to ensure that information about assessments and their outcome is passed to professional colleagues where appropriate, eg where an application for admission is not immediately necessary but might be in the future. This information will need to be available at short notice at any time of day or night.

14.108 More generally, making out-of-hours services aware of situations that are ongoing – such as when there is concern for an individual but no assessment has begun or when a person has absconded before an assessment could start or be completed – assists out-of-hours services in responding accordingly.

Resolving disagreements

14.109 Sometimes there will be differences of opinion between professionals involved in the assessment. There is nothing wrong with disagreements: handled properly these offer an opportunity to safeguard the interests of the patient by widening the discussion about the best way of meeting their needs. Doctors and AMHPs should be ready to consult other professionals, especially care co-ordinators and others involved with the patient's current care, and to consult carers and family, while retaining for themselves the final responsibility for their decision. Where disagreements do occur, professionals should ensure that they discuss these with each other.

14.110 Where there is an unresolved dispute about an application for detention, it is essential that the professionals do not abandon the patient. Instead, they should explore and agree an alternative plan – if necessary on a temporary basis. Such a

plan should include a risk assessment and identification of the arrangements for managing the risks. The alternative plan should be recorded in writing, as should the arrangements for reviewing it. Copies should be made available to all those who need it (subject to the normal considerations of patient confidentiality).

Responsibilities of approving bodies for doctors approved under section 12

14.111 The Secretary of State for Health's functions of approving medical practitioners under section 12(2) of the Act are exercised by the approving bodies listed on the gov.uk website. Medical practitioners who are approved clinicians under the Act are automatically treated as being approved under section 12 as well.

14.112 Approving bodies should:

- take active steps to encourage doctors, including GPs and those working in prison health services and police services, to apply for approval, and
- ensure that the up-to-date list of approved doctors and details of their availability are available to all those who may need them, including GPs, providers of hospital and community mental health services and social services. There is now an online national Section 12/Approved Clinician register in England available to providers, AMHPs and others.[10]

Co-operation between local agencies

14.113 NHS commissioners, NHS-funded providers and local authorities should co-operate in ensuring that there are opportunities for regular communication 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. NHS commissioners, NHS-funded providers and local authorities should also keep in mind the interface with the criminal justice agencies, including the probation service and the police.

14.114 Opportunities should also be sought to involve and learn directly from people with experience of being assessed (patients and former patients), their carers, family and advocates.

Patients who are deaf

14.115 AMHPs and doctors assessing a deaf person should, wherever possible, have had deaf awareness training, including basic training in issues relating to mental health and deafness. Where required, they should also seek assistance from specialists with appropriate expertise in mental health and deafness. This may be

[10] Instructions for Approving Doctors and Clinicians under the Mental Health Act 1983. Department of Health. 2013. https://www.gov.uk/government/publications/mental-health-act-exercise-of-approval-instructions-2013

available from one of the specialist hospital units for deafness and mental health. Contact with such units may, in particular, help to prevent deaf people being wrongly assessed as having a learning disability or another mental disorder.

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

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

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

14.119 Cultural issues need to be taken into account, for instance in people who are pre-lingually deaf, as they have a visual perspective of the world and may consider themselves to be part of a cultural and linguistic minority. This means that they may behave in ways which are misperceived as evidence of mental disorder. For example, animated signing may be misunderstood as aggression, while touching a hearing person to talk to them may be misunderstood as an assault. A deaf person's spoken or written English may be poor, giving rise to a false assumption of thought disorder.

Patients with dementia

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

14.121 Generally, people who have dementia present a range of behaviours:

- dementia is generally progressive, meaning symptoms gradually get worse over time. How quickly it progresses varies from person to person
- people with dementia experience memory loss, have problems recalling things that happened recently and can sometimes repeat themselves

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

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

14.123 Where possible, professionals with specialist skills and knowledge to support people who have dementia should be involved in any decision to use the Act. Professionals working in hospital or the community to support patients who have dementia should have appropriate skills, knowledge and expertise, or be able to acquire these, to support patients with dementia effectively.

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

14.125 Individuals identified by various local agencies as having dementia may never have had a thorough clinical assessment and diagnosis. Professionals should use validated assessment tools, eg Mini Mental State Examinations, to conduct such an assessment and diagnosis.

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

14.126 Section 48 of the Act empowers the Secretary of State for Justice to direct the removal from custody to hospital of individuals who are detained under particular provisions of the Immigration Act 1971 or under section 62 of the Nationality Immigration and Asylum Act 2002,[11] who are suffering from a mental disorder of a nature or degree which makes it appropriate for them to be detained in a hospital, are in need of urgent medical treatment and where appropriate medical treatment is available. Section 53 makes further provision in relation to such detainees and

[11] Immigration Act 1971. http://www.legislation.gov.uk/ukpga/1971/77/contents
Section 62 of the Nationality Immigration and Asylum Act 2002. http://www.legislation.gov.uk/ukpga/2002/41/section/62

their transfer to hospital or back to custody, and when a transfer direction ceases to have effect.[12]

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

14.128 Professionals should be aware that immigration detainees may be particularly vulnerable patients – for example, they may be victims of violence, war or torture; they may have limited access to friends or relatives to support them and they may need additional support, eg interpretation services. Consideration should be given to any special support they might require as a result of their background, including their culture, ethnicity or religion. Consideration should also be given to why they may behave in certain ways (eg why they might be unwilling to disclose mental health problems).

14.129 Due consideration should be given to appropriate discharge planning and care following the discharge of a patient from an in-patient setting, including if they are returning to an immigration removal centre.

Related material

- Mental Capacity Act 2005. http://www.legislation.gov.uk/ukpga/2005/9/contents
- Mental Capacity Act 2005. Code of Practice. Department for Constitutional Affairs (now Ministry of Justice). The Stationery Office. 2007. https://www.gov.uk/government/publications/mental-capacity-act-code-of-practice
- Mental Capacity Act 2005: Deprivation of Liberty Safeguards – Code of Practice to supplement the main Mental Capacity Act 2005 Code of Practice. 2008. http://webarchive.nationalarchives.gov.uk/20130107105354/http:/www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_085476
- Care Act 2014. http://www.legislation.gov.uk/ukpga/2014/23/contents/enacted
- European Convention on Human Rights. http://www.echr.coe.int/Documents/Convention_ENG.pdf
- Quality Standard for Supporting People to Live Well with Dementia. National Institute for Health and Care Excellence quality standard 30. https://www.nice.org.uk/guidance/qs30
- Dementia Pathway. National Institute for Health and Care Excellence. http://pathways.nice.org.uk/pathways/dementia

This material does not form part of the Code. It is provided for assistance only.

[12] See Reference Guide to the Mental Health Act 1983. Department of Health. 2015. https://www.gov.uk/government/publications/reference-guide-to-the-mental-health-act-1983

15 Emergency applications for detention

Why read this chapter?

15.1 The Act permits an application for detention for assessment to be made under section 4 on the basis of a single medical recommendation, but only in very limited circumstances. This chapter provides guidance on the making of such emergency applications.

Applications for detention for assessment in an emergency

15.2 The Act permits an application for detention for assessment to be made under section 4 on the basis of a single medical recommendation, but only in very limited circumstances. An application for detention under section 4 may be made only when:

- the criteria for detention for assessment under section 2 are met
- the patient's detention is required as a matter of urgent necessity, and
- obtaining a second medical recommendation would cause undesirable delay.

15.3 An application under section 4 may be made only if the applicant has seen the patient personally within the previous 24 hours. Otherwise, the duties of approved mental health professionals (AMHPs) in respect of applications are the same as for applications under section 2.

15.4 If the application is made by an AMHP, the nearest relative should be informed at the same time, or within a reasonable time afterwards, unless the patient requests otherwise (or does not have a nearest relative). The circumstances detailed in paragraph 14.62 should be considered in deciding whether to inform the nearest relative against the patient's wishes.

15.5 The guidance given in chapter 14 about the way in which assessments should be carried out applies equally to applications under section 4 (except, of course, that there will only be one doctor involved).

Urgent necessity

15.6 Section 4 should be used only in a genuine emergency, where the patient's need for urgent assessment outweighs the desirability of waiting for a second doctor.

15.7 Section 4 should never be used for administrative convenience. So, for example, patients should not be admitted under section 4 merely because it is more convenient for the second doctor to examine the patient in, rather than outside, hospital.

15.8 An emergency may arise where the patient's mental state or behaviour presents problems which those involved cannot reasonably be expected to manage while waiting for a second doctor. To be satisfied that an emergency has arisen, the person making the application and the doctor making the supporting recommendation should have evidence of:

- an immediate and significant risk of mental or physical harm to the patient or to others
- danger of serious harm to property, or
- a need for the use of restrictive interventions on a patient (see chapter 26).

Availability of second medical recommendation

15.9 It is the responsibility of clinical commissioning groups (and the NHS Commissioning Board) to ensure that doctors are available in a timely manner to examine patients under the Act when requested to do so by AMHPs and in other cases where such an examination is necessary.

15.10 If AMHPs find themselves having to consider making emergency applications because of difficulties in securing a second doctor, they should report that to the local authority on whose behalf they are acting (or in accordance with other agreed arrangements, if they are different). The local authority should review this issue promptly with the relevant NHS commissioner (see paragraph 14.80 on locally agreed policies).

15.11 Hospital managers and local authorities should monitor the use of section 4 to ensure that it is not misused and to allow action to be taken to rectify any problems with the availability of doctors.

Admission under section 4

15.12 The authority to transport a patient to hospital and to start their detention there on the basis of an emergency application lasts only for 24 hours from the last time at which the doctor examined the patient for the purposes of the application, or from the time the application is made – whichever is the earlier. A patient may then be detained only for a maximum of 72 hours unless a second medical recommendation is provided to the hospital managers in accordance with the Act.

15.13 Patients admitted under section 4 should be examined by an appropriate second doctor as soon as possible to decide whether they should continue to be detained. If the doctor making the recommendation for the section 4 application was not a doctor approved under section 12, the Act requires the doctor making the second recommendation to be so approved.

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15.14 Patients detained on the basis of emergency applications who have the capacity to consent to or refuse treatment may not be treated without their consent under part 4 unless or until the second medical recommendation is received. Until then they are in exactly the same position as patients who are not detained under the Act in respect of the rules for consent to treatment. Patients detained under section 4 who lack capacity to consent to treatment may be treated under the Mental Capacity Act (MCA) if it is deemed to be in their best interests and within the scope of the MCA.

15.15 An application for detention for treatment under section 3 of the Act may be made while a patient is detained under section 4 – but two fresh medical recommendations would be required.

15.16 It should also be borne in mind that a person who is removed to a place of safety may already be on a community treatment order (CTO) (chapter 29), conditional discharge (chapter 22) or leave of absence (chapter 27), or might be absent without leave (chapter 28) and that they may need to be recalled or returned to hospital. If it becomes apparent that this is the case, the professionals assessing the patient should make an effort to contact the patient's responsible clinician as soon as possible.

15.17 Where the person is known to be on a CTO and compulsory admission is indicated, the recall power should be used (see chapter 29). An application for detention should not be made in respect of a person who is known to be on a CTO.

16 Police powers and places of safety

Why read this chapter?

16.1 Under the Act, police officers have a power to enter private premises with a warrant and temporarily remove people to a place of safety, and a power to remove persons from public places to a place of safety, provided that specified criteria are met. This chapter gives guidance on obtaining a warrant, the need for agreed local policies, the definition of a place of safety, transfer of patients between places of safety, and assessment.

16.2 Approved mental health professionals (AMHPs), doctors and police officers should, in particular, be aware of the guidance given in this chapter.

Section 135: warrant to search for and remove patients

Section 135(1) warrant

16.3 The purpose of a section 135(1) warrant is to provide police officers with a power of entry to private premises, for the purposes of removing the person to a place of safety for a mental health assessment or for other arrangements to be made for their treatment or care. The warrant must be applied for by an AMHP and can be granted by a magistrate when the person is believed to be suffering from mental disorder and is being ill-treated, neglected or kept otherwise than under proper control, or is living alone and unable to care for themselves.

16.4 The warrant gives any police officer the right to enter the premises, by force if necessary. The police officer may remain even if asked to leave, and may also search the premises for the person believed to be suffering from a mental disorder. When acting on the warrant, the officer must be accompanied by an AMHP and a doctor. It may be helpful if the doctor who accompanies the police officer is approved for the purposes of section 12(2) of the Act. A person should be told the reasons for the removal before they are removed. The police officer may then remove the person to a place of safety, where they can be detained for up to 72 hours from the time of their arrival.

16.5 Where it is reasonably practicable, the intended place of safety should be identified, and the necessary arrangements made, before a warrant is applied for under section 135(1). Proper planning should ensure that it is not necessary to use a police station as a place of safety for people removed under section 135(1), other than in the exceptional circumstances described in paragraph 16.38.

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16.6 Before the execution of the warrant, the AMHP should contribute to any assessment of the risk presented by the person that is carried out by the police, in order to plan to mitigate the risks identified and to help to keep that person safe during the process of their assessment or removal.

16.7 Following entry under section 135(1), the AMHP and doctor between them should determine whether the person needs to be taken to a place of safety for further assessment or for arrangements to be made for their treatment or care. The power to detain a person under section 135(1) ceases once an application for further detention has been made under the Act, other arrangements have been made for their treatment or care, or it has been decided that no further action is to be taken in respect of the person.

16.8 The AMHP and the doctor may convene a mental health assessment in the person's home if it is safe and appropriate to do so and the person consents to this. In taking this decision, consideration should be given as to who else is present, particularly if a person might be distressed by the assessment taking place in these circumstances.

16.9 Local authorities should ensure that guidance to AMHPs on how and when to apply for a warrant is also available to the relevant partner agencies (including the relevant local authority and police force).

16.10 Local authorities and hospital managers should ensure that there are procedures in place for obtaining warrants, both during and outside court hours. These procedures should describe the necessary processes, the evidence which individuals may be reasonably expected to produce, and the documents that should be prepared to help the process run smoothly and quickly.

16.11 Magistrates have to be satisfied that it is appropriate to issue a warrant. They are likely to ask applicants why they are applying for a warrant, whether reasonable attempts to enter without a warrant have been made and, if not, why not. Although it is not necessary for permission to enter to have been refused in order for a section 135(1) warrant to be granted, applicants should provide documented reasons for seeking a warrant if they have not already tried to gain access.

16.12 Magistrates should ensure that section 135 warrants can be granted in a timely way, taking into account that situations can be very urgent and that it should be possible to grant a warrant outside of normal business hours.

16.13 Reliance upon section 135 to gain entry in an emergency situation may be inappropriate due to the time it can take to obtain the necessary warrant. The police may use their power of entry under Section 17(1)(e) of the Police and Criminal Evidence Act 1984 (PACE)[1] for the purposes of saving life or limb or preventing serious damage to property: however this does not confer on the police any power to remove the person to a place of safety or to detain them.

[1] Section 17(1)(e) of the Police and Criminal Evidence Act 1984. http://www.legislation.gov.uk/ukpga/1984/60/section/17

Section 135(2) warrant

16.14 The purpose of a section 135(2) warrant is to provide police officers with a power of entry to private premises for the purposes of removing a patient who is liable to be taken or returned to hospital or any other place or into custody under the Act. The warrant must be granted by a magistrate. It enables a police officer to enter the premises, search for, and remove the patient so they can be taken to, or returned to, where they ought to be. Such a warrant may be used, for example to help return a patient who has absconded, or who needs to be transported to hospital, if access to the premises where they are staying has been refused or is likely to be refused. (See chapter 28 for detailed guidance on patients who are absent from hospital without leave.)

16.15 When a warrant issued under section 135(2) is being used, it is good practice for the police officer to be accompanied by a person with authority from the managers of the relevant hospital (or local authority, if applicable) to detain the patient and to take or return them to where they ought to be. For patients on a community treatment order (CTO) it is good practice for this person to be a member of the multi-disciplinary team responsible for the patient's care. The patient should be told why they are being detained, taken or retaken, before this happens. See chapters 29 and 31 for further information on CTOs.

16.16 When taking the person to a place of safety on a section 135 warrant, the AMHP, hospital managers or the local authority (as appropriate) should ensure that an ambulance or other transport is available to take the person to the place of safety or to the place where they ought to be, in accordance with a locally agreed policy on the transport of patients under the Act (see chapter 17). It may be helpful for the AMHP to escort the person or meet them on arrival at the place of safety, in order to ensure continuity of care and to provide information for the hand-over. The police should not normally be needed to transport the person or to escort them for a section 135 warrant.

Section 136: mentally disordered people found in public places

16.17 Section 136 is an emergency power which allows for the removal of a person who is in a place to which the public have access, to a place of safety, if the person appears to a police officer to be suffering from mental disorder and to be in immediate need of care or control, if the police officer believes it necessary in the interests of that person, or for the protection of others. The person should then receive a mental health assessment, and any necessary arrangements should be made for their on-going care.

16.18 'A place to which the public have access' includes places to which members of the public have open access, access if a payment is made, or access at certain times of the day. It does not include private premises, such as the person's own place of residence or private homes belonging to others, in which case a section 135 warrant is needed. It is not appropriate to encourage a person outside in order to use section 136 powers. Section 135 should be used if the person is in private premises.

16.19 A police officer may use section 136 if they encounter the person in a public place, including if they are already on scene, responding to a call, are approached, or otherwise come into contact with the person.

16.20 The police should not be called to a hospital ward to use their section 136 powers. If the person is already an in-patient in hospital, a nurse, doctor or approved clinician should instead use their holding powers under section 5 if it is considered necessary to detain the person (see chapter 18). It may be appropriate for the police to attend a hospital if the person is in the grounds, or another public part of the hospital, such as a part of the accident and emergency department to which the public have access, in which case they may use section 136.

16.21 Section 136 is not intended to be used as a way to gain access to mental health services and the person should be encouraged to take a route via primary care services, or to contact local mental health community services. A police officer may, without the use of section 136 powers, decide to escort a person who is voluntarily seeking urgent mental healthcare to an appropriate service.

16.22 When considering the use of police powers to detain people under the Act, less restrictive alternatives to detention should be considered. Health and/or social care professionals may be able to identify alternative options. For example, with the person's consent, the police, or any other qualified person may convene a mental health assessment without using section 135 or section 136 powers, by requesting that a section 12-approved doctor attend in order to assess the person and make any arrangements for their on-going care. Where appropriate, and depending on specific circumstances, consultation with carers may help, particularly in the case of children and young people. Health and social care professionals, and the police, should have regard to the principles of the Mental Capacity Act 2005 (see chapter 13 for more information).

16.23 When deciding that detention may be necessary, the police may also benefit from seeking advice before using section 136 powers in cases where they are unsure that the circumstances are sufficiently serious for using these powers. Local protocols should set out how this advice can be provided and who the police should contact, including outside of normal business hours.

16.24 The use of physical restraint or force may be required when removing a person, or in a place of safety, for the protection of the person or others (such as the public, staff or patients). If physical restraint is used, it should be necessary and unavoidable to prevent harm to the person or others, and be proportionate to the risk of harm if restraint was not used. The least restrictive type of restraint should be used. There should be a clear local protocol about the circumstances when, very exceptionally, police may be asked to use physical restraint in a health-based place of safety. For definitions of restraint and guidance on the use of restraint in hospital see chapter 26.

16.25 The purpose of removing a person to a place of safety in these circumstances is only to enable the person to be examined by a doctor and interviewed by an AMHP, so that the necessary arrangements can be made for the person's care and treatment. It is not a substitute for an application for detention under the Act, even if it is thought that the person will need to be detained in hospital only for a short time. It should not be used as a substitute for, or affect the use of, other police powers.

16.26 The maximum period a person may be detained under section 136 is 72 hours. In practice, detentions should not need to be this long. The imposition of consecutive periods of detention under section 136 is unlawful. The maximum 72-hour period begins at the time of arrival at the first place of safety (including if the person needs to be transferred between places of safety).

16.27 The person should be assessed by a doctor and interviewed by an AMHP as soon as possible after the person is brought to the place of safety. As soon as practicable after the assessment and interview, the person should either be discharged, informally admitted, further detained under the Act, or other arrangements made for the person's treatment or care in the community. The person may continue to be detained while these arrangements are being made, provided that the maximum period of detention is not exceeded.

16.28 People detained under section 136 are sometimes far from home. Arrangements should be in place so that the police can take a patient to the nearest available health-based place of safety, which should admit the person even when the person resides in another area. Local authorities should also have arrangements in place so that the nearest AMHP can attend, although consideration should always be given to whether an AMHP from the person's home authority, with the benefit of local knowledge and understanding of any relevant history, could reasonably travel to assess the person. These arrangements should also ensure that, when a place of safety serves an area that includes more than one local authority, the relevant AMHP services work together to ensure continuity of care and timely attendance.

16.29 Police should generally use section 135 or 136, rather than their common law power of arrest for breach of the peace, when the person appears to be suffering from mental disorder which makes it necessary for them to be taken to a place of safety.

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Local policies on use of police powers and places of safety

16.30 Local authorities, NHS commissioners, hospitals, police forces and ambulance services should have local partnership arrangements in place to deal with people experiencing mental health crises. The objective of local partnership arrangements is to ensure that people experiencing mental health crises receive the right medical care from the most appropriate health agencies as soon as possible. The police will often, due to the nature of their role, be the first point of contact for individuals in crisis, but it is crucial that people experiencing mental health crises access appropriate health services at the earliest opportunity.

16.31 It is also important to ensure that a jointly agreed local policy is in place governing all aspects of the use of section 135 and section 136. Good practice depends on a number of factors. For example:

- local authorities, hospitals, NHS commissioners, police forces and ambulance services should ensure that they have a clear and jointly agreed policy for use of the powers under sections 135 and 136, as well as the operation of agreed places of safety within their localities
- all professionals involved in implementation of the powers should understand them and their purpose, the roles and responsibilities of other agencies involved, and follow the local policy
- professionals involved in implementation of the powers should receive the necessary training to be able to carry out fully the role ascribed to their agency
- the parties to the local policy should meet regularly to discuss its effectiveness in the light of experience and review the policy where necessary, and
- partner agencies should decide when relevant information about specific cases can be shared between them for the purposes of safeguarding the person and the protection of others, if there is thought to be a risk of harm.

16.32 The policy should define responsibilities for:

- commissioning and providing sufficient safe and secure health-based places of safety, including for people under the age of 18
- identifying and agreeing the most appropriate places of safety in local areas, including contingency arrangements for those cases where the preferred place of safety is not available. This should ensure that local agency boundaries are not an overriding constraint, and that there are arrangements to ensure children and young people can access a place of safety in their local area
- escalating and reviewing decisions, particularly in the event of disagreement
- providing prompt assessment (including how soon the doctor and AMHP should attend) and, where appropriate, admission to hospital for further assessment or treatment

- securing the attendance of police officers at health-based places of safety, where appropriate, for the patient's health or safety or the protection of others
- the safe, timely and appropriate transport of the person to and between places of safety (bearing in mind that hospital or ambulance transport will usually be preferable to police transport, which should only be used exceptionally, such as in cases of extreme urgency or where there is an immediate risk of violence)
- deciding whether it is appropriate to transfer the person from the place of safety to which they have been taken to another place of safety (see paragraphs 16.53 – 16.58)
- ensuring that people who are intoxicated can be safely managed in any place of safety or an emergency department, and receive an assessment of both their physical and mental health needs. Intoxication should not be used as a basis for excluding people from particular places of safety, except in the circumstances outlined in the policy such as where the patient's current behaviour clearly indicates that there may be a risk to their own safety, or that of the staff, which cannot be safely managed in the health-based place of safety.
- ensuring that people who are behaving, or have behaved, violently can be safely managed in a place of safety taking into account the needs of the person and the safety of staff and others
- arranging access to a hospital emergency department for assessment for people who need it, and having an agreed list of circumstances when this will be necessary, such as where a person is self-harming, has a high body temperature or physical injury
- record keeping (see paragraphs 16.59 – 16.62) and monitoring (see paragraphs 16.63 – 16.65) and audit of practice against policy
- the release, transport and follow-up of people assessed under section 135 or 136 who are not then admitted to hospital or immediately accommodated elsewhere, and
- preparing multi-agency care plans for people who are repeatedly detained under section 136.

16.33 Responsibilities should be allocated to those who are best placed to discharge them, bearing in mind the different purposes for which health and social services and the police service exist. Local policies should ensure that police officers know who to contact prior to the removal of a person to a place of safety under section 136, in order to help secure their acceptance into a health-based place of safety.

16.34 Such policies should cover arrangements for police officers to remain in attendance when a person arrives at a health-based place of safety. Healthcare staff, including ambulance staff, should take responsibility for the person as soon as possible, including preventing the person from absconding before the assessment can be carried out. The police officer should not be expected to remain until the assessment is completed; the officer should be able to leave when the situation is agreed to be safe for the patient and healthcare staff.

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16.35 Such policies may be best maintained by the establishment of a liaison committee, which might also take responsibility for examining the processes in place for other multi-agency tasks, such as transport of persons under the Act and policies in respect of patients who go absent without leave.

Places of safety

16.36 The locally agreed policy should contain a list of identified places of safety. The process for identifying the most appropriate place of safety to which a particular person is to be removed should be clearly outlined in the local policy. This should be a hospital or other health-based place of safety where mental health services are provided. Health-based places of safety should ensure that they have arrangements in place to cope with periods of peak demand, for example using other suitable parts of a hospital, neighbouring health-based places of safety, or alternative places of safety.

16.37 Other options which might be appropriate to the individual's needs should be considered, for example a residential care home or the home of a relative or friend of the person who is willing to accept them temporarily. There is nothing that precludes other areas of a psychiatric hospital (such as a ward) being used as a temporary place of safety, provided that it is a suitable place and it is appropriate to use that place in the individual case.

16.38 A police station should not be used as a place of safety except in exceptional circumstances, for example it may be necessary to do so because the person's behaviour would pose an unmanageably high risk to other patients, staff or other users if the person were to be detained in a healthcare setting. A police station should not be used as the automatic second choice if there is no local health-based place of safety immediately available.

16.39 If, exceptionally, a police station is used, the locally agreed policy should set out the time within which the appropriate health and social care professionals will attend the police station to assess the person or to assist in arranging to transfer them to a more suitable place of safety.

16.40 Although the Act provides a limit of 72 hours for detention under section 136, when a police station is used as a place of safety in the absence of a health-based place of safety being available, an assessment should be made as quickly as possible and made a priority by the doctor and AMHP (see paragraphs 16.47 and 16.49 below). Alternatively, a transfer to a more appropriate place of safety should be made as soon as one becomes available unless it is clearly in the best interests of the person not to move them. Wherever practicable, detention in a police station under section 136 should not exceed a maximum period of 24 hours.

16.41 People taken to a health-based place of safety should be transported there by an ambulance or other health transport arranged by the police who should, in the case of section 136, also escort them in order to facilitate hand-over to healthcare staff.

16.42 If, in exceptional circumstances, a police officer needs to take a person to an emergency department after detaining that person under section 136, for example because emergency medical assessment or treatment is required, the emergency department should provide a safe and suitable place for immediate care for that person.

16.43 In identifying the most appropriate place of safety for an individual, consideration should be given to the impact that the proposed place of safety (and the journey to it) may have on the person and on their examination and interview. It should always be borne in mind that the use of a police station can give the impression that the person detained is suspected of having committed a crime. This may cause distress and anxiety to the person concerned and may affect their co-operation with, and therefore the effectiveness of, the assessment process. In the event that a person is taken to a police station, it should be clearly explained to them that they are not suspected of any crime or other wrongdoing, and they are being kept there until they can be assessed to see if they need any care or treatment.

16.44 Where an individual is removed to a place of safety by the police, the following apply:

- where the place of safety is a hospital, the police should make contact as soon as is practicable with the hospital and local authority (or the people arranging AMHP services on its behalf) before the person's arrival at the place of safety. This will allow arrangements to be made for the person to be interviewed and examined as soon as possible. Where a warrant has been issued under section 135, these arrangements should, wherever possible, have been made in advance by the AMHP, the hospital or any other organisation responsible for the person
- where a hospital is used as a place of safety, it is a local decision whether the person is admitted to a bed on arrival or whether that happens only after they have been interviewed and examined
- where a police station is to be used as the place of safety, the police should make contact quickly with the local authority (or its AMHP service) and with an appropriate doctor. This will enable the examination and interview to be conducted as quickly as possible, thus ensuring that the person spends no longer than necessary in police custody before being allowed to leave or taken 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
- intoxication (whether through drugs or alcohol) should not be used as a basis for exclusion from places of safety, except in circumstances set out in the local policy, where there may be too high a risk to the safety of the individual or staff. Health-based places of safety should not be conducting tests to determine intoxication as a reason for exclusion, and

- a child or young person should not be taken to a place of safety in a police station unless, having regard to the best interests of the child or young person, there is no suitable alternative available. If this occurs, consideration should also be given to using a different part of a police station or other place under the supervision of a police officer and not a police custody suite.

Assessment at a place of safety

16.45 The same care should be taken in examining and interviewing people in places of safety as in any other assessment. No assumptions should be made about them simply because the police have been involved, nor should they be assumed to be in any less need of support and assistance during the assessment. Guidance in chapters 14 and 15 on assessment applies in these circumstances as in any others.

16.46 Doctors examining patients should, wherever possible, be approved under section 12 of the Act. Where the examination has to be conducted by a doctor who is not approved under section 12, the doctor concerned should record the reasons for that.

16.47 Assessment by the doctor and AMHP should begin as soon as possible after the arrival of the individual at the place of safety. In cases where there are no clinical grounds to delay assessment, it is good practice for the doctor and AMHP to attend within three hours; this is in accordance with best practice recommendations made by the Royal College of Psychiatrists. Where possible, the assessment should be undertaken jointly by the doctor and the AMHP.

16.48 If possible, either a consultant psychiatrist in learning disabilities or an AMHP with knowledge and experience of working with people with learning disabilities should be available to make the assessment where it appears that the detained person has a learning disability.

16.49 Where the person detained is under the age of 18, or is known to have moved recently to adult mental health services, they should be taken to an appropriate place of safety (see paragraph 19.105), where either a child and adolescent mental health services (CAMHS) consultant or an AMHP with knowledge and experience of caring for this age group should undertake the assessment. If arranging for a CAMHS specialist to assess the person would result in a substantial delay, then those assessing the person should at least discuss the case with an appropriately qualified person. Where there is no local place of safety specifically for under 18s, the local health-based place of safety should be used.

16.50 The authority to detain a person under section 135(1) or 136 ends as soon as the assessment has been completed and suitable arrangements have been made. This may include detention under part 2 of the Act, informal admission, an offer of community treatment or other arrangements necessary for a safe discharge

including necessary social arrangements. If a doctor assesses the person and concludes that the person is not suffering from a mental disorder then the person must be discharged, even if not seen by an AMHP.

16.51 If the doctor sees the person first and concludes that they have a mental disorder and that compulsory admission to hospital is not necessary, but that they may still need treatment or care (whether in or out of hospital), the person should still be seen by an AMHP. The AMHP should consult the doctor about any arrangements that might need to be made for the person's treatment or care.

16.52 It is important to remember that the definition of mental disorder is wide and includes personality disorder (see chapter 2). If the assessment by a doctor reveals that the person is not suffering from a mental disorder, but there are physical symptoms which require treatment, then the person should be released and appropriate steps taken to manage the physical condition.

Transfer between places of safety

16.53 A person removed to a place of safety under section 135(1) or section 136 may be moved to a different place of safety within the maximum 72-hour period for which they may be detained. Transfers should take place only when it is in the person's best interests. The maximum period of detention begins from the time of the person's arrival at the first place of safety to which they are taken and cannot be extended if the person is transferred to another place of safety.

16.54 The person may be taken to the second or subsequent place of safety by transport arranged by a police officer, the AMHP or a person authorised by either a police officer or the AMHP.

16.55 A person may be transferred before their assessment has begun, while it is in progress, or after it is completed and they are waiting for any necessary arrangements for their care or treatment to be put in place. If it is unavoidable, or it is in the person's interests, an assessment begun by one AMHP or doctor may be taken over and completed by another, either in the same location or at another place to which the person is transferred.

16.56 Although it may be helpful for local policies to outline circumstances in which a person is usually to be transferred between places of safety, the decision in each case should reflect the individual circumstances, including the person's needs and the level of risk. For example, where the purpose of the transfer would be to move a person from a police station to a more appropriate health-based place of safety, the benefit of that move needs to be weighed against any delay it might cause in the person's assessment and any distress that the journey might cause them. Any delays resulting from transferring the person cannot result in an overall period of detention which exceeds 72 hours.

16.57 Unless it is an emergency, a person should not be transferred without the agreement of an AMHP, a doctor or another healthcare professional who is competent to assess whether the transfer would put the person's health or safety (or that of other people) at risk. Someone with the authority to effect a transfer should proceed by agreement wherever possible. It is for those professionals to decide whether they first need to see the person personally.

16.58 A person should never be moved from one place of safety to another unless it has been confirmed that the new place of safety is willing and able to accept them.

Record keeping

16.59 A record of the person's time of arrival must be made immediately when they reach the place of safety. As soon as detention in a place of safety under section 135(1) or 136 ends, the individual must be told that they are free to leave by those who are detaining them. The organisation responsible for the place of safety should ensure that proper records are kept of the end of the person's detention under these sections. In cases where alternative places of safety are used (such as the home of a relative or friend), local policies should define responsibilities to ensure that proper records are kept of the time of arrival, and the time the detention ends.

16.60 Given that the maximum period of detention at a place of safety is not affected by any subsequent transfer to a different place of safety (see paragraph 16.26 above), it is very important to ensure that the time of arrival at the first place of safety is recorded clearly. This information should be shared between the transferring and receiving place of safety in the event of a transfer.

16.61 When admitted to a place of safety in a hospital, a record of the admission, and of the outcome of the assessment, should be made by the hospital. Where persons who do not work for the hospital undertake the assessment, local procedures should be in place to ensure good record keeping.

16.62 If a person is excluded from a place of safety in a hospital and taken to a police station as a place of safety a record should be made of the decision, of who made the decision, and the reason it was made.

Monitoring use of the Act to remove people

16.63 The locally agreed policy should include arrangements for the use of section 136 (in particular) to be monitored effectively so that:

- a check can be made of the circumstances and outcomes of its use, including in relation to people from black and minority ethnic communities, children and young people, and with people with protected characteristics as defined under the Equality Act 2010 (see chapter 3), and

- the parties to the policy can consider any changes to the mental health services or police operations or any other matters that might result in a reduction of its use.

16.64 The local policy should address who is responsible for collecting, analysing, and disseminating the information required for monitoring purposes. Although information systems (and definitions) may differ between organisations, efforts should be made to ensure that the most important data for monitoring purposes is collected in a way that allows it to be analysed so that it is of use to all the parties to the policy.

16.65 It should also set the expected time limits within which the assessment at a place of safety should commence, and the relevant NHS bodies and local authorities should review local practice against these targets.

Rights of people detained in places of safety

16.66 The PACE Code of Practice C applies to persons removed to a police station as a place of safety under sections 135 and 136 (with the exception of section 15 of Code C). This provides the benefit of many of the safeguards applicable to any person who is in police detention. A person should expect to receive a copy of the Notice of Rights and Entitlements, which states that an individual can tell the police if they want access to a solicitor, if they want someone to be told that they are at the police station, and if they want medical help. It also states that an individual can tell the police that they want to look at the PACE Codes of Practice.[2]

16.67 PACE Code of Practice C also requires an appropriate adult to be available for a person who appears to be mentally disordered or mentally vulnerable, who can be a relative, guardian or other person responsible for their care or custody, someone experienced in dealing with mentally disordered or mentally vulnerable people but who is not a police officer or employed by the police or, failing these, some other responsible adult aged 18 or over who is not a police officer or employed by the police. Although an appropriate adult should be available, they have no role in the doctor's assessment or AMHP's interview of the patient and their presence is not required for these to be undertaken.

16.68 A person detained under section 136 may be searched by the constable to ascertain what they have on them which could be used to harm themselves or others, damage property, or assist them to escape. The constable can hold on to anything found in the search, including clothes and personal effects, which the constable believes the person may use to cause such harm or damage or escape.

16.69 Where a hospital is used as a place of safety, the managers must ensure that the provisions of section 132 (giving of information) are complied with. In addition, access to legal advice should be facilitated whenever it is requested.

[2] Revised code of practice for the detention, treatment and question of persons by Police officers. Police and Criminal Evidence Act 1984 (PACE) – Code C. Home Office. 2014. https://www.gov.uk/government/publications/pace-code-c-2014

16.70 In all cases, the person detained should be told that the maximum period of detention is 72 hours.

16.71 Police and healthcare services should have regard to the Equality Act 2010 when using section 135 and 136 (see chapter 3).

Places of safety and consent to treatment

16.72 Detaining a patient in a place of safety under sections 135 or 136 does not confer any power under the Act to treat them without their consent. In other words, they are in exactly the same position in respect of consent to treatment as patients who are not detained under the Act.

Making necessary arrangements following assessment

16.73 Once the assessment has been concluded, it is the responsibility of the doctors and AMHPs involved to make any necessary further arrangements for the person's treatment or care.

16.74 Where compulsory admission is indicated, the AMHP should arrange for a second doctor to examine the patient in accordance with the Act (unless it has been agreed locally that someone else should make such arrangements).

16.75 It is unlikely that an emergency application would be justified in these circumstances. If there was an urgent need to secure the transfer of the patient to hospital, the power of transfer between places of safety could be used.

16.76 A person who is detained under section 135 or 136 in hospital pending completion of their assessment cannot have their detention extended by use of section 5(2) or section 5(4).

Related material

- Revised code of practice for the detention, treatment and question of persons by Police officers. Police and Criminal Evidence Act 1984 (PACE) – Code C. Home Office. 2014. https://www.gov.uk/government/publications/pace-code-c-2014
- Mental Health Crisis Care Concordat: improving outcomes for people experiencing mental health crisis. Department of Health and Concordat signatories. 2014. https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/281242/36353_Mental_Health_Crisis_accessible.pdf

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17 Transport of patients

Why read this chapter?

17.1 Patients may need to be transported between different locations. This chapter provides information about how patients should be conveyed in a manner that is most likely to preserve their dignity and privacy consistent with managing any risk to their health and safety or to other people, and the factors that should be taken into account.

17.2 Agencies, including NHS commissioners responsible for hospitals and ambulance and transport services, NHS-funded providers and the police, should agree joint local policies to ensure that patients can be conveyed without delay. When transport between hospitals is required, hospital managers should make appropriate arrangements. Guidance is provided on transporting patients to hospital on the basis of an application for detention, transporting patients who abscond and transporting patients who are subject to a community treatment order (CTO) ('community patients') who are recalled to hospital.

General considerations

17.3 Patients should always be transported in the manner which is most likely to preserve their dignity and privacy consistent with managing any risk to their health and safety or to other people. Patients should be informed as soon as possible of the reasons for any planned transfers and their views taken into consideration. They should also be supported, where appropriate, to discuss the planned transfer with carers (who should usually be informed if the patient is under 18, or has a learning disability, autistic spectrum disorder or dementia). A record of these discussions should be made in the patient's notes. Where a patient may lack capacity, professionals should have regard to the principles and provisions of the Mental Capacity Act, see chapter 13.

17.4 If, under exceptional circumstances, a patient is being transported out of area, commissioners should consider whether they can provide any additional assistance as part of the care package to support any carers to visit and contact the patient, and/or encourage the carer to have a carer's assessment (see paragraph 14.85). This is particularly relevant when the patient is a child or young person.

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

- taking patients to hospital to be detained for assessment or treatment
- transferring patients between hospitals
- returning patients to hospital if they are absent without leave
- taking community patients or patients who have been conditionally discharged to hospital on recall

- taking and returning patients who are subject to guardianship to the place in which their guardian requires them to live
- taking patients to, and between, places of safety, and
- taking patients to and from court.

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

- the availability of different transport options
- the distance to be travelled
- the wishes and views of the patient, including any relevant statement of those views or wishes made in advance
- the patient's age and gender
- cultural sensitivities
- any physical disability the patient has
- any risks to the health and safety of the patient – including their need for support, supervision and clinical care or monitoring during the journey. This is particularly important where sedation has been, or may be used
- the nature of the patient's mental disorder and their current state of mind
- the likelihood of the patient behaving in a violent or dangerous manner
- the health and safety of the people transporting the patient and anyone else accompanying them
- the likelihood that the patient may attempt to abscond and the risk of harm to the patient or other people were that to happen
- the impact that any particular method of transporting the patient will have on the patient's relationship with the community to which they will return
- the effect on the patient of who accompanies them (eg whether the presence of the approved mental health professional (AMHP) or one of the doctors involved in the decision to detain them may have a detrimental effect)
- the availability of transport to return those who accompany the patient, and
- whether an alternative to transporting the patient is available and appropriate, eg video conferencing for a court appearance.

Transporting to hospital on the basis of an application for detention

17.7 Patients who have been sedated before being transported should always be accompanied by a health professional who is knowledgeable in the care of such patients, is able to monitor the patient closely, identify and respond to any physical distress which may occur and has access to the necessary emergency equipment to do so.

17.8 A properly completed application for detention under the Act, together with the required medical recommendations, gives the applicant (the AMHP or nearest relative) the authority to transport the patient to the hospital named in the application.

17.9 Where the AMHP is the applicant, they have a professional responsibility to ensure that all the necessary arrangements are made for the patient to be transported to hospital. All relevant agencies should co-operate fully with the AMHP to ensure safe transport to hospital.

17.10 Relevant bodies should ensure locally agreed arrangements are in place (see paragraphs 17.22 – 17.28).

17.11 If the nearest relative is the applicant, any AMHP and other professionals involved in the assessment of the patient should give advice and assistance. However, they should not assist in a patient's detention unless they believe it is justified and lawful.

17.12 AMHPs should make decisions on which method of transport to use in consultation with the other professionals involved, the patient and (as appropriate) their carer. The decision should be made following a risk assessment carried out on the basis of the best available information.

17.13 If the patient is likely to be unwilling to be moved, the applicant will need to provide the people who are to transport the patient (including any ambulance staff or police officers involved) with authority to transport the patient. This will give them the legal power to transport patients against their will, using reasonable force if necessary, and to prevent them absconding en route.

17.14 If the patient's behaviour is likely to be violent or dangerous, the police should be asked to assist in accordance with locally agreed arrangements. Where practicable, given the risk involved, an ambulance service (or similar) vehicle should be used even where the police are assisting.

17.15 The locally agreed arrangements should set out what assistance the police will provide to AMHPs and health services in transporting patients safely, and what support ambulance or other health services will be expected to provide where patients are, exceptionally, transported in police vehicles.

17.16 Where it is necessary to use a police vehicle because of the risk involved, it may be necessary for the highest qualified member of an ambulance crew to ride in the same vehicle with the patient, with the appropriate equipment to deal with immediate problems. In such cases, the ambulance should follow directly behind to provide any further support that is required.

17.17 AMHPs should agree to a patient being transported by private vehicle only if they are satisfied that the patient and others will be safe from risk of harm and that it is the most appropriate way of transporting the person. In these circumstances there should be a medical escort for the patient other than the driver.

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17.18 People authorised by the applicant to transport patients act in their own right and not as the agent of the applicant. They may act on their own initiative to restrain patients and prevent them absconding, if absolutely necessary. When they are the applicant, AMHPs retain a professional responsibility to ensure that the patient is transported in a lawful and humane manner and should give guidance to those asked to assist.

17.19 Patients may be accompanied by another person, provided that the AMHP and the person in charge of the vehicle are satisfied that this will not increase the risk of harm to the patient or others.

17.20 Before patients are moved, the applicant should ensure that the receiving hospital is expecting the patient and has been told the likely time of arrival. If possible, the name of the person who will be formally receiving the patient and their admission documents should be obtained in advance.

17.21 Where the applicant is not travelling in the same vehicle as the patient, the application form and medical recommendations should be given to the person authorised to transport the patient, with instructions for them to be presented to the member of hospital staff receiving the patient.

Locally agreed arrangements

17.22 It is for clinical commissioning groups (CCGs) to commission ambulance and patient transport services to meet the needs of people living in their areas. This includes services for transporting patients to and from hospital (and other places) under the Act.[1]

17.23 CCGs should ensure, through their contracts, that appropriate transport will be made available in a timely manner where it is needed to transport patients under the Act. It is for service providers, whoever they are, to provide those services in accordance with their contracts.

17.24 If the patient is a privately-funded patient, it is for the managers of that hospital to make arrangements for any necessary transport.

17.25 The respective responsibilities of different agencies and service providers for transporting patients in different circumstances should be clearly established locally and communicated to the professionals who need to know.

17.26 In particular, it is essential to have clear agreements in place so that people who need assistance in transporting patients under the Act can obtain it without delay. Agencies, including NHS commissioners responsible for hospitals and ambulance

[1] Local crisis care policies and transport agreements should already be in place in line with the Crisis Care Concordat. Mental Health Crisis Care Concordat: improving outcomes for people experiencing mental health crisis. Department of Health and Concordat signatories. 2014. https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/281242/36353_Mental_Health_Crisis_accessible.pdf

and transport services, NHS-funded providers and the police, should agree joint local policies and procedures. These should include:

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

17.27 Policies should ensure that AMHPs (in particular) are not left to negotiate arrangements with providers of transport services on an ad hoc basis, in the absence of clear expectations about the responsibilities of all those involved.

17.28 Policies should also be consistent with those agreed in relation to the use of the police powers in sections 135 and 136 of the Act (see chapter 16).[2]

Transporting patients between hospitals and returning patients who abscond

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

17.30 Where a patient who is absent without leave from a hospital is taken into custody by someone working for another agency, the managers of the hospital from which the patient is absent are responsible for making sure that any necessary transport arrangements are put in place for the patient's return.

[2] Under the national protocol in the Crisis Care Concordat, from April 2014, ambulance trusts in England agreed that where people are detained under section 136 of the Act they would aim to respond within 30 minutes to make a clinical assessment and arrange transportation to a health-based place of safety or other appropriate place of care.

17.31 The agency which temporarily has custody of the patient is responsible for them in the interim and should assist in ensuring that the patient is returned in a timely and safe manner.

17.32 When making arrangements for the return of patients temporarily held in police custody, hospital managers should bear in mind that police transport to return them to hospital will not normally be appropriate. Decisions about the kind of transport to be used should be taken in the same way as for patients being detained in hospital for the first time.

Transporting patients subject to a CTO who are recalled to hospital

17.33 A notice of recall, properly completed by the responsible clinician and served on the patient in accordance with regulations, provides the authority to transport a patient subject to a CTO to hospital compulsorily, if necessary (see paragraphs 29.54 – 29.58).

17.34 Unless locally it has been agreed otherwise, the responsible clinician has responsibility for co-ordinating the recall process. The factors outlined above at paragraph 17.5, and the urgency of the situation, will need to be considered in deciding the best way to transport the patient to hospital. The guidance above in paragraphs 17.7 – 17.21 about taking patients to hospital when they are first to be detained applies here as well, except that an AMHP will not necessarily be involved.

17.35 A patient subject to a CTO who has been recalled can be transported by any officer on the staff of the hospital to which the patient is recalled, any police officer, any AMHP or any other person authorised in writing by the responsible clinician or the managers of that hospital. The identity of the most appropriate person to transport the patient will depend on the individual circumstances.

Transporting patients subject to part 3 of the Act

17.36 Information on transporting patients subject to part 3 of the Act, including children and young people, is available at paragraphs 22.32 – 22.34.

Related material

- Mental Health Crisis Care Concordat: improving outcomes for people experiencing mental health crisis. Department of Health and Concordat signatories. 2014. https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/281242/36353_Mental_Health_Crisis_accessible.pdf

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18 Holding powers

Why read this chapter?

18.1 This chapter provides guidance about the use of 'holding powers' and how they should be exercised.

18.2 Doctors and approved clinicians have 'holding powers' under section 5(2) of the Act and certain nurses have the same powers under section 5(4) of the Act. This chapter provides guidance on the nature of this power, monitoring its use, the nomination of deputies if necessary, the role of hospital managers, and how patients should be assessed before invoking 'holding powers'. It also provides guidance on the transfer of those subject to this power, to other hospitals.

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

Nature of the power

18.3 The power can be used where the doctor or approved clinician in charge of the treatment of a hospital in-patient (or their nominated deputy) concludes that an application for detention under the Act should be made. It authorises the detention of the patient in the hospital for a maximum of 72 hours so that the patient can be assessed with a view to such an application being made. Decision-makers should always consider whether there are less restrictive alternatives to detention under the Act (chapter 14).

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

18.5 There may be more than one person who could reasonably be said to be in charge of a patient's treatment, eg where a patient is already receiving treatment for both a physical and a mental disorder. In a case of that kind, the psychiatrist or approved clinician in charge of the patient's treatment for the mental disorder is the preferred person to use the power in section 5, if necessary.

18.6 The period of detention starts at the moment the doctor's or approved clinician's report is furnished to the hospital managers (eg when it is handed to an officer who is authorised by the managers to receive it, or when it is put in the hospital's internal mail system).

18.7 In this context, a hospital in-patient means any person who is receiving in-patient treatment in a hospital. It does not apply to a patient who is already liable to be detained under section 2, 3 or 4 of the Act, subject to a community treatment order, or a person who is being kept in a hospital as a place of safety under section 135 or 136. It includes patients who are in hospital by virtue of a deprivation of liberty authorisation under the Mental Capacity Act 2005 (MCA) (see chapter 13). It does not matter whether or not the patient was originally admitted for treatment primarily for a mental disorder. The patient could be receiving in-patient treatment in a general hospital for a physical condition.

18.8 The power cannot be used for an out-patient attending a hospital's accident and emergency department, or any other out-patient. Patients should not be admitted informally with the sole intention of then using the holding power.

18.9 Section 5(2) should only be used if, at the time, it is not practicable or safe to take the steps necessary to make an application for detention without detaining the patient in the interim. Section 5(2) should not be used as an alternative to making an application, even if it is thought that the patient will only need to be detained for 72 hours or less.

18.10 Doctors and approved clinicians should use the holding power only after having personally examined the patient.

18.11 Sometimes a report under section 5(2) may be made in relation to a patient who is not at the time under the care of a psychiatrist or an approved clinician. In such cases, the doctor invoking the power should make immediate contact with a psychiatrist or an approved clinician to obtain confirmation of their opinion that the patient needs to be detained so that an application can be made. If possible, the doctor should seek such advice before using the power.

Nomination of deputies

18.12 Section 5(3) allows the doctor or approved clinician in charge of an in-patient's treatment to nominate a deputy to exercise section 5(2) powers in their absence. The deputy will then act on their own responsibility.

18.13 Only a doctor or approved clinician on the staff of the same hospital may be a nominated deputy (although the deputy does not have to be a member of the same profession as the person nominating them). Only one deputy may be authorised at any time for any patient, and it is unlawful for a nominated deputy to nominate another.

18.14 Doctors should not be nominated as a deputy unless they are competent to perform the role. If nominated deputies are not approved clinicians (or doctors approved under section 12 of the Act), they should wherever possible seek advice from the person for whom they are deputising, or from someone else who is an approved clinician or section 12 approved doctor, before using section 5(2). Hospital managers should see that arrangements are in place to allow nominated deputies to do this.

18.15 Nominated deputies should report the use of section 5(2) to the person for whom they are deputising as soon as practicable.

18.16 It is permissible for deputies to be nominated by title, rather than by name – eg the junior doctor on call for particular wards – provided that there is only one nominated deputy for any patient at any time and it can be determined with certainty who that nominated deputy is.

18.17 Hospital managers should ensure that ward staff know who the nominated deputy for a particular patient is at any given time.

18.18 Doctors and approved clinicians may leave instructions with ward staff to contact them (or their nominated deputy) if a particular patient wants or tries to leave. But they may not leave instructions for their nominated deputy to use section 5, nor may they complete a section 5 report in advance to be used in their absence. The deputy must exercise their own professional judgment.

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

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

Ending section 5(2)

18.20 Although the holding power lasts for a maximum of 72 hours, it should not be used to continue to detain patients after:

- the doctor or approved clinician decides that, in fact, no assessment for a possible application needs to be carried out, or
- a decision is taken not to make an application for the patient's detention.

18.21 Patients should be informed immediately that they are no longer detained under the holding power and are free to leave the hospital, unless, of course, the patient is to be detained under some other authority.

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Holding powers of nurses under section 5(4)

Nature of the power

18.22 Nurses of the 'prescribed class' may invoke section 5(4) of the Act in respect of a hospital in-patient who is already receiving treatment for mental disorder.[1]

18.23 This power may be used only where the nurse considers that:

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

18.24 It can be used only when the patient is still on the hospital premises.

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

18.26 The patient may be detained from the moment the nurse makes the necessary record. The record must then be sent to the hospital managers.

18.27 The decision to invoke the power is the personal decision of the nurse, who cannot be instructed to exercise the power by anyone else.

18.28 Hospital managers should ensure that suitably qualified, experienced and competent nurses are available to all wards where there is a possibility of section 5(4) being invoked, particularly acute psychiatric admission wards and wards where there are patients who are acutely unwell or who require intensive nursing care. Where nurses may have to apply the power to patients from outside their specialist field, it is good practice for hospital managers to arrange suitable training in the use of the power in such situations.

Assessment before invoking section 5(4)

18.29 Before using the power, nurses should assess:

- the likely arrival time of the doctor or approved clinician, as against the likely intention of the patient to leave. It may be possible to persuade the patient to wait until a doctor or approved clinician arrives to discuss it further, and
- the consequences of a patient leaving the hospital before the doctor or approved clinician arrives – in other words, the harm that might occur to the patient or others.

[1] The prescribed classes at the time of publication are nurses registered in sub-parts 1 or 2 of the register maintained by the Nursing and Midwifery Council whose entry in the register indicates that their field of practice is either mental health nursing or learning disabilities nursing. See the The Mental Health (Nurses) (England) Order. 2008. SI 2008/1207. http://www.legislation.gov.uk/uksi/2008/1207/pdfs/uksi_20081207_en.pdf

18.30 In doing so, the nurse should consider:

- the patient's expressed intentions
- the likelihood of the patient harming themselves or others
- the likelihood of the patient behaving violently
- any evidence of disordered thinking
- the patient's current behaviour and, in particular, any changes in their usual behaviour
- the patient's recent communications with family and friends
- whether the date is one of special significance for the patient (eg the anniversary of a bereavement)
- any recent disturbances on the ward
- any relevant involvement of other patients
- any history of unpredictability or impulsiveness
- any formal risk assessments which have been undertaken (specifically looking at previous behaviour), and
- any other relevant information from other members of the multi-disciplinary team.

18.31 Nurses should be particularly alert to cases where patients suddenly decide to leave or become determined to do so urgently.

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

Action once section 5(4) is used

18.33 The reasons for invoking the power should be entered in the patient's notes. Details of any patients who remain subject to the power at the time of a shift change should be given to staff coming on duty.

18.34 The use of section 5(4) is an emergency measure, and the doctor or approved clinician with the power to use section 5(2) in respect of the patient should treat it as such and arrive as soon as possible. The doctor or approved clinician should not wait six hours before attending simply because this is the maximum time allowed.

18.35 If the doctor or approved clinician arrives before the end of the six-hour maximum period, the holding power lapses on their arrival. But if the doctor or approved clinician then uses their own holding power, the maximum period of 72 hours runs from when the nurse first made the record detaining the patient under section 5(4).

18.36 If no doctor or approved clinician able to make a report under section 5(2) has attended within six hours, the patient is no longer detained and may leave if not prepared to stay voluntarily. This should be considered as a serious failing, and should be reported and investigated locally.

General points about using section 5

Recording the end of detention

18.37 The time which a patient ceases to be detained under section 5(2) or 5(4) should be recorded, preferably using a standardised system established by the hospital managers for the purpose. The reason why the patient is no longer detained under the power should be recorded, and what then happened to the patient (eg the patient remained in hospital voluntarily, was discharged, or was detained under a different power).

18.38 Detention under section 5(2) or 5(4) cannot be renewed, but that does not prevent it being used again on a future occasion if necessary.

Monitoring use

18.39 Hospital managers should monitor the use of section 5, including:

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

Information

18.40 Hospital managers must ensure that patients detained under section 5 are given information about their position and their rights as required by section 132 of the Act.

Medical treatment of patients

18.41 Detaining patients under section 5 does not confer any power under the Act to treat them without their consent. The rules in part 4 of the Act do not apply to these patients. In other words, they are in exactly the same position as patients who are not detained under the Act in respect of consent to treatment.

Transfer to other hospitals

18.42 It is not possible for patients detained under section 5 to be transferred to another hospital under section 19 (because they are not detained by virtue of an application made under part 2 of the Act).

18.43 A patient who is subject to section 5(2) of the Act but needs to go to another hospital urgently for treatment, security or other exceptional reasons, can only be taken there if they consent to the transfer. If the patient lacks capacity to consent to the transfer, any transfer must be carried out in accordance with the MCA, including that it is in the person's best interests and any restrictions on the person's liberty are permitted by the MCA.

18.44 If, following transfer, the patient tries to leave the receiving hospital, a new situation will have arisen. In this circumstance, the receiving hospital may need to use section 5(2) to provide authority to detain the patient in that hospital.

18.45 In all cases, if the conditions are met, an emergency application for detention under section 4 of the Act could be made to the sending hospital (see chapter 15). The patient could then be transferred to the receiving hospital under section 19. Alternatively, an emergency application under section 4 could be submitted to the managers of the receiving hospital.

Related material

- Mental Capacity Act 2005. http://www.legislation.gov.uk/ukpga/2005/9/contents
- Mental Capacity Act 2005: Code of Practice. Department for Constitutional Affairs (now Ministry of Justice). 2007. https://www.gov.uk/government/publications/mental-capacity-act-code-of-practice
- Mental Capacity Act 2005: Deprivation of Liberty Safeguards – Code of Practice to supplement the main Mental Capacity Act 2005 Code of Practice. 2008. http://webarchive.nationalarchives.gov.uk/20130107105354/http:/www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_085476

This material does not form part of the Code. It is provided for assistance only.

18

Additional considerations for specific patients

Certain groups of patients require consideration in addition to the general guidance that applies to all patients and is provided elsewhere in this Code. This group of chapters addresses the particular needs of children and young people under the age of 18 and the role of professionals and others responsible for their care. The key issues from the Act and the Mental Capacity Act which are relevant to people with learning disabilities or autistic spectrum conditions are identified and guidance for professionals is provided to ensure independence, dignity and respect.

Guidance is given on the assessment and appropriate medical treatment of people with personality disorders, and guidance is also given on the use of the Act to arrange treatment for people with mental disorders who come into contact with the criminal justice system (part 3 patients).

Chapter 19 Children and young people under the age of 18

Chapter 20 People with learning disabilities or autistic spectrum disorders

Chapter 21 People with personality disorders

Chapter 22 Patients concerned with criminal proceedings

19 Children and young people under the age of 18

Why read this chapter?

19.1 Particular issues arise in relation to children (under 16 years of age) and young people (16 or 17 years old). In addition to the Act, other relevant legislation includes the Children Acts 1989 and 2004, the Mental Capacity Act (MCA) 2005 and the Human Rights Act (HRA) 1998. Professionals, practitioners and others responsible for the care of children and young people should be familiar with this legislation.

19.2 This chapter provides guidance on the role of those with parental responsibility for a child or young person; confidentiality and sharing information; how children and young people should be safeguarded where admission to hospital is not appropriate and on decisions related to admission and treatment. It should be read in conjunction with other chapters in this Code.

19.3 This chapter sets out some of the key factors including:

- some of the main concepts to be considered when providing care and treatment to children and young people, such as 'parental responsibility' and decisions within the 'scope of parental responsibility'[1]
- assessing the competence of children and the capacity of young people to make decisions about their admission and/or treatment
- when informal admission might be appropriate and when the Mental Health Act 1983 (the Act) should be used
- specific provisions relating to the treatment of children and young people under the Act
- the duty to provide age appropriate services
- applications and references to the Tribunal, and
- general duties of local authorities in relation to children and young people in hospital.

[1] The term 'scope of parental responsibility' replaces the term 'zone of parental control' used in the Mental Health Act 1983: Code of Practice. Department of Health. 2008. http://webarchive.nationalarchives.gov.uk/20130107105354/http:/www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_084597

General considerations

19.4 In addition to the Act, those responsible for the care of children and young people in hospital should be familiar with other relevant legislation, including the Children Acts 1989 and 2004, the MCA and the HRA. They should also be aware of the United Nations Convention on the Rights of the Child (UNCRC), and keep up-to-date with relevant case law and guidance.

19.5 When making decisions in relation to the care and treatment of children and young people, practitioners should keep the following points in mind:

- the best interests of the child or young person must always be a significant consideration
- everyone who works with children has a responsibility for keeping them safe and to take prompt action if welfare needs or safeguarding concerns are identified
- all practitioners and agencies are expected to contribute to whatever actions are needed to safeguard and promote a child or young person's welfare
- the developmental process from childhood to adulthood, particularly during adolescence, involves significant changes in a wide range of areas, such as physical, emotional and cognitive development – these factors need to be taken into account, in addition to the child and young person's personal circumstances, when assessing whether a child or young person has a mental disorder
- children and young people should always be kept as fully informed as possible and should receive clear and detailed information concerning their care and treatment, explained in a way they can understand and in a format that is appropriate to their age
- the child or young person's views, wishes and feelings should always be sought, their views taken seriously and professionals should work with them collaboratively in deciding on how to support that child or young person's needs
- any intervention in the life of a child or young person that is considered necessary by reason of their mental disorder should be the least restrictive option and the least likely to expose them to the risk of any stigmatisation, consistent with effective care and treatment, and it should also result in the least possible separation from family, carers, friends and community or interruption of their education
- where hospital admission is necessary, the child or young person should be placed as near to their home as reasonably practicable, recognising that placement further away from home increases the separation between the child or young person and their family, carers, friends, community and school
- all children and young people should receive the same access to educational provision as their peers
- children and young people have as much right to expect their dignity to be respected as anyone else, and
- children and young people have as much right to privacy and confidentiality as anyone else.

19

People with parental responsibility

19.6 Those with parental responsibility have a central role in relation to decisions about the admission and treatment of their child (see paragraphs 19.38 – 19.43 below). It is therefore essential that those proposing the admission and/or treatment identify who has parental responsibility.

19.7 Those with parental responsibility will usually, but not always, be the parents of the child or young person. Other people may also acquire parental responsibility. Where the parents are not married, it will be necessary to ascertain whether the father has gained parental responsibility (this might be by a court order, parental responsibility agreement, or (since 1st December 2003) as a result of the father registering his child's birth jointly with the child's mother).[2] The question whether the father has acquired parental responsibility will also be relevant when ascertaining who is the nearest relative under the Act[3] (see paragraph 5.3 above in chapter 5).

19.8 Those taking decisions under the Act must be clear about who has parental responsibility. When seeking to identify who has parental responsibility for the child or young person, practitioners should always check whether the child or young person's medical and/or social service files include any relevant court orders, and request copies of any such orders. These orders may include care orders, child arrangements orders (which replace residence orders and contact orders),[4] special guardianship orders, evidence of appointment as the child or young person's guardian, parental responsibility agreements or orders under section 4 of the Children Act 1989 and any order under wardship. Practitioners should always check with those caring for the child or young person whether any child arrangements orders, parental responsibility agreements or orders, or special guardianship orders have been obtained.

19.9 Where the parents of a child or young person (both of whom have parental responsibility), are separated and the child or young person is living with one parent in accordance with a child arrangements order (formerly known as a residence order), practitioners should be aware that the parents continue to share parental responsibility and both should be involved in making decisions about their child.

19.10 Where a special guardianship order is in place, the special guardian will share parental responsibility with the child or young person's parents. However, except for certain purposes specified in the Children Act 1989, the special guardian is entitled to exercise parental responsibility to the exclusion of any other person with parental responsibility for the child (apart from another special guardian) (see section 14C of the Children Act 1989).

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[2] For a list of persons who may have parental responsibility see Reference guide to consent for examination or treatment. Department of Health. 2009. https://www.gov.uk/government/publications/reference-guide-to-consent-for-examination-or-treatment-second-edition

[3] Section 26(2)(b) of the Mental Health Act 1983. http://www.legislation.gov.uk/ukpga/1983/20/section/26

[4] Section 12 of the Children and Families Act 2014 amends section 8(1) of the Children Act 1989. http://www.legislation.gov.uk/ukpga/2014/6/section/12/enacted

Children looked after by the local authority

19.11 Where children or young people are looked after by the local authority (see section 22 of the Children Act 1989), it will be important to establish whether they are subject to a care order (or interim care order) or are being voluntarily accommodated by the local authority.

19.12 If a child or young person is voluntarily accommodated by the local authority, parents or others with parental responsibility have the same rights and responsibilities in relation to treatment as they would otherwise. Admission and/or treatment decisions should therefore be discussed with the parent or other person with parental responsibility who continues to have parental responsibility for the child.

19.13 If the child or young person is subject to a care order, the parents (and any others with parental responsibility) share parental responsibility with the local authority. The local authority and those with parental responsibility should negotiate and agree who should be consulted about admission and/or treatment decisions. However, where the local authority is satisfied that it is necessary to do so in order to safeguard or promote the child or young person's welfare, they can limit the extent to which parents (or others) may exercise their parental responsibility (see section 33(3)(b) of the Children Act 1989).

Confidentiality and sharing information

19.14 As with adults, children and young people have a right to confidentiality (see chapter 10). Where children are competent, and young people have the capacity, to make decisions about the use and disclosure of information they have provided in confidence, their views should be respected. (Paragraphs 19.24 – 19.37 below provide guidance on assessing a child's competence and a young person's capacity to decide.) However, as with adults, in certain circumstances confidential information may be disclosed without the child or young person's consent; for example if there is reasonable cause to believe that the child or young person is suffering, or is at risk of suffering, significant harm. Practitioners should be familiar with the Department of Health's *Information Sharing: guidance for practitioners and managers* 2008, which includes guidance on assessing a child or young person's ability to make decisions about sharing information.

19.15 The same principles of confidentiality apply if a child who is competent, or a young person who has capacity, to make a decision regarding the information does not wish their parent (or others with parental responsibility) to be involved in decision-making about their care and treatment. Their decision should be respected unless the disclosure can be justified; for example, if there is cause to suspect that the child or young person is suffering or is likely to suffer, serious harm. Practitioners should encourage the child or young person to involve their parents (unless it is considered that to do so would not be the best interests of the child or young person). They should also be proactive in discussing with the child or young person the consequences of their parent(s) not being involved.

19.16 Where a child or young person does not wish their parent(s) to be involved, every effort should be made to understand the child or young person's reasons with a view to establishing whether the child or young person's concerns can be addressed. For example, the child or young person may be receiving counselling that they do not want their parents to know about, but would be happy for their parents to be informed about more general aspects of their care and treatment. See also paragraph 10.6 on sharing information with carers, relatives and friends, which also applies to people with parental responsibility.

19 Safeguarding children and young people where admission to hospital is not appropriate

19.17 There is no minimum age limit for detention in hospital under the Act. It may be used to detain children or young people who need to be admitted to hospital for assessment and/or treatment of their mental disorder, when they cannot be admitted and/or treated on an informal basis (see paragraphs 19.49 – 19.70 below), and where the criteria for detention under the Act are met.

19.18 Where practitioners conclude that admission to hospital is not the appropriate course of action, consideration must be given to alternative means of care and support that will meet the needs of the child or young person. The appropriate action will usually be to refer the child or young person's case to the relevant local authority's children's services, in accordance with local protocols for interagency working to safeguard and promote the welfare of children and young people.

19.19 In cases where admission to hospital under the Act is not appropriate, but the child or young person has significant needs which mean that the level and type of intervention is likely to amount to a deprivation of liberty, their placement in secure accommodation under section 25 of the Children Act 1989 may be required.[5] This will be a matter for the local authority children's services to consider in the light of the provisions of section 25 of the Children Act 1989, and relevant Children Act 1989 guidance.[6] Children who are not Gillick competent (see paragraphs 19.34 – 19.37) or young people who lack capacity (see paragraphs 19.26 – 19.30) whose needs are severe and long-term, and where deprivation of liberty is one necessary element of their education or care, may also be accommodated in other placements.[6a]

[5] Note that section 25 of the Children Act 1989 refers to 'restricting liberty'. The court held in Re K (A Child (Secure Accommodation Order: Right to Liberty). 2001. Fam 377 that a secure accommodation order is a deprivation of liberty within the meaning of article 5 of the European Convention on Human Rights.

[6] Court orders and pre-proceedings for local authorities. Department of Education. 2014. https://www.gov.uk/government/publications/children-act-1989-court-orders--2

[6a] See by way of example: P v Cheshire West and Chester Council and another and P and Q v Surrey County Council ('Cheshire West'). 2014. WLR 2. https://www.supremecourt.uk/decided-cases/docs/UKSC_2012_0068_Judgment.pdf and Barnsley Metropolitan Borough Council vs GS and ES. 2014. EWCOP 46. http://www.bailii.org/ew/cases/EWCOP/2014/46.html

Decisions on admission and treatment of under 18s

19.20 The decision to admit a child or young person to hospital is inextricably linked to the decision to treat them once they have been admitted. They are, however, different decisions and need to be considered separately. In addition, the law about admission and treatment of young people aged 16 and 17 differs from that applicable to children under 16. The following four concepts will be relevant to admission and treatment decisions of both children and young people:

- consent
- assessing capacity (young people) or competence (children) to make decisions
- the role of those with parental responsibility and the 'scope of parental responsibility', and
- deprivation of liberty (DoL).

These four concepts are discussed below.

Children and young people and consent

19.21 The valid consent of a child or young person will be sufficient authority for their admission to hospital and/or treatment for mental disorder; additional consent by a person with parental responsibility will not be required. It is good practice to involve the child or young person's parents and/or others involved in their care in the decision-making process, if the child or young person consents to information about their care and treatment being shared.

19.22 Consent should be sought for each aspect of the child or young person's admission, care and treatment as it arises. 'Blanket' consent forms (ie forms that purport to give consent to any proposed treatment) are not acceptable and should not be used.

19.23 A young person must have the capacity, or a child must have competence, to make the particular decision in question (see paragraph 19.24 below). They must have sufficient information to make that decision (see chapter 4) and not be subject to any undue influence when doing so (see paragraph 24.34). Unlike adults, the refusal by a competent child or young person with capacity under the age of 18 may in certain circumstances, be overridden by a court.[7] In the case of Re W (a minor) (medical treatment: court's jurisdiction), the court decided that it has jurisdiction to override the refusal of a child or young person of treatment in circumstances that will, in all probability, lead to the death of the child or young person or to severe permanent injury; or where there is a serious and imminent risk that the child or young person will suffer grave and irreversible mental or physical harm.[8] However, the court also emphasised that the child or young person's refusal is a very important consideration when deciding whether treatment should

[7] See paragraph 19.53 in relation to section 131 of the Act and informal admission of those aged 16 and 17.

[8] Re W (a minor) (medical treatment: court's jurisdiction). 1992. 3 WLR 758.

be given, despite the child or young person's refusal, noting that its importance increases with their age and maturity. Guidance on the action that can be taken in cases requiring emergency life-saving treatment is set out below at paragraphs 19.71 – 19.72.

Assessing a young person's capacity and a child's competence to make decisions

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19.24 Before relying on the consent of a child or young person it is necessary to ascertain whether they can give valid consent. The test for assessing whether a child under 16 can give valid consent differs from that of a young person aged 16 or 17. The capacity of a young person aged 16 or 17 to consent is assessed in accordance with the MCA, while the test for children under 16 is determined by considering whether they are 'Gillick competent'.[9] Practitioners with expertise in working with children and young people should be consulted in relation to these assessments. The different tests are explained in more detail below.

19.25 Practitioners should consider the following three questions which should be read in conjunction with the paragraphs below:

- has the child or young person been given the relevant information in an appropriate manner (such as age appropriate language)?
- have all practicable steps been taken to help the child or young person make the decision? The kind of support that might help the decision-making will vary, depending on the child or young person's circumstances. Examples include:
  - steps to help the child or young person feel at ease
  - ensuring that those with parental responsibility are available to support their child (if that is what the child or young person would like)
  - giving the child or young person time to absorb information at their own pace, and
  - considering whether the child or young person has any specific communication needs (and if so, adapting accordingly).
- can the child or young person decide whether to consent, or not to consent, to the proposed intervention?

Decision-making and young people

19.26 The MCA applies to people aged 16 or over, so young people must be assumed to have capacity to make the decision about a proposed admission to hospital and/or treatment unless it is established that they lack capacity, as is the case with adults (paragraphs 13.17 – 13.22).

[9] See Gillick v West Norfolk and Wisbech Area Health Authority. 1986. AC 112. http://www.bailii.org/uk/cases/UKHL/1985/7.html

19.27 Section 2 of the MCA states that a person lacks capacity in relation to a matter if at the relevant 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 is permanent or temporary (see section 2(2)). Section 3 of the MCA then states that a person is unable to make a decision if they are unable to:

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

19.28 The MCA also states that a person must not be regarded as unable to understand the information relevant to the decision if they are able to understand an explanation of it given in a way that is appropriate to their circumstances. It is therefore essential that steps are taken to enable a person to understand information, such as using simple language and visual aids (see section 3(2) MCA).

19.29 Where there are concerns that the young person is unable to make the particular decision, the young person's capacity should be assessed by a professional with expertise in working with children and young people. Wherever possible, consideration should be given to whether the decision could be delayed to a time when the young person might be able to make the decision.

19.30 If the young person is unable to decide about the proposed action at the relevant time 'because of an impairment of, or disturbance in the functioning of, the mind or brain', they will lack capacity as defined in section 2 of the MCA. The reason for the young person's inability to decide about the proposed admission or treatment may be because of their mental disorder. Alternatively, the young person's inability to decide might arise from a temporary 'impairment of, or disturbance in, the functioning of, their mind or brain' that does not amount to a mental disorder (eg an impairment or disturbance caused by the distress related to the proposed admission or treatment). In either case, the young person will lack capacity within the meaning of the MCA and the MCA will apply in the same way as it does for adults. It may therefore be possible for the particular decision to be made in accordance with the MCA for, and in the best interests of, the young person.

19.31 When assessing a young person's capacity to make the decision in question, practitioners should be aware that in some cases a young person may be unable to make a decision for reasons other than an impairment of, or a disturbance in the functioning of, their mind or brain (even if that is only temporary). In such cases, the person will not lack capacity within the meaning of the MCA. For example, a young person who is informed that they need to be admitted into hospital may, in the particular circumstances of the case, be unable to make a decision. This might be because they find themselves in an unfamiliar and novel situation, having never

before been asked to absorb that type and quantity of information, or they are worrying about the implications of deciding one way or the other.

19.32 In such cases (which are likely to be rare) every effort should be made to ensure that the young person is supported in making the decision (eg by involving those with parental responsibility and/or advocates). Steps should also be taken to explain fully and clearly why admission is thought necessary, what the alternatives to the admission are and why they are considered not to be the best option. Save where the case requires urgent action, the young person should be given the time that they need to think things over and ask for clarification.

19.33 It is important that practitioners are aware of the distinction between those cases that fall within the MCA and those that do not. If it is not clear whether the young person's inability to decide is because of an 'impairment of, or a disturbance in the functioning of, the mind or brain' or whether due to some other reason, a specialist opinion should be sought from a professional with expertise in working with children and young people. The relevance of this distinction to admission and treatment is explained below at paragraphs 19.53 – 19.64.

Decision-making and children under 16

19.34 Children under 16 should be assessed to establish whether they have competence to make a particular decision at the time it needs to be made. This is because in the case of Gillick,[10] the court held that children who have sufficient understanding and intelligence to enable them to understand fully what is involved in a proposed intervention will also have the competence to consent to that intervention. In such cases, the child is sometimes described as being 'Gillick competent'.[11] A child may be Gillick competent to consent to admission to hospital, medical treatment, research, or any other activity that requires their consent.

19.35 The concept of Gillick competence reflects the child's increasing development to maturity. The understanding required to make decisions about different interventions will vary considerably. A child may have the competence to consent to some interventions but not others. The child's competence to consent should be assessed carefully in relation to each decision that needs to be made.

19.36 When considering whether a child has the competence to decide about the proposed intervention, practitioners may find it helpful to consider the following questions.

- Does the child understand the information that is relevant to the decision that needs to be made?

[10] Gillick v West Norfolk and Wisbech Area Health Authority. 1986. AC 112. http://www.bailii.org/uk/cases/UKHL/1985/7.html

[11] This term is used by the courts to refer to a child who has been assessed as having sufficient maturity and understanding to be able to consent to the decision in question (see Re R (a minor) (wardship: consent to treatment) [1992] Fam 11). It should not be confused with 'Lord Fraser's Guidelines' which concern the conditions which must be met before advising a child on sexual matters without parental consent (see R(Axon) v Secretary of State for Health and the Family Planning Association. 2006. EWHC 37 (Admin). http://www.bailii.org/ew/cases/EWHC/Admin/2006/37.html).

- Can the child hold the information in their mind long enough so that they can use it to make the decision?
- Is the child able to weigh up that information and use it to arrive at a decision?
- Is the child able to communicate their decision (by talking, using sign language or any other means)?

19.37 A child may lack the competence to make the decision in question either because they have not as yet developed the necessary intelligence and understanding to make that particular decision; or for another reason, such as because their mental disorder adversely affects their ability to make the decision. In either case, the child will be considered to lack Gillick competence.

The role of those with parental responsibility and decisions within the scope of parental responsibility

19.38 Those who have parental responsibility for the child or young person, who may be able to provide parental consent to the proposed admission and/or treatment, should be identified. This is because, subject to the child or young person's right to confidentiality (see paragraphs 19.14 – 19.16), they should be consulted about the proposed decision concerning their child. In relation to 16 and 17 year olds, if decisions are to be made in accordance with the MCA (on the basis that the young person lacks capacity within the meaning of the MCA) those with parental responsibility should be consulted about the best interests of the young person (see section 4 of the MCA).

19.39 Parental consent should not be relied upon when the child is competent or the young person has capacity to make the particular decision. The effect of section 131(4) of the Act in relation to the informal admission to hospital of a 16 or 17 year old, who has capacity, is that parental consent cannot be relied upon to override that young person's decision about their admission. In relation to decisions about such a young person's treatment, it is inadvisable to rely on the consent of a person with parental responsibility to treat a young person who has capacity to make the decision and has refused the treatment. Similarly, in relation to children, it is not advisable to rely on the consent of a parent with parental responsibility to admit or treat a child who is competent to make the decision and does not consent to it. Although in the past the courts have found that a person with parental responsibility can overrule their child's refusal, such decisions were made before the introduction of the HRA and since then court decisions concerning children and young people have given greater weight to their views.[12]

[12] See for example R (on the application of Axon) v Secretary of State for Health and the Family Planning Association. 2006. EWHC 37 (Admin), in which the court expressed doubt as to why a parent should retain a right to parental authority relating to a medical decision where the young person concerned understood the advice provided by the medical professional and its implications. http://www.bailii.org/ew/cases/EWHC/Admin/2006/37.html

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19.40 In some circumstances, it will be possible for children lacking competence and young people lacking capacity to be admitted to hospital and/or treated on the basis of parental consent (see paragraphs 19.53 – 19.70). However, practitioners must be satisfied that it is appropriate to rely on parental consent. This is important because court decisions relating to parental consent have emphasised that there are limits to both the types of decisions that can be made by those with parental responsibility on behalf of their child, and the circumstances in which these decisions can be made.[13] For example, when making decisions on behalf of their child, parents must act in their child's best interests. The limits to what a parent can consent to on behalf of their child is relevant to whether a deprivation of liberty has arisen (see paragraphs 19.44 – 19.48). This guidance uses the term 'scope of parental responsibility' to highlight the need to establish whether the particular decision can be authorised by parental consent or not. Those cases in which parental consent is sufficient are described as falling within the scope of parental responsibility.

19.41 Whether the particular intervention can be undertaken on the basis of parental consent will need to be assessed in the light of the particular circumstances of the case. Practitioners will need to consider a range of factors. These are set out below, under the two key questions that must be addressed (the term 'parent' is used to cover all people with parental responsibility):

- **First, is this a decision that a parent should reasonably be expected to make?** If the decision goes beyond the kind of decisions parents routinely make in relation to the medical care of their child, clear reasons as to why it is acceptable to rely on parental consent to authorise this particular decision will be required. When considering this question, any relevant human rights decisions made by the courts should be taken into account. Significant factors in determining this question are likely to include:
  - the type and invasiveness of the proposed intervention – the more extreme the intervention, the greater the justification that will be required. Relying on parental consent to authorise an intrusive form of treatment might be justified because it is necessary to prevent a serious deterioration of the child or young person's health, but this would need to be balanced against other factors such as whether the child or young person is resisting the treatment; whether the specific form of treatment is particularly invasive and/or controversial (eg careful consideration should be given to the appropriateness of relying on parental consent to authorise electro-convulsive therapy (ECT)[14]
  - the age, maturity and understanding of the child or young person: the role of parents in decision-making should diminish as their child develops greater independence, with accordingly greater weight given to the views of the child or young person
  - the extent to which the decision accords with the wishes of the child or young person, and whether the child or young person is resisting the decision, and

[13] See for example, RK v BCC. 2011. EWCA Civ 1305; Nielsen v Denmark. 1989. 11 EHRR (paragraph 72) Gillick v West Norfolk and Wisbech Area Health Authority. 1986. A.C. 112; and Hewer v Bryant. 1970. 1 QB 357.

[14] Section 58A of the Act includes specific safeguards for all children and young people for whom ECT is proposed, whether or not they are detained under the Act – see paragraphs 19.80 – 19.88.

- whether the child or young person had expressed any views about the proposed intervention when they had the competence or capacity to make such decisions; for example, if they had expressed a willingness to receive one form of treatment but not another, it might not be appropriate to rely on parental consent to give the treatment that they had previously refused.

- **Secondly are there any factors that might undermine the validity of parental consent?** Irrespective of the nature of the decision being proposed, there may be reasons why relying on the consent of a person with parental responsibility may be inappropriate; for example:
  - where the parent is not able to make the relevant decision; for example, this may arise, if the parent lacks capacity as defined in the MCA, because of their own mental health problems or learning disabilities. In cases of doubt, the parent's capacity will need to be assessed in accordance with the MCA
  - where the parent is not able to focus on what course of action is in the best interests of their child; for example, where the parents have gone through a particularly acrimonious divorce, they may find it difficult to separate the decision whether to consent to their child's admission to hospital from their own hostilities
  - where the poor mental health of the child or young person has led to significant distress and/or conflict between the parents, so that they feel unable to decide on what is best for their child and/or cannot agree on what action should be taken, and
  - where one parent agrees with the proposed decision but the other is opposed to it. Although parental consent is usually needed from only one person with parental responsibility,[15] it may not be appropriate to rely on parental consent if another person with parental responsibility disagrees strongly with the decision to admit and/or treat their child, and is likely to take action to prevent the intervention, such as removing the child from hospital or challenging the decision in court.

19.42 If the decision is not one that a parent would reasonably be expected to make, or there are concerns about the validity of the consent of the person with parental responsibility, it will not be appropriate to rely on parental consent. In such cases, the proposed intervention must be lawfully authorised by other means. In cases where the proposed intervention relates to the assessment and/or treatment of the child or young person's mental disorder, they could be admitted and treated under the Act if the criteria are met. This is discussed below. If the Act is not applicable, legal advice should be sought on the need to seek authorisation from a court before further action is taken. If there is doubt as to whether or not parental consent can be relied upon to authorise the particular intervention, professionals should take legal advice so that account may be taken of the most recent case law.

19.43 Whether persons with parental responsibility can consent to restrictions that would otherwise amount to a deprivation of liberty is considered below.

[15] See section 2(7) of the Children Act 1989. http://www.legislation.gov.uk/ukpga/1989/41/section/2

Deprivation of liberty

19.44 Determining whether the admission to hospital and assessment and/or the treatment proposed amounts to a deprivation of liberty is as important for admission and treatment decisions concerning children and young people as it is for adults. Article 5 (the right to liberty) of the European Convention on Human Rights (ECHR) applies to individuals of all ages.

19.45 In establishing whether there is a deprivation of liberty the circumstances of each case should be considered, looking at a range of factors, such as the type and duration of the restrictions imposed on the person and the impact of such restrictions on that person. Paragraphs 13.44 – 13.47 provide guidance on assessing whether the particular circumstances give rise to a deprivation of liberty.

19.46 Decisions as to whether the child or young person's admission and/or treatment amounts to a deprivation of liberty must be considered on a case by case basis. Where children and young people are admitted informally, the question of whether the care regime amounts to a deprivation of liberty must be kept under regular review. This is because although initially informal admission might be appropriate because the child or young person's care plan involves only restrictions of liberty, a change in circumstances may mean that the restrictions placed upon the child or young person amount to a deprivation of liberty for which lawful authority will be needed.

19.47 An additional and significant factor when considering whether the proposed intervention in relation to a child or young person is a restriction of liberty or amounts to a deprivation of liberty is the role of parental control and supervision. Practitioners will need to determine whether the care regime for, and restrictions placed on, the child or young person accord with the degree of parenting control and supervision that would be expected for a child or young person of that age. For example, whereas it is usual for a child of under 12 years not to be allowed out unaccompanied without their parent's permission, this would not usually be an acceptable restriction on a 17 year old. Account also needs to be taken of the particular experience of the child or young person. For example, a younger child who has been caring for their parent, including shopping for the household and/or accompanying their parent to medical appointments, might not be used to being prevented from going out unaccompanied.

19.48 Prior to the Supreme Court's judgment in Cheshire West,[16] case law had established that persons with parental responsibility cannot authorise a deprivation of liberty.[17] Cheshire West clarified the elements establishing a deprivation of liberty, but did not expressly decide whether a person with parental responsibility could, and if so in what circumstances, consent to restrictions that would, without their

[16] P v Cheshire West and Chester Council and another and P and Q v Surrey County Council ('Cheshire West'). 2014. AC 896. https://www.supremecourt.uk/decided-cases/docs/UKSC_2012_0068_Judgment.pdf

[17] See RK (by her litigation friend and the official Solicitor) v BCC, YK and AK. 2011. EWCA Civ 1305. http://www.bailii.org/ew/cases/EWCA/Civ/2011/1305.html

consent, amount to a deprivation of liberty. In determining whether a person with parental responsibility can consent to the arrangements which would, without their consent, amount to a deprivation of liberty, practitioners will need to consider and apply developments in case law following Cheshire West. In determining the limits of parental responsibility, decision-makers must carefully consider and balance: (i) the child's right to liberty under article 5, which should be informed by article 37 of the UNCRC, (ii) the parent's right to respect for the right to family life under article 8, which includes the concept of parental responsibility for the care and custody of minor children, and (iii) the child's right to autonomy which is also protected under article 8. Decision makers should seek their own legal advice in respect of cases before them. (Chapter 26 provides guidance on the use of restrictive interventions.)

Informal admission and treatment

19.49 The law about admission to hospital and treatment for mental disorder of young people aged 16 and 17 differs from that of children under 16. In both cases, whether they are competent (in the case of children) or have capacity (in the case of young people) to decide about their admission and/or treatment is of central importance. (See paragraphs 19.24 – 19.37 for assessing the competence of children and the capacity of young people to make decisions.)

19.50 In relation to admission, children and young people may be admitted to hospital for treatment for mental disorder informally, on the basis of their consent (see section 131 of the Act (informal admission of patients). Where they lack capacity as defined in the MCA (16 or 17 year olds) or competence ('Gillick competence' in respect of under 16s) they can be admitted informally in the circumstances outlined below.

19.51 In all cases concerning admission and/or treatment, practitioners must determine whether the proposed intervention can be undertaken on an informal basis. Informal admission and treatment can be authorised by either the child or young person's consent, parental consent (where the child lacks competence or the young person lacks capacity) or in relation to young people who lack capacity, in accordance with the MCA. The following paragraphs provide guidance on how to determine whether such routes to informal admission and/or treatment are applicable. These should be considered in the light of the particular circumstances of each case. Where the proposed admission and/or treatment cannot be authorised on an informal basis, the criteria for detention under the Act must be met for the child or young person to be admitted under the Act or (where the Act is not applicable), the admission can be authorised by the High Court. The only exception to this is where a life-threatening emergency has arisen (see paragraphs 19.71 – 19.72).

19.52 In cases where a child or young person cannot be admitted and/or treated informally, and the criteria for detention under the Act are not met, legal advice should be obtained on whether to seek the assistance of the High Court. The court's authorisation may be sought by way of an order or declaration, under its inherent jurisdiction, or for a section 8 order under the Children Act 1989. Whether the court is prepared to assist will depend on the facts of the particular case. It should also be noted that the Court of Protection can make a deprivation of liberty order in respect of young people aged 16 and 17.

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16 and 17 year olds

Informal admission of 16 and 17 year olds with capacity to consent

19.53 The effect of section 131 of the Act is that where a young person aged 16 or 17 has capacity (as defined in the MCA) to consent to being admitted to hospital for treatment for mental disorder, they may either consent, or refuse to consent, to the proposed informal admission. If a young person has the capacity to consent to informal admission and gives such consent, they can be admitted, irrespective of the views of a person with parental responsibility (who cannot prevent the admission). If the young person with capacity does not consent to the admission, then a person with parental responsibility cannot consent on their behalf.

19.54 In some cases, the young person may be unable to decide whether or not to agree to their admission to hospital, but not because they lack capacity within the meaning of the MCA. For example, this might be because, despite every effort in helping the young person to make this decision, the young person finds the decision too difficult to make (see paragraphs 19.31 – 19.33 above). In such cases, it will not be possible for a person with parental responsibility to consent on their behalf. This is because section 131 of the Act only allows informal admission on the basis of parental consent if the young person lacks capacity within the meaning of the MCA.

19.55 Where the young person does not consent to their admission to hospital, but the admission is thought to be necessary, consideration should be given to whether the criteria for admission under the Act are met. If the Act is not applicable, legal advice should be sought on the need to seek authorisation from the court before further action is taken.

19.56 If the young person is admitted informally, the considerations set out in paragraphs 19.58 – 19.64 will apply to their treatment.

Informal admission of 16 and 17 year olds who lack capacity to consent

19.57 Where a young person aged 16 or 17 lacks capacity it may be possible for them to be admitted informally, in accordance with the MCA, unless the admission and treatment amounts to a deprivation of liberty. In cases where the MCA cannot authorise informal admission, but the admission is thought to be necessary, consideration should be given to as whether the criteria for admission under the Act are met. If the Act is not applicable, legal advice should be sought on the need to seek authorisation from the court before further action is taken.

Informal treatment of 16 and 17 year olds with capacity to consent

19.58 Section 8 of the Family Law Reform Act 1969[18] means that young people aged 16 or 17 can consent to their medical treatment and to any ancillary procedures involved in that treatment, such as an anaesthetic. Accordingly, treatment can be given if the young person, who has capacity, gives valid consent.

19.59 Where a young person has the capacity to consent to proposed medical treatment but refuses to consent, it would be inadvisable to rely on the consent of a person with parental responsibility in order to treat the young person (see above, paragraph 19.39). In such cases, consideration should be given to whether admission under the Act for the purposes of treatment is necessary, and if so, whether the criteria are met. If the Act is not applicable, legal advice should be sought on the need to seek authorisation from the court before further action is taken.

Informal treatment of 16 and 17 year olds who lack capacity to consent

19.60 Different considerations apply to a decision to treat a young person aged 16 or 17 informally where the young person lacks capacity or is otherwise not able to decide whether or not to consent to the proposed treatment.

19.61 Where the young person lacks capacity, the MCA will apply in the same way as it does to those aged 18 and over, and treatment may be given in accordance with the MCA, unless it amounts to a deprivation of liberty.

19.62 A person with parental responsibility may also be able to consent on behalf of the young person who lacks capacity to make decisions about their treatment. Factors to consider in deciding whether it is possible to rely on parental consent are in paragraph 19.41. The guidance at paragraphs 19.44 – 19.48 should be considered in relation to whether persons with parental responsibility can consent to restrictions that would otherwise amount to a deprivation of liberty.

[18] Section 8 of the Family Law Reform Act 1969. http://www.legislation.gov.uk/ukpga/1969/46/section/8

19.63 A person with parental responsibility may be able to consent to the treatment on behalf of a young person who although unable to decide about the proposed treatment, does not lack capacity within the meaning of the MCA (the circumstances when this might occur is explained at paragraph 19.31). In such cases every effort must be made to help the young person in making the decision for themselves (see paragraph 19.32).

19.64 If it is not possible to provide treatment relying on the MCA or parental consent, consideration should be given to whether admission under the Act for the purposes of treatment is necessary, and if so, whether the criteria are met. If the Act is not applicable, legal advice should be sought on the need to seek authorisation from the court before further action is taken.

Under 16s

Informal admission and treatment of under 16s who are Gillick competent

19.65 Where a child who is Gillick competent to decide about their admission to hospital for assessment and/or treatment of their mental disorder consents to this, they may be admitted to hospital as an informal patient. A child who is Gillick competent and has consented to being admitted informally, may also be given treatment if they are competent to consent to the proposed treatment, and do consent. Consent will be required for each aspect of the child's care and treatment as it arises. This will involve an assessment of the child's competence to make the particular decision and, where the child is competent to do so, confirmation that they have given their consent.

19.66 Where a child who is Gillick competent refuses to be admitted for treatment it may be inadvisable to rely on the consent of a person with parental responsibility (see paragraph 19.39). In such cases, consideration should be given to whether admission under the Act is necessary, and if so, whether the criteria are met. If the Act is not applicable, legal advice should be sought on the need to seek authorisation from the court before further action is taken.

Informal admission and treatment of under 16s who are not Gillick competent

19.67 Where a child is not Gillick competent then it may be possible for a person with parental responsibility to consent, on their behalf, to their informal admission to hospital for treatment for mental disorder.

19.68 If parental consent can be relied upon and consent is given by a person with parental responsibility, then the child may be admitted and treated as an informal patient.

19.69 Consent will be required for each aspect of the child's care and treatment as it arises. This will involve consideration as to whether the child is competent to make decisions about their treatment, and if not whether such treatment can be authorised by parental consent.

19.70 If it is not considered appropriate to rely on parental consent for the proposed admission and/or treatment, for example because the consent of a person with parental responsibility is not given or the matter is outside the scope of parental responsibility (see paragraphs 19.38 – 19.43), the child cannot be admitted and treated informally. In such cases, consideration should be given to whether admission under the Act is necessary, and if so, whether the criteria are met. If the Act is not applicable, legal advice should be sought on the need to seek authorisation from the court before further action is taken.

Emergency treatment

19.71 A life-threatening emergency may arise when treatment needs to be given but it is not possible to rely on the consent of the child, young person or person with parental responsibility and there is no time to seek authorisation from the court or (where applicable) to detain and treat under the Act. If the failure to treat the child or young person would be likely to lead to their death or to severe permanent injury, treatment may be given without their consent, even if this means overriding their refusal when they have the competence (children) or the capacity (young people and those with parental responsibility), to make this treatment decision. In such cases, the courts have stated that doubt should be resolved in favour of the preservation of life, and it will be acceptable to undertake treatment to preserve life or prevent irreversible serious deterioration of the child or young person's condition.

19.72 The treatment given must be no more than necessary and in the best interests of the child or young person. Once the child or young person's condition is stabilised, legal authority for on-going treatment must be established; this might be on an informal basis (see paragraphs 19.49 – 19.70) or in accordance with either a court order or, if the child or young person is detained, under part 4 of the Act (see paragraphs 19.78 – 19.89).

Assessing whether to make an application under the Act

19.73 At least one of the people involved in assessing whether a child or young person should be admitted to hospital, and if so whether they should be detained under the Act (ie one of the two medical practitioners or the approved mental health professional (AMHP)), should be a child and adolescent mental health services (CAMHS) professional. Where this is not possible, and admission to hospital is considered necessary, the AMHP should have access to an AMHP with experience of working in CAMHS, and the medical practitioners should consult a CAMHS clinician as soon as possible and involve them as closely as the circumstances of the case allow. In cases where the child or young person has complex or multiple needs, other clinicians may need to be involved, for example, a learning disability CAMHS consultant where the child or young person has a learning disability. (See chapter 14 for fuller information on the assessment process, and chapter 20.)

19.74 As part of their role in setting up an assessment (see paragraphs 14.49 – 14.56) AMHPs should consider whether to inform the relevant local authority children's services that an assessment is being arranged and request that any relevant information about the child or young person is provided prior to the assessment. The AMHP should consider with children's services whether a representative from children's services should attend the assessment. The AMHP should employ their best efforts to identify those who have parental responsibility, and who would be the nearest relative (see chapter 5).

Information to under 18s detained

19.75 Chapter 4 provides guidance on the provision of information to people detained under the Act and chapter 6 provides guidance on the role of independent mental health advocates. Both these chapters apply to children and young people.

19.76 Hospital managers should ensure that staff providing children and young people with information about their rights in accordance with section 132 of the Act have sufficient knowledge and experience to be able to provide information to children and young people and determine whether the information has been understood. Written information must always be made available. Such information should be age appropriate and include an explanation about when they have the right to see an independent mental health advocate (IMHA) under the Act and an explanation of how one can be made available.

19.77 IMHAs have an important role in ensuring that children and young people understand, and are able to exercise, their rights under the Act, such as applying to a Tribunal (see paragraph 19.107), and to the hospital managers for discharge from detention (see chapter 38 for further guidance). It is therefore essential that the IMHAs working in CAMHS (or providing assistance to under 18s who are admitted

to adult psychiatric wards – see paragraph 19.94 below) have experience of working with children and young people and an understanding of children's services and relevant law and policy, as well as an in-depth knowledge of the Act.

Treatments for under 18s regulated by the Act

19.78 As with adults, treatment for mental disorder for under 18s is regulated by part 4 and part 4A of the Act. Chapters 24 and 25 provide general guidance and the following paragraphs highlight issues of relevance to children and young people under 18. Although in some cases the Act provides that treatment can be given to a child or young person without their consent, their consent should still be sought, wherever practicable. This will necessitate an assessment of the child's competence or young person's capacity to decide about the treatment proposed.

Treatments requiring the patient's consent (section 57)

19.79 Treatment covered by section 57 of the Act (primarily neurosurgery for mental disorder) cannot be given to a child or young person who does not personally consent to it, whether they are detained or not. These treatments cannot, therefore, be given to any young person or child who does not have the competence or capacity to consent, even if a person with parental responsibility consents. If such treatment is proposed in respect of a child or young person who has the competence or capacity to consent (such cases are likely to be rare), the requirements set out under section 57 of the Act must be met before the treatment can be given and these are explained in chapter 25 (paragraphs 25.7 – 25.10). The child or young person is eligible for help from an IMHA and must be informed of this right.

Electro-convulsive therapy (ECT) (section 58A)

19.80 The Act provides specific safeguards in relation to ECT for patients who are under 18.

19.81 As with adults, children and young people who are detained under the Act cannot be given ECT without their consent, if they are capable of consenting to the treatment, unless it is emergency treatment (see section 62 of the Act ('emergency treatment'). If they are not capable of consenting, or if it is emergency treatment, they may be given ECT without their consent in accordance with the rules described in chapter 25.

19.82 Children and young people on a community treatment order (CTO) who are competent (children) or who have capacity (young people) to make such treatment decisions cannot be given ECT without their consent, even in emergencies. If they are recalled to hospital ECT can be given in accordance with the treatment

provisions under part 4 of the Act. Part 4A sets out the circumstances in which children who are not competent, and young people who lack capacity, to consent can be given treatment, including ECT when on a CTO. Part 4A is explained in chapter 25.

19.83 Whether or not they are detained under the Act, except where emergency treatment is given under section 62 of the Act, no child or young person under the age of 18 can be given ECT without the approval of a second opinion appointed doctor (SOAD). This means:

- for children and young people who are 'capable of understanding the nature, purpose and likely effects' of ECT and consent to it, the SOAD must certify, in writing, that the child or young person is capable of consenting, they have consented to ECT, and it is appropriate for ECT to be given, and
- for children and young people who are not capable of consenting to ECT, the SOAD must certify that the child or young person is not capable of understanding the nature, purpose and likely effects of ECT, but it is appropriate for ECT to be given. In addition, in relation to a young person who lacks capacity to consent to ECT, the SOAD must certify that giving the treatment would not conflict with a decision made by a deputy appointed by the Court of Protection, or the Court of Protection.

19.84 The legal authority to give ECT to children and young people who are neither detained under the Act, nor subject to a CTO and who lack the capacity (young people) or the competence (children) to consent to ECT will need to be clarified. (The approval of a SOAD is not in itself sufficient authorisation for ECT to be given.) This means that in the case of young people who lack capacity, the MCA could provide the necessary authority to give ECT, so long as this would not involve a deprivation of liberty.

19.85 Although the Act does not prevent a person with parental responsibility from consenting to ECT on behalf of a child who lacks competence, or young person who lacks capacity, to consent and who is neither detained under the Act nor a patient subject to a CTO, careful consideration should be given as to whether to rely on parental consent. This is because although there is no case law at present directly on this point, given the nature and invasiveness of ECT, it may lie outside the types of decision that parents can make on behalf of their child. The factors to consider whether it is possible to rely on parental consent are set out in paragraph 19.41 above.

19.86 In cases where ECT cannot be given on the basis of either the child or young person's consent, or parental consent, or the MCA, consideration should be given to whether the child or young person should be admitted under the Act for ECT, if the criteria are met (or recalled to hospital, in case of a community patient).

19.87 In cases where the Act is not applicable, court authorisation should be sought. Although the application to the court should be made before a SOAD is asked to approve the treatment the views of a SOAD should be sought before making the application as the court is likely to wish to consider a SOAD's opinion before determining whether to authorise ECT. In practice, the issues the court is likely to address will mirror those that the SOAD is required to consider.

19.88 All children and young people, whether or not they are detained under the Act, are eligible for help from IMHAs if ECT is proposed and must be informed of this right.

Other treatments under the Act in respect of patients who are liable to be detained and CTO patients who have been recalled

19.89 Part 4 of the Act sets out when people of all ages who are liable to be detained, or have been recalled to hospital from a CTO, can be given other types of treatment for mental disorder (see chapters 24 and 25).

Age-appropriate services

19.90 Section 131A of the Act says that children and young people admitted to hospital for the treatment of mental disorder should be accommodated in an environment that is suitable for their age (subject to their needs). This duty applies to the admission of all under 18s, whether or not they are detained under the Act and includes children and young people who are subject to a CTO, who are recalled to hospital, or who agree to informal admission.

19.91 This means that children and young people should have:

- appropriate physical facilities
- staff with the right training, skills and knowledge to understand and address their specific needs
- a hospital routine that will allow their personal, social and educational development to continue as normally as possible, and
- equal access to educational opportunities as their peers, in so far as that is consistent with their ability to make use of them, considering their mental state.

19.92 The duty requires hospital managers to ensure that the environment in the hospital is suitable. When determining the suitability of the environment, they must consult a person whom they consider to have knowledge or experience in working with children and young people receiving in-patient mental healthcare and who are able to make this assessment (this will usually be a CAMHS professional). The duty applies to all in-patient mental health services, including highly specialised services such as eating disorder units, and learning disability services.

19.93 The Care Quality Commission (CQC) must be notified without delay if an under 18-year old is placed on an adult psychiatric ward for longer than a continuous period of 48 hours.[19] Section 140 of the Act requires clinical commissioning groups to notify local authorities in their area of the hospitals that are designed to be specifically suitable for patients under the age of 18.

19.94 Section 131A does not prohibit all admissions of individuals aged under 18 to adult wards. Such admissions are permissible only in exceptional circumstances, where this is considered to be the most suitable place for an under 18 year old. These exceptional circumstances generally fall into two distinct categories, referred to in this guidance as 'emergency situations' and 'atypical cases' (see paragraphs 19.98 – 19.101).

19.95 In all cases, to be lawful, the admission of a person aged under 18 to an adult ward must be suitable for that particular individual at the time that the admission is being considered.

19.96 In all cases where an under 18 year old is admitted to an adult ward, the reasons for the admission should be recorded, including an explanation as to why this is considered to be suitable having regard to their age and why other options were not available and/or suitable. Details of whether action will be necessary to rectify the situation, and what action taken by whom, and when, should also be recorded.

19.97 In the case of children aged under 16, it is Government policy that they should not be admitted to an adult ward. If this occurs or if the child is treated in any other inappropriate setting due to lack of appropriate CAMHS beds, the commissioner of the CAMHS inpatient services should be notified. The commissioner should report it as a serious incident and investigate it in accordance with the NHS Serious Incident Framework.

19.98 In a small number of cases the child or young person'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 (referred to as an 'emergency situation'). Such situations will arise where the child or young person needs to be admitted urgently to hospital and accordingly waiting for a bed to become available on a CAMHS unit is not considered to be an acceptable option. An 'emergency situation' should be a rare and unusual case. It is not unusual for children or young people to require unplanned admissions and accordingly local policies should be in place to ensure that such admissions are to age appropriate environments.

19.99 There is a clear difference between what is a suitable environment for a child or young person in an emergency situation, and what is a suitable environment for a child or young person on a longer-term basis. In an emergency, such as when the patient is in crisis, the first imperative is to ensure that the child or young person

[19] Care Quality Commission (Registration) Regulations. 2009. SI 2009/3112. Regulation 18.2(h): Any placement of an individual under the age of eighteen in a psychiatric unit whose services are intended for persons over that age where that placement has lasted for longer than a continuous period of 48 hours.

is in a safe environment. Once the initial emergency situation is over, hospital managers must ensure that action is taken to transfer the child or young person to more appropriate accommodation unless they have determined that the adult ward is the most appropriate environment for the child or young person. In determining whether the environment is suitable beyond the initial crisis, in addition to the appropriateness of the mental healthcare that can be provided on the adult ward, the hospital managers would need to consider issues such as whether the child or young person can mix with individuals of their own age, can receive visitors of all ages, and has access to education.

19.100 An 'atypical case' describes a situation where those arranging a young person's admission conclude that the best option for that young person is to be admitted to an adult ward even if a CAMHS bed were available. While likely to be rare, such cases may arise from time to time when the young person is very close to their 18th birthday and placing them on a CAMHS ward for a matter of weeks or days before transferring them to an adult ward would be counter-therapeutic and:

- the young person may express a preference to be on an adult ward, such as when they are under the care of the early intervention psychosis (EIP) team which has beds on an adult ward. The young person may prefer to have continuity of care from the EIP team rather than be admitted to a unit with different clinicians, or
- if a young mother requires admission for post-natal depression, admission to an adult mother and baby unit would allow the young mother to remain with her child, whereas admission to a CAMHS unit would not.

19.101 Where, whether owing to an emergency or because the admission is an 'atypical' case, it is considered appropriate for the child or young person to be admitted to an adult ward, it will still be necessary to ensure that appropriate steps have been taken to safeguard the young person. Discrete accommodation in an adult ward, with facilities, security and staffing appropriate to the needs of that young person, might provide the most satisfactory solution; for example, young female patients should be placed in single sex accommodation. Wherever possible all those involved in the care and treatment of children and young people should be CAMHS specialists. Anyone who looks after them must always have enhanced disclosure clearance from the disclosure and barring service (DBS), including a barred list check, and that clearance must be kept up-to-date.

19.102 Where the placement of a child or young person on a CAMHS unit might have a detrimental effect on the other children and young people, hospital managers need to ensure that the interests of other patients are protected. However, the needs of other children and young people should not override the need to provide accommodation in an environment that is suitable for the patient's age (subject to their needs) for an individual patient aged under 18. This means that the detrimental impact on other young patients is not an acceptable reason for transferring a child or young person to an adult ward.

19.103 Children and young people aged under 18 should also have access to age-appropriate leisure activities and facilities for visits from parents, guardians, siblings, or carers.

19.104 Section 131A of the Act applies to under 18s who are detained in hospital, as a place of safety under sections 135 or 136 of the Act, but not to other places of safety. People under 18 may be admitted to adult hospital facilities in 'emergency situations'. A child or young person may be detained in a place of safety that is not specifically designated for under 18s if this is assessed to be a suitable environment for the child or young person at that time, given the particular circumstances. If, subsequently, the child or young person is assessed as requiring admission to hospital, the admission must be to an age-appropriate (and otherwise suitable) environment and this should be arranged as soon as possible. Section 131A should never be relied upon as a reason for detaining a child or young person under the age of 18 in a police cell rather than a hospital. The safety of the child or young person should always be central to the decision-making process.

Under 18s detention in a place of safety

19.105 As chapter 16 states, the process for identifying the most appropriate place of safety to which a particular person is to be removed should be clearly outlined in the local place of safety policy. This applies to children and young people as much as adults. Unless there are specific arrangements in place with CAMHS, the healthcare setting identified by local policies as the place of safety should be used, and the fact that this is attached to an adult ward should not preclude its use for this purpose. In addition, the policies should make clear that a person under 18 should not be removed to a police station as a place of safety unless there are exceptional circumstances, and clear reasons (which should be recorded according to the local policy and shared with relevant local authority children's services), why this is the most appropriate place in which to safeguard that child or young person (see paragraphs 16.43 – 16.52).

The responsible clinician and others caring for and treating under 18s

19.106 Wherever possible, those responsible for the care and treatment of children and young people should be CAMHS specialists. Chapter 36 provides guidance in relation to identifying responsible clinicians. In the exceptional cases where a young person is admitted to an adult psychiatric ward, the hospital managers should ensure that the clinical staff have regular access to, and make use of, a CAMHS specialist for advice and consultation.

The Tribunal

19.107 Children and young people who are detained under the Act have the same rights as other patients to apply to the Tribunal (see chapter 12). It is important that children and young people are informed of their right to apply to the Tribunal and are assisted in obtaining legal representation at an early stage. IMHAs have an important role in ensuring that children and young people understand, and are able to exercise, their rights under the Act. The IMHA's help in relation to applications to Tribunal will be particularly important, such as helping the child or young person contact a lawyer and understanding the role of the Tribunal, and what to expect at the Tribunal hearing.

19.108 A CAMHS panel of the Tribunal has been established so that, wherever possible, at least one member of the panel considering a child or young person's case will have experience of working with under 18s.

19.109 Professionals preparing social circumstances reports for the Tribunal must ensure that such reports include any information required in the Tribunal's Practice Directions.[20]

19.110 Hospital managers should ensure that systems are in place to identify cases requiring referral to a Tribunal in accordance with section 68 of the Act. They have a duty to refer patients to the Tribunal under section 68(6) of the Act after a one-year period without a Tribunal hearing in relation to under 18s. Hospital managers should also consider asking that the Secretary of State refers a child or young person's case to a Tribunal under section 67 of the Act in cases where that child or young person is unable to have their case considered speedily by the Tribunal (see paragraphs 37.44 – 37.46).

After-care

19.111 Prior to their discharge from hospital all children and young people should have an assessment of their needs, on which a care plan for their after-care is based. Guidance on the duty to provide after-care under section 117 of the Act, is set out in chapter 33. Such guidance is applicable to individuals of all ages, but in relation to children and young people additional factors will need to be considered. This may include ensuring that the after-care integrates with any existing provision made for looked after children and those with special educational needs or disabilities, as well as safeguarding vulnerable children. Whether or not section 117 of the Act applies, a child or young person who has been admitted to hospital for assessment and/or treatment of their mental disorder may be 'a child in need' for the purpose of section 17 of the Children Act 1989. See also paragraph 19.118 below in relation to children and young people with special educational needs.

19.112 For information about after-care payments, see chapter 33 for relevant details covering children and young people.

[20] At the time of publication this was detailed in Annex E of Practice Direction. First-tier Tribunal, Health, Education and Social Care Chamber: statements and reports in mental health cases. Tribunals Judiciary. 2013. http://www.judiciary.gov.uk/wp-content/uploads/JCO/Documents/Practice+Directions/Tribunals/statements-in-mental-health-cases-hesc-28102013.pdf

Community treatment order (CTO) and guardianship

19.113 There is no lower age limit for a CTO. The number of children and young people whose clinical and family circumstances make them suitable to move from being detained to being a community patient is likely to be small, but it should be used where appropriate (see chapters 29 and 31).

19.114 Parents (or other people with parental responsibility) cannot consent (or refuse consent) to treatment for mental disorder on a child or young person's behalf while the child or young person is on a CTO. If community patients under the age of 18 are living with one or both parents, the responsible clinician should consult with the parent(s) about the particular treatment (subject to the normal considerations of patient confidentiality). This dialogue should continue throughout the period of the CTO. If a parent is unhappy with the particular treatment or conditions attached to the CTO, and the child is not competent to consent (or young person lacks capacity to consent), a review by the child or young person's team should take place. This will be to consider whether the treatment and care plan, and CTO in general, are still appropriate for them.

19.115 The powers of guardianship under the Act apply to individuals aged 16 and over and may be appropriate for young people aged 16 and 17 (see chapter 30).

Education

19.116 Local authorities must make arrangements to provide suitable education for all children of compulsory school age. Suitable education means education suitable to their age, ability and aptitude and to any special educational needs (SEN) they may have. This education must be full-time, unless the local authority determines that, for reasons relating to the physical or mental health of the child, a reduced level of education would be in the child's best interests. Children and young people admitted to hospital under the Act should have access to education that is on a par with that of mainstream provision, including appropriate support for those with SEN. Practitioners and local authorities should work together to minimise any disruption to education, and in order to ensure that local authorities can meet their duty to provide suitable education, when a child or young person is admitted under the Act, they should be notified as soon as possible, ideally in advance of the placement. The duty on local authorities to ensure suitable education also applies when a child or young person is receiving treatment in an area where they are not normally resident.

19.117 Young people over the school leaving age should also be encouraged to continue learning. Under Raising the Participation Age legislation (part of the Education and Skills Act 2008),[21] local authorities have duties to promote effective participation in education or training for 16 and 17 year olds including those admitted to hospital.

[21] Education and Skills Act 2008. http://www.legislation.gov.uk/ukpga/2008/25/contents

19.118 When a child or young person with a statement SEN, a learning difficulty assessment (LDA) or an education, health and care plan (EHC plan) is admitted to hospital under the Act the local authority who maintains the plan should be informed, so that they can ensure that educational support continues to be provided. If necessary, the plan may be reviewed and amended to ensure targets and provisions remain appropriate. The local authority should also be involved in creating the discharge plan, so that the statement, LDA or EHC plan is revised as necessary to continue to reflect the child or young people educational, health and social care needs.

Transition from CAMHS

19.119 Young people's transition from CAMHS requires careful planning, which should start at least six months before the young person is due to leave CAMHS. The planning process should ensure the full involvement of the child or young person and (subject to issues of confidentiality) those who will be involved in their care, including those with parental responsibility. The young person should be listened to and helped to improve their self-sufficiency; they should be provided with appropriate and accessible information so they can exercise choice effectively and participate in decisions about which adult and other services they receive.

19.120 Where a young person has an EHC plan that includes agreed provision to support mental health then health commissioners must put arrangements in place to secure that provision. Commissioners should be aware that where appropriate, local authorities may maintain EHC plans up to the age of 25.

Duties of local authorities in relation to children and young people in hospital

19.121 Local authorities should ensure that they arrange for visits to be made to:

- children and young people looked after by them who are in hospital, whether or not they are under a care order, and
- children and young people accommodated or intended to be accommodated for three months or more by NHS-funded providers. Such visits must be undertaken in accordance with the relevant regulations.[22]

19.122 Local authorities should consider whether it would be appropriate to provide financial support to enable families to visit children and young people placed in hospital, taking into account their duties to promote contact between children and young people and their families. Such duties arise when children and young people are being looked after by local authorities as well as when they are accommodated in hospital for three months or more. The provision of financial support to cover the travel costs of visiting might be essential for some families on low incomes, especially if their child has been placed out of area (see paragraphs 8A and 16 of schedule 2 of the Children Act 1989).

[22] See Visits to Children in Long-term Residential Care Regulations. SI 2011/1010. 2011. http://www.legislation.gov.uk/uksi/2011/1010/contents/made

19.123 Section 116 of the Act also places duties on local authorities in respect of children and young people in their care by virtue of a care order and who are admitted to a hospital, independent hospital or care home in England and Wales. In such cases, local authorities are required to arrange for the child or young person to be visited and to take such other steps in relation to the child or young person while they are in a hospital, independent hospital or care home as would be expected to be taken by their parent(s).

19.123 Local authorities are under a duty in the Children Act 1989 to:

- promote contact between children and young people who are children in need, or looked after children, and their families, if they live away from home, and to help them get back together (paragraphs 10 and 15 of Schedule 2 to the Children Act 1989), and
- arrange for people (independent visitors) to visit, advise and befriend children and young people looked after by the authority wherever they are, if they have not been regularly visited by their parents (paragraph 17 of Schedule 2 to the Children Act 1989).

19.125 Local authorities should be alerted if the whereabouts of the person with parental responsibility is not known or if that person has not visited the child or young person for a significant period of time. When alerted to this situation the local authority should consider whether visits should be arranged.

19.126 Hospital managers should set up systems to ensure that directors of children's services are notified of cases in which their duty to visit and consider the welfare of children and young people in hospital arises (see chapter 37 for further details on the functions of hospital managers).

Related material

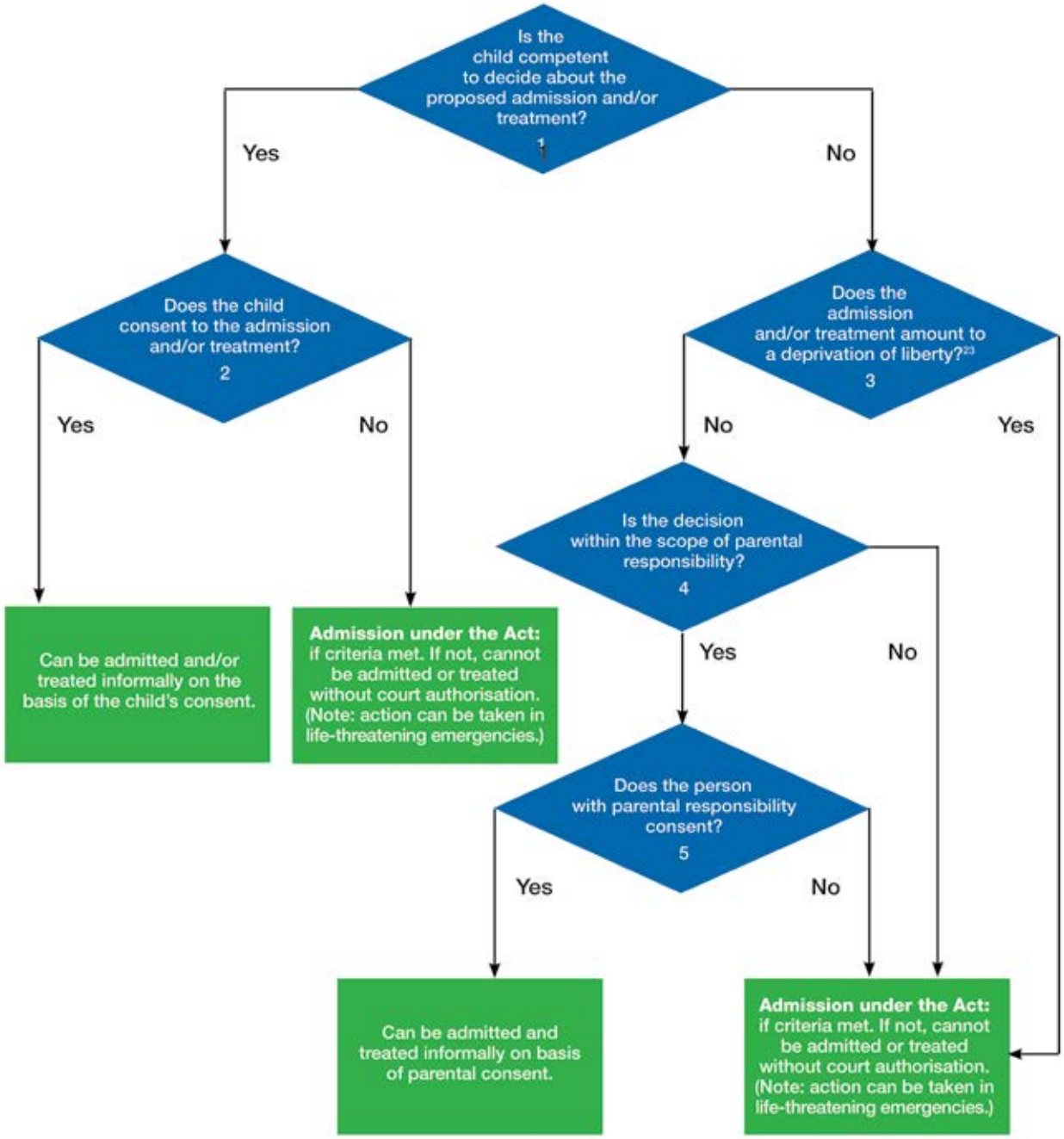
- Children Act 1989 and guidance: https://www.gov.uk/government/publications/children-act-1989-court-orders--2
- Information Sharing: guidance for practitioners and managers. HM Government 2008. https://www.gov.uk/government/publications/information-sharing-for-practitioners-and-managers
- NHS Confidentiality Code of Practice. Department of Health. 2003. https://www.gov.uk/government/publications/confidentiality-nhs-code-of-practice
- Working Together to Safeguard Children: a guide to inter-agency working to safeguard and promote the welfare of children. Department for Education. 2013. https://www.gov.uk/government/publications/working-together-to-safeguard-children
- Disclosure Barring Service checks: https://www.gov.uk/disclosure-barring-service-check

This material does not form part of the Code. It is provided for assistance only.

Notes to flowcharts

19.127 The following flowcharts are for assistance only and do not form part of the Code. They summarise the issues that practitioners will need to consider when determining the legal authority to admit and/or treat a child (under 16s) or young person (16 or 17 year olds). They should be read in conjunction with this chapter. The additional notes should be read with the corresponding boxes in the flow chart. The numbers in brackets refer to paragraphs of the Code. Annex D provides a written description of figures 7-9.

Figure 7: Informal admission and treatment of under 16s

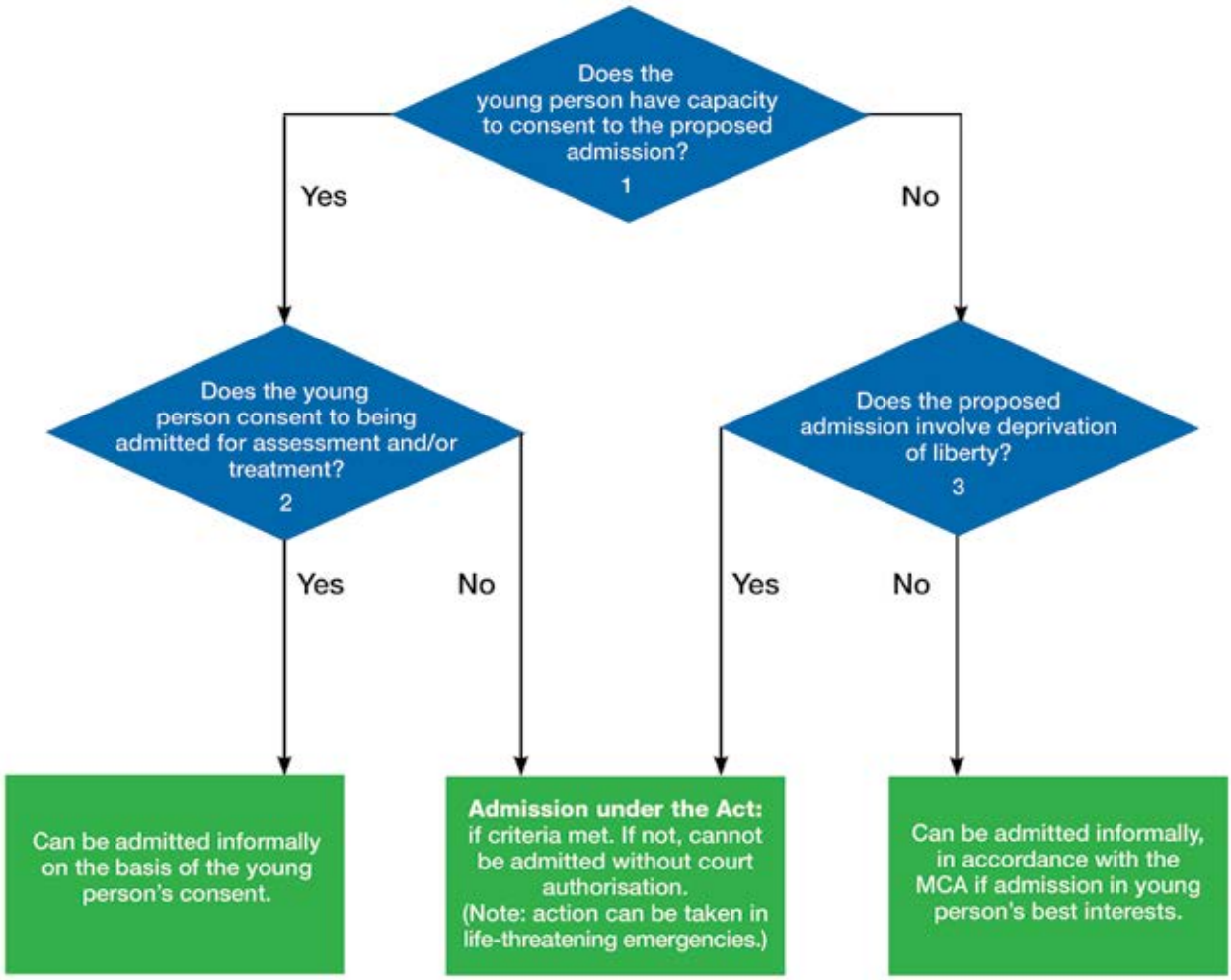


[23] Consideration should be given to whether a person with parental responsibility can consent to the admission or treatment which would, without consent, amount to a deprivation of liberty.

Additional notes to Figure 7

1. Is the child competent to decide about the proposed admission and/or treatment? It will be important to identify the decision to be made: decisions about admission need to be treated separately from decisions about treatment. Consider whether the child is competent ('Gillick' competent) to consent to the admission and/or treatment (see paragraph 19.34 – 19.37).
2. Does the child consent to the admission and/or treatment? The consent of a 'Gillick competent' child will be sufficient authority to admit and/or treat the child (paragraphs 19.65 – 19.66). Note: there may be reasons for not relying on the child's consent to admission (paragraphs 14.14 – 14.16). If a Gillick competent child does not consent to the proposed admission and/or treatment it would be inadvisable to override their refusal by relying on parental consent (paragraph 19.39).
3. Does the admission and/or treatment amount to a deprivation of liberty? Consideration should be given to whether a person with parental responsibility can consent to the proposed admission and/or treatment which would, without consent, amount to a deprivation of liberty (see paragraphs 19.44 – 19.48).
4. Is the decision within the scope of parental responsibility? (This is explained in paragraphs 19.38 – 19.43.)
5. Does the person with parental responsibility consent? A child who is not competent to make decisions about their admission and/or treatment may be admitted and/or treated if the person with parental responsibility consents to the particular intervention. If the person with parental responsibility is unwilling to consent to the admission and/or treatment, consider whether the criteria for admission under the Act are met.

Figure 8: Informal admission of 16 and 17 year olds

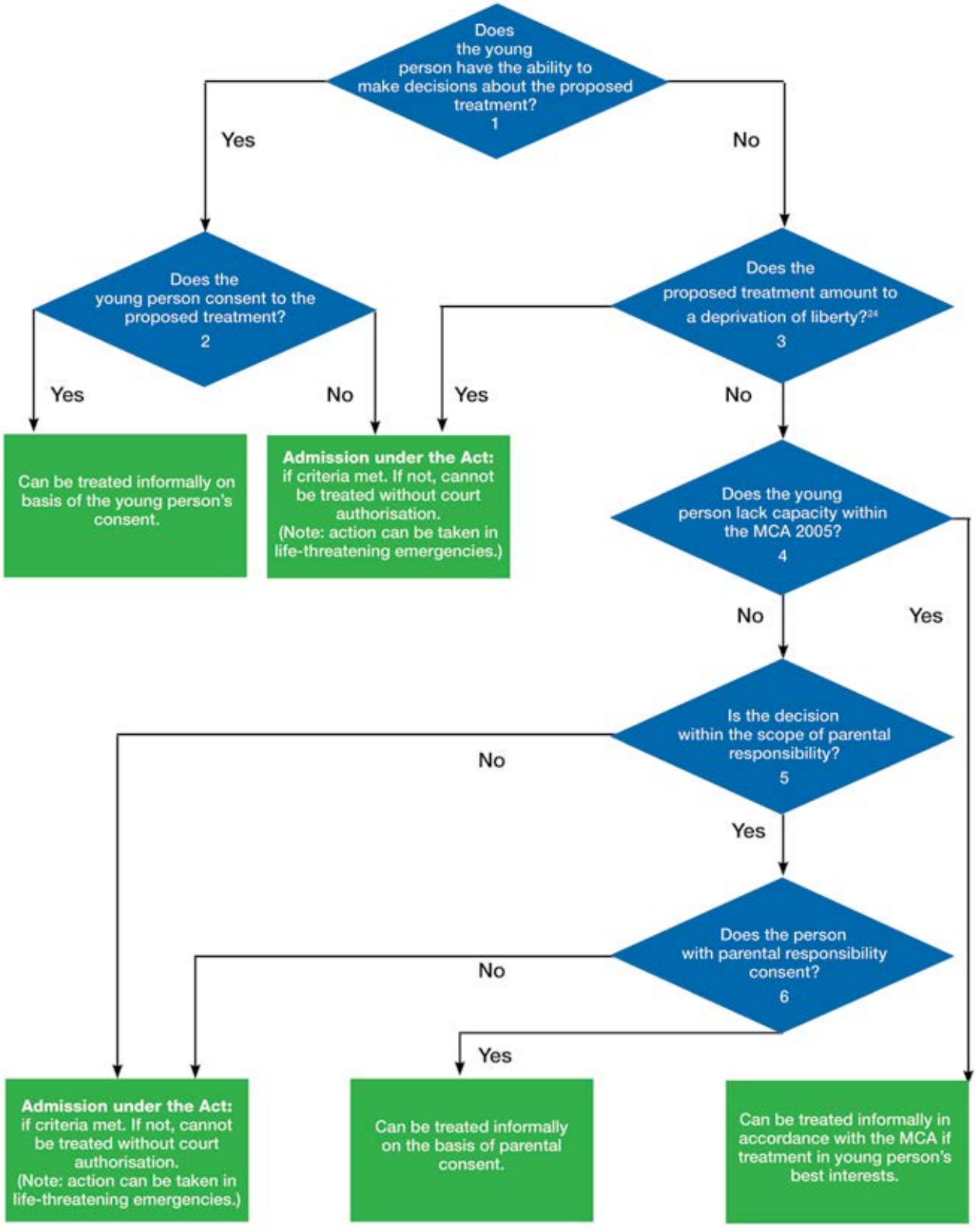


Additional notes to Figure 8

1. Does the young person have capacity to consent to admission? (See paragraphs 19.26 – 19.33.)
2. Does the young person consent to being admitted? The consent of a young person with capacity to consent is sufficient authority to admit them (paragraph 19.53). Note: there may be reasons for not relying on the young person's consent to admission to hospital (paragraphs 14.14 – 14.16). Parental consent cannot override a young person's refusal to being admitted (section 131 the Act, see paragraph 19.39).
3. Does the admission involve deprivation of liberty? A young person cannot be admitted informally if the admission amounts to a deprivation of liberty. If the young person lacks capacity, the admission is in the young person's best interests and does not amount to a deprivation of liberty then the young person can be admitted informally in accordance with the MCA (paragraph 19.57).

19

Figure 9: Informal treatment of 16 and 17 year olds



[24] Consideration should be given to whether a person with parental responsibility can consent to the admission or treatment which would, without consent, amount to a deprivation of liberty.

Additional notes to Figure 9

1. Is the young person unable to make decisions about the proposed treatment? If so, is this because they lack capacity under the MCA? Or are they unable to decide about the proposed treatment but not because they lack capacity within the meaning of the MCA? (See paragraphs 19.26 – 19.33.)
2. Does the young person consent to the proposed treatment? The consent of a young person who has capacity to make the decision is sufficient authority to treat the young person – (paragraphs 19.58 – 19.59). It would be inadvisable to rely on parental consent to authorise the young person's treatment when the young person has capacity and is refusing the treatment (paragraph 19.39).
3. Does the treatment involve a deprivation of liberty? Consideration should be given to whether a person with parental responsibility can consent to the arrangements which would, without consent, amount to a deprivation of liberty. (See paragraphs 19.44 – 19.48.) If it does amount to a deprivation of liberty, admission under the Act will need to be considered. If the criteria for admission under the Act are not met, the young person cannot be treated without court authorisation (although it should be noted that action can be taken in life-threatening emergencies).
4. If the treatment does not involve a deprivation of liberty, consideration should be given to whether the young person lacks capacity within the meaning of the MCA. If the young person lacks capacity, and the treatment is in the young person's best interests then the young person can be treated informally in accordance with the MCA (paragraphs 19.60 – 19.64).
5. If the young person does not lack capacity within the meaning of the MCA 2005, consider whether the decision is within the scope of parental responsibility (see paragraphs 19.41 – 19.42). Paragraphs 19.31 – 19.33 and 19.63 explain that there may be cases in which a young person is unable to decide about the proposed treatment but for reasons other than an impairment of, or a disturbance in the functioning of, their mind or brain (and therefore the young person does not lack capacity within the meaning of the MCA 2005).
6. Does the person with parental responsibility consent? In cases where the young person is unable to decide about their treatment but not because they lack capacity within the meaning of the MCA (see paragraph 19.31) it may be possible for the treatment to be given on the basis of parental consent, if the treatment is within the scope of parental responsibility (see paragraphs 19.41 – 19.42 and 19.63).

Examples

The following examples should be read in conjunction with the above text and the preceding flowcharts.

Example A

A 13 year old child is assessed as not being Gillick competent. The primary purpose of the intervention is to provide medical treatment for mental disorder. The child has been in hospital before and is happy to return there. However, neither of the parents (both of whom have parental responsibility) consents. Given that it is not possible to rely on the child's consent (the child is not Gillick competent) or parental consent (the parents do not consent and no other person has parental responsibility) the child cannot be admitted informally in accordance with section 131(1) of the Act. If the child meets the relevant criteria, the child could be admitted to hospital for assessment (section 2) or for treatment (section 3) under the Act. If the criteria for detention under the Act are not met, legal advice should be sought on the need to seek authorisation from the court before further action is taken.

Example B

A 14 year old girl is assessed as not being Gillick competent. The primary purpose of the intervention is to provide medical treatment for mental disorder. She is severely anorexic and the proposed treatment is that she is fed by naso-gastric tube. The naso-gastric tube may need to be in place for several weeks in order to restore the child to a safe BMI (body mass index). The care team conclude that as this is a particularly invasive form of treatment and the girl is likely to resist the insertion of the tube, it would not be appropriate to rely on parental consent to authorise this intervention. Accordingly, even though a person with parental responsibility consents, the child is not admitted and treated informally under section 131(1) of the Act. If the child meets the relevant criteria, she could be admitted to hospital for assessment (section 2) or for treatment (section 3) under the Act. If the criteria for detention under the Act are not met, legal advice should be sought on the need to seek authorisation from the court before further action is taken.

Example C

A 15 year old child is assessed as being Gillick competent. The primary purpose of the intervention is to provide medical treatment for mental disorder. The child does not consent to treatment in hospital. The child's parents are keen for the child to be admitted to hospital and give their consent. However, it is not considered safe to rely on the parent's consent where a Gillick competent child is refusing. Accordingly, the child cannot be admitted informally under section 131(1) of the Act as the child is competent to consent but does not do so. If the child meets the relevant criteria, the child could be admitted to hospital for assessment (section 2) or for treatment (section 3) under the Act. If the criteria for detention under the Act are not met, legal advice should be sought on the need to seek authorisation from the court before further action is taken.

Example D

A 16 year old young person is assessed as needing a period of in-patient treatment. Under the MCA applies, he should be presumed to have capacity to make decisions. There is no evidence to show that he lacks capacity. The primary purpose of the intervention is to provide medical treatment for mental disorder. The young person consents to admission and treatment in hospital. The young person can be admitted to hospital and treated as an informal patient in accordance with section 131 of the Act without being detained.

20 People with learning disabilities or autistic spectrum disorders

Why read this chapter?

20.1 This chapter deals with issues of particular relevance to people with learning disabilities, autistic spectrum conditions (autism) or both, including patients who are children or young people.

20.2 People with learning disabilities or autism have the same rights and protections as other people under the Act and this Code. Professionals and practitioners working with people with learning disabilities or autism should also be familiar with the Human Rights Act 1998, the Mental Capacity Act 2005 (MCA) and the Equality Act 2010.

20.3 The chapter identifies the key issues from the MCA and the Equality Act that should be considered and provides guidance about the detention of people with learning disabilities or autism. People with learning disabilities or autism are particularly vulnerable and are likely to require a range of reasonable adjustments, for example to aid communication. This chapter should be read and understood in the context of the Code as a whole and with particular regard to the guiding principles (see chapter 1), which include using the least restrictive option and maximising independence, and respect and dignity.

Learning disabilities

20.4 For the purposes of the Act, a 'learning disability' is defined as 'a state of arrested or incomplete development of the mind which includes significant impairment of intelligence and social functioning'. A learning disability has also been described as a:

- significantly reduced ability to understand new or complex information, to learn new skills, and
- reduced ability to cope independently which starts before adulthood with lasting effects on development.[1]

20.5 Although learning disability is defined as a mental disorder in this way, it shares few features with the serious mental illnesses that are the most common reason for using the Act. The vast majority of people with learning disability or autism will never come into contact with the Act. Learning disability and autism both cover a wide spectrum of people with diverse needs and other possible co-morbidities and evidence-based good practice is that most of their needs can best be met at home or in community settings.

[1] Valuing People: a new strategy for learning disability for the 21st Century. Department of Health. 2001. https://www.gov.uk/government/publications/valuing-people-a-new-strategy-for-learning-disability-for-the-21st-century

20.6 The identification of an individual with a learning disability is a matter for clinical judgement, guided by current professional practice. It is important to assess the person holistically, as well as to consider their behaviour in light of the person's current and past circumstances (see paragraph 20.15). Where a learning disability is identified, three further issues have to be considered:

- whether the MCA has to be applied in addition to the Act and, if so, how
- how reasonable adjustments would benefit the person with learning disabilities, and
- how to ensure the inclusion and promotion of the person's human rights adds to the wellbeing of the person.[2]

Abnormally aggressive or seriously irresponsible behaviour

20.7 A person with a learning disability can only be considered to have a mental disorder for the purposes of the provisions specified in section 1(2B) of the Act, without another concomitant mental disorder, where the learning disability is associated with one or both of the following further features:

- abnormally aggressive behaviour, or
- seriously irresponsible conduct.

20.8 This means that, for the purposes of those provisions, which include applications for detention for treatment or guardianship, or the making of hospital orders or community treatment orders, a person must not be considered to be suffering from a mental disorder solely because they have a learning disability: the disability must be associated with abnormally aggressive or seriously irresponsible conduct.

20.9 Neither term is defined in the Act, and it is not possible to define exactly what kind of behaviour would fall into either category. Inevitably, it will depend on the nature of the behaviour and the circumstances in which it is exhibited, and also on the extent to which it gives rise to a serious risk to the health or safety of the person or others, or both.

20.10 It is important to establish whether a person's learning disability is associated with conduct that could be categorised as abnormally aggressive, not simply aggressive. Relevant factors when assessing this include:

- when such aggressive behaviour has been observed, and how persistent and severe it has been
- whether it has occurred without a specific trigger or seemed disproportionate to the circumstances that triggered it
- whether, and to what degree, it has resulted in harm or distress to other people, or actual damage to property

[2] Valuing People: a new strategy for learning disability for the 21st Century. Department of Health. 2001. https://www.gov.uk/government/publications/valuing-people-a-new-strategy-for-learning-disability-for-the-21st-century

- how likely it is to recur, and
- how common similar behaviour is in the population generally.

20.11 Similarly, in assessing whether a person's learning disability is associated with conduct that is not only irresponsible but seriously irresponsible, relevant factors may include:

- whether behaviour has been observed that suggests a disregard or an inadequate regard for its serious or dangerous consequences
- how recently such behaviour has been observed and, when it has been observed, how persistent it has been
- how seriously detrimental to the individual, or to other people, the consequences of the behaviour were or might have been
- whether, and to what degree, the behaviour has actually resulted in harm to the person or the person's interests, or in harm to other people or to damage to property, and
- how likely it is to recur.

20.12 Bizarre or unusual behaviour is not the same as abnormally aggressive or seriously irresponsible behaviour.

20.13 When assessing whether a person with a learning disability should be detained for treatment under the Act, it is important to establish whether any abnormally aggressive or seriously irresponsible behaviour identified stems from difficulties in communication or an underlying condition or syndrome or unmet need. Challenging behaviour may be due to an unmet support need, unmet social or emotional need, or an unmet physical health need (including untreated pain), rather than to a mental disorder. This area is often referred to as functional assessment. Challenging behaviour due to these factors should be addressed by addressing the underlying condition or unmet need.

20.14 Unless very urgent action is required, it would not be good practice to diagnose a person as having a learning disability associated with abnormally aggressive behaviour or seriously irresponsible conduct (or both) without an assessment by a consultant psychiatrist in learning disabilities and a formal specialist psychological assessment. This should be part of a holistic appraisal by medical, nursing, social work, speech and language and occupational therapy and psychology clinicians with experience in learning disabilities, in consultation with a relative, advocate or supporter of the person. An approved mental health professional (AMHP) who assesses someone with a learning disability under the Act should have training and experience in working with people with learning disabilities. Information from the person-centred care plan, a hospital passport,[3] and health action plan may also inform the assessment process.

[3] For an example see: http://www.nhs.uk/Livewell/Childrenwithalearningdisability/Documents/Hospital%20Passport%20Template%20example%20from%20South%20West%20London%20Access%20to%20Acute%20Group.doc

20.15 Recent reviews of serious cases have shown that people's life experiences and life stories are important in helping to understand some aggressive behaviour. People with learning disabilities experience disproportionate harassment, 'hate crime' and 'mate crime', and they are disproportionately the victims of violence. These are all factors that may make aggressive behaviour sometimes a learned protective behaviour rather than a sign of a mental disorder.

20.16 Professionals should record on the relevant form their reasons for concluding that the individual's conduct is abnormally aggressive or seriously irresponsible, and why it relates to the person's learning disability and is not attributable to others factors such as an unmet physical health, social or emotional need (see paragraph 20.13).

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

Autistic spectrum conditions

20.18 Autistic spectrum conditions (autism) have been defined as a lifelong developmental disability that affects the way a person communicates with, and relates to, other people. It also affects how they make sense of the world around them. It is a spectrum condition meaning each individual will have different needs.[4]

20.19 The Act's definition of mental disorder includes the full range of autistic spectrum conditions, including those existing alongside a learning disability or any other kind of mental condition. It is possible for someone on the autistic spectrum to meet the criteria in the Act for detention without having any other form of mental disorder, even if the autism is not associated with abnormally aggressive or seriously irresponsible behaviour, but this will be very rare.

20.20 Compulsory treatment in a hospital setting is rarely likely to be helpful for a person with autism, who may be very distressed by even minor changes in routine and is likely to find detention in hospital anxiety provoking. Sensitive, person-centred support in a familiar setting will usually be more helpful. Wherever possible, less restrictive alternative ways of providing the treatment or supporting a person should be found. The specialist expertise and skills of staff should be regularly audited, particularly the ability to recognise social and health needs, and specialist communication skills.

[4] Think Autism 2014. Fulfilling and Rewarding Lives, the Strategy for Adults with Autism in England: an update. Department of Health. 2014. https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/299866/Autism_Strategy.pdf

20.21 Autistic spectrum conditions are disorders occurring from early stages in development where a person shows marked difficulties with social communication, social interaction and social imagination. They may be preoccupied with a particular subject of interest. This spectrum includes high functioning people who need person-centred care as well as those with little or no verbal communication. The key to appropriate care is having staff with the relevant expertise and experience, who can consider a range of care options, with an emphasis on those which are least restrictive to the person.

20.22 Autism is developmental in nature and is not a mental illness. People with autism may have additional or related problems, which frequently include anxiety. These may be related to social factors associated with frustration or communication problems or rigid or literal patterns of thought and behaviour. As with people with learning disabilities, people with autism may also have co-morbid mental disorders, including mood disorders and, occasionally, personality disorders and this should be kept in mind.

20.23 A person with autism may have additional sensory and motor difficulties, which make them behave in an unusual manner which might be interpreted as a mental illness but are, in fact, a coping mechanism. These include sensitivity to light, sound, touch and balance and may result in a range of regulatory behaviours, including rocking, self-injury and avoidance, such as running away.

20.24 A person with autism is likely to behave in ways that seem odd to other people. Mere eccentricity, in anyone, does not however justify the use of the Act.

20.25 There can also be a repetitive or compulsive element to much of the behaviour of people with autism. The person may appear to be choosing to act in a particular way, but their behaviour may be distressing even to themselves. It may be driven or made worse by anxiety and could lead to harm to self or others. Repetitive behaviour does not in itself constitute a mental disorder.

20.26 A person with autism may show a marked difference between their intellectual and their emotional development. Their behaviour may occasionally seem aggressive or seriously irresponsible. They may be able to discuss an act intellectually and express a desire to do or not do it, but they may not have the instinctive social empathy to keep to their intentions. This should be understood and responded to by professionals, who should recognise that specialist structured approaches to communication may be required. When a person is unable to prevent themselves from causing severe harm to themselves or others, compulsory measures under the Act may be needed.

20.27 If people with autism do need to be detained under the Act, it is important that they are treated in a setting appropriate to their social and communication needs as well as being able to treat their mental condition. Practitioners working with or detaining people with autism should have relevant specialist training and experience.

20.28 People with autism should be detained for as short a period as possible. Many people with autism who have been detained will require, and be entitled to, after-care (chapter 33). Discharge planning for people with autism should begin when the person is admitted and involve health and local authorities to work together in the interests of an individual to ensure appropriate community-based support is in place before discharge. This will require assessment by a practitioner with expertise in autism, as set out by the statutory adult autism guidance.

Mental Capacity Act

20.29 In addition to the information in chapter 13 for individuals with a learning disability or autism the following should be taken into consideration:

- where a person with learning disabilities or autism who is detained under the Act has a physical illness or condition which is unrelated to their mental disorder for which they need treatment (eg cancer treatment or pregnancy), the MCA will apply to assessing whether they have the capacity to give consent to that treatment. If they are assessed to lack capacity to consent, any treatment given must be in accordance with the MCA, and
- where a decision needs to be made about where a person with learning disabilities or autism is discharged to, and they lack the capacity to make that decision, then the MCA needs to be applied to reach a best interests decision for the person. An independent mental capacity advocate (IMCA) should be involved, particularly if the person has no carers to be consulted, or if the carer disagrees with professionals on what is in the person's best interests. See the MCA Code of Practice chapter 10 for more detail.

20.30 A person with a learning disability or autism cannot be informally admitted if they do not have capacity to consent to or refuse that admission and treatment. If the person lacks that capacity and will (or will be likely to be) deprived of their liberty to receive the treatment, a deprivation of liberty authorisation (DoL authorisation) or a Court of Protection order must be in place to authorise the deprivation of liberty (see chapters 13 and 14). The Care Quality Commission (CQC) must be notified of all applications for authorisation of deprivation of liberty and the outcomes.

Equality Act and reasonable adjustments

20.31 If a person with a learning disability or autism is detained under the Act, a comprehensive assessment of their needs should be undertaken to ensure that reasonable adjustments required by the Equality Act are made (see chapter 3). As well as the following points, reasonable adjustments relate to many other areas of the Code, such as access to advocates, the Tribunal, and information giving. Further examples are included in paragraph 20.40. Reasonable adjustments should include:

- communication support
- information in an accessible format, in accordance with NHS Commissioning Board guidelines on making health and social care information accessible.[5] This could include, for example, easy read leaflets or simple videos, although this does not replace the need for clear and simple verbal explanation by professionals
- sufficient time for the person and any others supporting them for preparation before meetings
- accessible information explaining rights and how to raise safeguarding concerns or complaints
- treatment goals and support plans in an accessible format
- adapted treatment programmes including psychological therapies
- adapted therapeutic environment
- ensuring that meetings are held in an environment which is not intimidating
- risk assessment of personal safety (due to increased vulnerability), and
- prioritised access to and involvement of carers and/or advocates, unless the individual had indicated that they do not want this.

20.32 The examination or assessment of someone with learning disabilities or autism requires special consideration of how to communicate effectively with the person being assessed. Carers will often be able to assist clinicians with this and should be consulted where appropriate. Whenever possible the people carrying out assessments should have experience and training in working with people with learning disabilities or autism. If this is not possible they should seek assistance from specialists with appropriate expertise, but this should not be allowed to delay action that is immediately necessary. Assessment should ideally be part of a complete appraisal – a multi-disciplinary process involving medical, nursing, social work, occupational therapy, speech and language therapy and psychology professionals (as necessary) with relevant specialist experience.

[5] Making Health and Social Care Information Accessible. http://www.england.nhs.uk/ourwork/patients/accessibleinfo-2/

20.33 In addition to the information in chapter 3 for individuals with a learning disability or autism the following should be taken into consideration in relation to the Equality Act:

- where some people with learning disabilities or autism find it difficult to manage 'queuing' at meal times, a hospital or assessment or treatment centre should make different arrangements for meal times
- in a hospital or assessment and treatment setting where social activities are provided on a 'first come first served' basis, positive action should be used to enable people with reduced ability or confidence due to their learning disability or autism, to access these activities
- in an institutional setting where aggressive behaviour can occur, institutions should take extra steps to protect those who are vulnerable
- staff should be aware, and if a patient with a learning disability or autism is being harassed or victimised by other people using the service, and carefully considered 'adjustments' to the care regime may be needed to prevent this, and
- if it can reasonably be foreseen that restrictive interventions may need to be used, the patient's individualised care and treatment plan should include primary preventative strategies, secondary preventative strategies and tertiary strategies including the types of restrictive interventions that may be used (see paragraphs 26.15 – 26.17). People with learning disabilities need individualised care and support plans to be carefully targeted to their understanding, their needs and their history and to be assisted to understand when restrictive interventions may be used and for what purpose.

20.34 These examples illustrate the principle that health services can take proportionate positive action to achieve equality of access and of outcome. The Equality Act allows persons with disabilities to be treated more favourably than others if necessary to comply with the public sector equality duty, and includes a duty to make 'reasonable adjustments' to help to eliminate barriers to access and participation for disabled persons (see paragraph 3.7).

Practice considerations

Alternatives to section 3 detention

20.35 An application under section 3 of the Act to detain a person with a learning disability or autism cannot be made unless the criteria in that section are met (see paragraphs 14.2 – 14.8). Learning disabilities and autism share few features with the serious mental illnesses that are the most common reason for using the Act, and so consideration should be given to whether detention of a person with learning disability or autism is appropriate. Behaviour may be due to an underlying condition, syndrome or unmet need and may not be best treated in hospital (see paragraph 20.13). Hospitals are not homes, and most support for people with a learning disability or autism should be provided in a local community setting. The following practice considerations should also be kept in mind.

20.36 Consideration should be given to whether there are alternative means of providing the care and treatment which the patient requires before it is decided that admission to hospital is necessary. Alternatives to detention under the Act should always be considered (see paragraphs 14.11 – 14.13).

20.37 Detaining a person with learning disabilities or autism under the Act because there is no treatment available for them in the community is not a substitute for appropriate commissioning of care.

20.38 The purpose of treatment under the Act is to alleviate or prevent a worsening of the mental disorder or its symptoms. A person's underlying learning disability or autism cannot be 'treated'.

Risks relating to people with learning disabilities or autism

20.39 All those involved in examining, assessing, treating or taking other decisions in relation to people with learning disabilities or autism should bear particular risks in mind in relation to people with learning disabilities or autism including:

- incorrect assumptions that they do not have capacity to make decisions for themselves and a tendency to be over-protective. The MCA makes clear that a person must be assumed to have capacity unless it is established that they do not
- incorrect assumptions that a tendency to acquiesce is the same as informed consent
- failing to consult or fully listen to carers who, as 'experts by experience', can play an important role in providing relevant information about the person's past, or about effective communication methods
- over-reliance on carers, both for support and for decision-making. The considerable expertise of carers should be acknowledged, and appropriately used in partnership with the clinical team. This should not mean that clinicians rely on carers to take decisions inappropriately and on their own on behalf of the person
- a lack of appreciation of the potential abilities of people with learning disabilities or autism, including their potential to make decisions for themselves
- the risk the person may be denied access to decision-making processes, meetings about them or information
- the person's limited life experiences to draw on when making choices, and
- attributing the person's symptoms and behaviours to their learning disability or autism rather than underlying undiagnosed and/or unmet physical or mental health needs or to something traumatic that happened to them in their past.

20.40 Those working under the Act with people with learning disabilities or autism should bear in mind the following general points:

- practitioners require a good understanding of the MCA. In particular, the requirement to assist people to make decisions for themselves where possible; the need to respect a decision by a person who has capacity which may be seen as unwise; and to offer care that is the least restrictive of people's rights. This should be audited as part of the quality monitoring within hospitals and other settings
- people with learning disabilities or some autistic spectrum conditions may use non-verbal communication rather than spoken language. This non-verbal communication may include behaviour, gestures, posture and body language, ways of moving, signing, noises and pointing. It is important to recognise people's communication in all its forms and to avoid assuming that people's behaviour is a symptom of a mental disorder, when it may be their way to communicate feelings or physical pain or discomfort
- people with learning disabilities or autism may find new environments, such as a medical setting, frightening. All 'reasonable adjustments' (as required by the Equality Act 2010, see paragraphs 3.14 – 3.16) need to be made to adapt and respond to each individual's needs. This may mean offering a quiet space, for example, or having a key worker with specialist training or a communication book[6]
- the least restrictive way of achieving the proposed assessment or treatment must be identified (see paragraph 14.11) and for people with learning disabilities or autism, this means they should usually be treated in the community. Inappropriate care in a hospital can lead to a worsening of challenging behaviour, which can cause a negative cycle of feelings of frustration leading to challenging behaviour and increased restriction of liberty. The most appropriate method of communication for each person with learning disabilities or autism should be identified as soon as possible, and the help of a speech and language therapist should be sought wherever appropriate. It is helpful to identify a specific person who will undertake this task
- some people with learning disabilities or autism may prefer to have written material in simple language with images or symbols to assist, or in pictures without written words, and this could be reinforced orally. It can be helpful to repeat information and leave a record of the information that has been shared so that the person can consult it later and ask others to clarify anything that is difficult to understand
- it is important to set aside sufficient time for preparation of suitable information and for preparation before meetings. Meetings should be held in an environment which is not intimidating in order to allow the person every chance to understand the information given, and
- individualised care and support plans (eg PBS) may help people with learning disabilities or autism (see paragraphs 26.15 – 26.17)

[6] Making Health and Social Care Information Accessible. http://www.england.nhs.uk/ourwork/patients/accessibleinfo-2/

The role of providers

20.41 It is good practice for hospitals providing treatment and care for people with learning disabilities or autism to have policies and practices which specifically address:

- staff training and supervision in how to effectively communicate with people with learning disabilities or autism, particularly in understanding their wishes and feelings
- specialist staff who create communication books for individual in-patients and who teach how to develop personalised care for people who have learning disabilities or autism
- training of staff to ensure sufficient awareness and knowledge of learning disability, autism, behaviour that challenges, and mental health, and training in positive behavioural support (see chapter 26)
- training in the safe and effective management of commonly associated physical health conditions, such as epilepsy
- ensuring physical health needs are met (eg annual health check and associated action plan)
- reasonable adjustments and capable environments, and
- regular audits of incidents involving restrictive practices to see whether less restrictive methods could be used.

20.42 Providers must ensure that their care and treatment of people with learning disabilities or autism is compliant with the law. People with learning disabilities, their families, carers and advocates should be helped to access information and (if necessary) legal advice on how to access the Tribunal (see paragraphs 12.6 – 12.9 and the MCA Code of Practice)[7] and, if the person lacks capacity, the Court of Protection. Providers should proactively promote people's rights and their access to human rights.

20.43 Promoting human rights such as the article 8 right to private life, may mean reviewing policies on: access to the person's sleeping area; mobile phones, visits from family and friends; and how to maintain family life (eg through contact with family members, such as sharing meals and celebrations, and performing roles such as being parents or grandchildren). The person's article 5 right to liberty should also be protected by developing and applying the least restrictive option and maximising independent principle in care and treatment regimes (see paragraphs 1.2 – 1.6 and 3.2 – 3.6).

[7] Mental Capacity Act 2005: Code of Practice. Department for Constitutional Affairs (now Ministry of Justice). 2007. https://www.gov.uk/ government/publications/mental-capacity-act-code-of-practice

20.44 Providers cannot assume that people with learning disabilities or autism necessarily understand how to access information and advice about their rights, for example in relation to consent to admission and treatment, applications for discharge and accommodation decisions on discharge. Providers should take such steps as are practicable to ensure people with learning disabilities or autism can access information and advice, including access to additional support such as IMHAs (see chapter 6) or, if applicable, independent mental capacity advocates (IMCAs). Hospital managers should ensure that those responsible for explaining the way the Act works and their rights to people who are subject to the Act, are adequately trained in understanding the Act, the MCA and the deprivation of liberty safeguards within it, and the Human Rights Act.

Seeking advice from specialists and carers

20.45 Where information relates to the right of the individual to have their case reviewed by the Tribunal, adjustments may need to be made to ensure people with learning disabilities or autism understand the Tribunal's role. An individual (and carers supporting them) may well need support to make an informed decision about whether and when and how to make an application, which may be provided by IMHAs, or other advocates.

20.46 Where professionals taking decisions under the Act have limited expertise in promoting the rights of people with learning disabilities or autism, it is good practice to seek advice from a specialist or specialist service (perhaps within the local authority or a voluntary organisation), which can suggest alternatives to using the Act and give advice on mental capacity issues and on communication.

20.47 Where appropriate, it is desirable that someone who knows the person with a learning disability or autism is present at an initial examination and assessment, provided that this does not breach the person's confidentiality. Knowledge of the person's early developmental history, usual pattern of behaviour, communication needs and any particular needs will help prevent someone with a learning disability or autism wrongly being made subject to the Act or treated inappropriately.

20.48 The potential of co-morbidity with mental illness and personality disorder should also be kept in mind so professionals with appropriate expertise can be involved in the person's assessment, treatment and care. The possibility of physical health problems underlying the presentation of abnormally aggressive or seriously irresponsible behaviour should always be kept in mind, including the impact of inadequately treated epilepsy or side effects of medication.

20.49 For children and young people under the age of 18, a children and adolescent mental health services (CAMHS) consultant with relevant experience of learning disability or autism should be involved.

20

Related material

Learning disabilities

- Guide for Commissioners of Services for People with Learning Disabilities who Challenge Services. National Development Team for Inclusion. 2010. http://www.ndti.org.uk/uploads/files/Challenging_behaviour_report_v7.pdf
- Services for People with Learning Disability and Challenging Behaviour or Mental Health Needs. Mansell Report. 2007. http://webarchive.nationalarchives.gov.uk/20130107105354/http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_080129
- Transforming Care: a national response to Winterbourne View Hospital Department of Health Review: Final Report. Department of Health. 2012. https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/213215/final-report.pdf
- Winterbourne View: transforming care one year on. Department of Health. 2013. https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/265752/Winterbourne_View_One_Year_On_Report.pdf
- Closing the Gap: priorities for essential change in mental health. Department of Health. 2014. https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/273649/Closing_the_gap.pdf
- Valuing People: a new strategy for the 21st century. Department of Health. 2001. http://webarchive.nationalarchives.gov.uk/20110601212422/http:/www.valuingpeoplenow.dh.gov.uk/
- Valuing People Now: a new three-year strategy for people with learning disabilities 'making it happen for everyone'. Department of Health. 2009. http://webarchive.nationalarchives.gov.uk/20130107105354/http:/www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_093377
- Positive and Proactive Care: reducing the need for restrictive interventions. Department of Health. 2014. https://www.gov.uk/government/publications/positive-and-proactive-care-reducing-restrictive-interventions
- Getting it Right for People with Learning Disabilities: what families need to know. NHS England. 2014. https://www.myhealth.london.nhs.uk/sites/default/files/u1217/NHS%20England%20-%20Getting%20it%20right%20for%20people%20with%20learning%20disabilities%20v6%20(Spreads).pdf

Autistic spectrum conditions

- Autism Strategy: fulfilling and rewarding lives. Department of Health. 2010. http://webarchive.nationalarchives.gov.uk/20130107105354/http:/www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/@ps/documents/digitalasset/dh_113405.pdf
- Think Autism: fulfilling and rewarding lives, the strategy for adults with autism in England: an update. Department of Health. 2014. https://www.gov.uk/government/publications/think-autism-an-update-to-the-government-adult-autism-strategy
- Implementing 'Fulfilling and Rewarding Lives': statutory guidance for local authorities and NHS organisations to support implementation of the autism strategy. Department of Health. 2010. https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/216129/dh_122908.pdf (To be replaced in 2015 by revised statutory guidance to implement the strategy for adults with autism in England.)
- Autism: recognition, referral and diagnosis and management of adults on the autistic spectrum. National Institute for Health and Care Excellence Clinical Guideline. 2012. http://www.nice.org.uk/guidance/CG142
- Good Practice in the Management of Autism (including Asperger Syndrome) in Adults. Royal College of Psychiatrists. 2014. http://www.rcpsych.ac.uk/usefulresources/publications/collegereports/cr/cr191.aspx

This material does not form part of the Code. It is provided for assistance only.

21 People with personality disorders

Why read this chapter?

21.1 The Act applies equally to all people with mental disorders, including those with either primary or secondary diagnosis of personality disorder. This chapter is particularly helpful for professionals and practitioners working with people with personality disorders. Guidance is given on assessment and appropriate medical treatment.

Personality disorders – general points

21.2 Generally, people who have personality disorders present a complex range of mental health and other problems:

- many people may have a diagnosis of more than one personality disorder, and they may also have other mental health problems such as depression, anxiety or post-traumatic stress syndrome
- suicidality, self-harm, substance misuse problems and eating disorders are also common in people with personality disorders
- some individuals experience very severe, periodic emotional distress in response to stressful circumstances and crisis, particularly people with borderline personality disorder
- some individuals can at times display a form of psychosis that is qualitatively different from that displayed by people with a diagnosis of mental illness
- people with personality disorders usually have long-standing and recurrent relationship difficulties
- people with personality disorders are more likely than other population groups to experience housing problems and long-term unemployment
- a very small subgroup of people with personality disorder may be anti-social and dangerous, and/or
- anti-social personality disorder is strongly associated with offending, and it is estimated that personality disorders have a high prevalence within offender populations.

Personality disorders and mental health legislation

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

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

Practice considerations

Assessment

21.4 People with personality disorders may present and behave in very different ways from those with other mental disorders. It is important that such behaviours and presentations are properly understood if the Act is to be used appropriately.

21.5 Especially in times of crisis, decisions about the use of the Act for people with personality disorders will often have to be made by professionals who are not specialists in the field. It is therefore important that approved mental health professionals (AMHPs) and doctors carrying out initial assessments have a sufficient understanding of personality disorder as well as other forms of mental disorder.

21.6 Individuals who have historically been labelled by various local agencies as having a personality disorder may never, in fact, have had a thorough clinical assessment and formulation. A number of validated assessment tools enable a more precise identification to be made. Professionals will need to ensure that any treatment and after-care plans are shaped by appropriate clinical assessments conducted by suitably trained practitioners.

21.7 In emergency or very high-risk situations, where such an assessment has not already been carried out and an application for detention under the Act is being considered, the first priority is responding to the immediate risk to the health or safety of the patient or to other people. Achieving an appropriate clinical assessment and formulation should be an immediate aim of detention.

Appropriate medical treatment

21.8 What constitutes appropriate medical treatment for a particular patient with personality disorder will depend on their individual circumstances. First and foremost that calls for a clinical judgment by the clinicians responsible for their assessment or treatment.

21.9 A proposed care plan will not meet the Act's definition of appropriate medical treatment unless it is for the purpose of alleviating or preventing a worsening of the patient's mental disorder, its symptoms or manifestations (see chapter 23).

21.10 Generally, treatment approaches for personality disorder need to be relatively intense and long-term, structured and coherent. Sustainable long-term change is more likely to be achieved with the voluntary engagement of the patient.

21.11 People with personality disorders may take time to engage and develop motivation for such longer-term treatment. But even patients who are not engaged in that kind of treatment may need other forms of treatment, including nurse and specialist care, to manage the continuing risks posed by their disorders, and this may constitute appropriate medical treatment.

21.12 In the majority of cases the primary model of intervention for personality disorder is rooted in a psycho-social model.

21.13 Patients who have been detained may often need to continue treatment in a community setting on discharge. Where there are continuing risks that cannot otherwise safely be managed, a community treatment order (CTO), guardianship or (for restricted patients) conditional discharge may provide a framework within which such can continue their treatment in the community.

21.14 In deciding whether treatment under the Act can safely be delivered in the community, account should be taken of:

- where the specific model of treatment intervention can be most effectively and safely delivered
- if management of personal and social relationships is a factor in the intervention, how the appropriate day-to-day support and monitoring for the patient's social as well as psychological needs can be provided
- to what degree the psycho-social model of intervention requires the active participation of the patient for an effective and safe outcome
- the degree to which the patient has the ability to take part in a psycho-social intervention that protects their own and others' safety
- the degree to which 24-hour access to support will be required, and

- the need for the intervention plan to be supervised by a professional who is appropriately qualified in the model of intervention and in risk assessment and management in the community.

21.15 In the case of personality disordered offenders who may already have received long-term treatment programmes within secure or prison settings, treatment in the community may well still be required while they resettle in the community.

Related material

- Personality Disorder: no longer a diagnosis of exclusion – policy implementation guidance for the development of services for people with personality disorder. Department of Health. 2003. http://www.candi.nhs.uk/_uploads/documents/miscellaneous/pd_no_longer_a_diagnosis_of_exclusion.pdf

This material does not form part of the Code. It is provided for assistance only.

22 Patients concerned with criminal proceedings

Why read this chapter?

22.1 This chapter provides guidance on the use of the Act to arrange treatment for mentally disordered people who come into contact with the criminal justice system, and to those people who are subject to Secretary of State for Justice restrictions (restricted patients). It includes a section specifically relating to children and young people who have reached the criminal age of responsibility (10 years) and who are also subject to criminal proceedings.

22.2 People who are subject to criminal proceedings have the same rights to psychiatric assessment and treatment as anyone else. Professionals and practitioners working with such patients must be mindful of the need to ensure that the restrictions imposed on the patient are proportionate and kept to a minimum needed to meet the purpose and aim of the restriction.

Assessment for potential admission to hospital

22.3 People who are subject to criminal proceedings have the same rights to psychiatric assessment and treatment as everyone else. Any person who is in prison or police custody or before the courts charged with a criminal offence and who is in need of medical treatment for mental disorder can be considered for admission to hospital where the criteria are met. Wherever possible, alternatives to custody for vulnerable individuals should be considered taking into account all information about the persons health needs, including assessment by the liaison and diversion service where one is available.

22.4 Wherever possible, people who appear to police custody officers or the court to be mentally disordered should have their treatment needs considered at the earliest possible opportunity, by the liaison and diversion service (see below) where there is one or other professionals providing healthcare in police custody. Vulnerable people may be at greatest risk of self-harm while in custody. Prompt access to specialist treatment may prevent significant deterioration in their condition and is likely to assist in a speedier justice process, helping to avoid longer-term harm or detention in an unsuitable environment.

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

Liaison and diversion services

22.6 Liaison and diversion (L&D) services aim to identify, assess and refer individuals of all ages who have mental health problems, learning disabilities and other needs, such as autistic disorder, when they come into contact with the youth and adult justice systems and help support the most appropriate criminal justice system outcome. L&D is not itself a treatment service, but it is an identification, assessment and referral service. It uses assessments to make appropriate referrals for treatment and support, and ensures youth and adult justice practitioners are notified of specific health requirements and vulnerabilities of an individual which can be taken into account when decisions about charging and sentencing are made. The service will aim to identify these individuals as early as possible after they come into contact with the police and criminal justice system. It should provide coverage at police custody suites, courts and link up to other parts of the justice process, such as prison and probation. For many people, contact with criminal justice agencies will be the first time they will have been assessed and diagnosed.

Agency responsibilities

22.7 The relevant NHS commissioners should:

- provide the courts, in response to a request under section 39 of the Act, with comprehensive information on the range of facilities available for the admission of patients subject to the criminal justice process. For children and young people this should include information regarding child and adolescent mental health services (CAMHS) beds which are or could be made available for patients. Similarly this should include information about mental health services with provision for people with learning disabilities
- appoint a named person to respond to requests for information, and
- ensure that prompt medical assessment of defendants is provided to assist in the speedy completion of the trial process, meeting individual needs and fulfilling the rights of the person and the most suitable disposal for the offender.

22.8 Section 39A requires a local authority to inform the court, if requested, whether it, or any person approved by it, is willing to receive an offender into guardianship and how the guardian's powers would be exercised. Local authorities should appoint a named person to respond to requests from the courts about mental health services available in the community including under guardianship.

Assessment by a doctor

22.9 A doctor who is asked to provide evidence in relation to a possible admission under part 3 of the Act should bear in mind that the request is not for a general report on the defendant's condition but for advice on whether or not the patient should be diverted from prison by way of a hospital order, or a hospital direction (or a community order with a mental health treatment requirement under criminal justice legislation).

22.10 Doctors should:

- identify themselves to the person being assessed, explain who has requested the report and make clear the limits of confidentiality in relation to the report. They should explain that any information disclosed, and the medical opinion, could be relevant not only to medical disposal by the court but also to the imposition of a punitive sentence, or to its length, and
- request relevant pre-sentence reports, the inmate medical record and previous psychiatric reports, as well as relevant documentation regarding the alleged offence. If any of this information is not available, the doctor's report should say so clearly.

22.11 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 clinician who does if they propose to recommend admission to hospital within the period of 28 days beginning with the date of the making of the order under section 37, section 38 or section 45A of the Act. If the court is making an order under the Criminal Procedure (Insanity) Act 1964,[1] the Court does not need a 'bed offer' as it does for other court orders but it is good practice for any doctor providing a recommendation of a hospital disposal under Domestic Violence, Crime and Victims Act 2004 (DVCVA)[2] to contact the anticipated named hospital in the order.

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

Hospital orders/remands to hospital

22.13 Assessments for remands to hospital or for hospital orders still require assessment by a section 12 approved registered medical practitioner. Her Majesty's Courts and Tribunal Services (HMCTS) commission these reports in accordance with the Costs in Criminal Cases (General) Regulations 1986.[3] Prison should not be the default option.

[1] Criminal Procedure (Insanity) Act 1964. http://www.legislation.gov.uk/ukpga/1964/84

[2] Domestic Violence, Crime and Victims Act 2004. http://www.legislation.gov.uk/ukpga/2004/28/contents

[3] The Costs in Criminal Cases (General) (Amendment) Regulations. 2012. SI 2012/1804. http://www.legislation.gov.uk/uksi/2012/1804/contents/made

Mental health treatment requirement (MHTR)

22.14 The legislative changes introduced by Legal Aid, Sentencing and Punishment of Offenders Act 2012 (LASPO)[4] introduces a simplified procedure for the assessment of an individual for a MHTR, this may now be undertaken by a mental health practitioner, rather than a section 12 approved registered medical practitioner. MHTRs are required to be administered under the direction of a registered medical practitioner or a chartered psychologist. Here the L&D service may undertake the assessment and liaise with the probation office preparing the pre-sentence report, but a registered medical practitioner (doctor) would still be required to provide direction for the administration of any order made by the court.

22.15 In cases where the doctor cannot state with confidence at the time of sentencing whether a hospital order or MHTR will be appropriate, they should consider recommending an interim hospital order under section 38 of the Act. This order provides for the person to be admitted to hospital for up to 12 weeks (which may be extended for further periods of up to 28 days to a maximum total period of 12 months) so that the court can reach a conclusion on the most appropriate and effective disposal. In this situation, the most appropriate setting for the person is a hospital, not a prison.

Independent medical assessment

22.16 A patient who is remanded to hospital for a report (section 35) or for treatment (section 36) is entitled to obtain, at their own expense, or where applicable through legal aid, an independent report on their mental condition from a doctor or other clinician of their choosing, for the purpose of applying to court for the termination of the remand. Hospital managers should help in the exercise of this right by enabling the patient to contact a suitably qualified and experienced solicitor or other legal adviser.

22.17 Where the court refers the patient for assessment or treatment under sections 35 or 36, the initial report that has been requested by the court would be remunerated from central funds and not by the legal aid agency. If, however, the patient wishes to obtain a report to challenge the report produced for the court, providing that the merits criteria are satisfied, this could be remunerated under the patient's criminal legal aid. Additionally, the patient would need to satisfy the financial eligibility criteria specified by either the magistrates' court or Crown Court. The patient's representative could also consider making an application to the legal aid agency for prior authority to commission a report to challenge the report produced by the clinical staff.

[4] Legal Aid, Sentencing and Punishment of Offenders Act 2012. http://www.legislation.gov.uk/ukpga/2012/10/contents/enacted

Reports to the court

22.18 Clinical opinion is particularly important in helping courts to determine the sentence to be passed. In particular, it will help to inform the decision whether to divert the offender from punishment by way of a hospital order is most appropriate, or whether a prison or community sentence is the most suitable disposal. Clinicians providing their assessment should have had experience (forensic) in working with mentally disordered offenders.

22.19 A medical report for the court should set out:

- the material on which the report is based
- how that material relates to the opinion given
- where relevant, how the opinion may relate to any other trial issue
- factors relating to the presence of mental disorder that may affect the risk that the patient poses to themselves or to others, including the risk of re-offending, and
- if admission to hospital is recommended, what, if any, special treatment or security is recommended and whether the doctor represents an organisation which is able to provide what is required.

22.20 Reports should include an assessment of the patient's fitness to plead. The report should not speculate about guilt or innocence.

22.21 The *Good Practice Guidance: Commissioning, administering and production of psychiatric reports for sentencing*, issued by HMCTS and the Ministry of Justice in 2010 drafted in conjunction with the judiciary and the Royal College of Psychiatrists provides further detailed guidance.[5]

Recommendations on disposal

22.22 Section 157 of the Criminal Justice Act 2003[6] requires the court to obtain a medical report before passing a custodial sentence other than one fixed by law. Before passing such a sentence, the court must consider any information before it which relates to the offender's mental condition and the likely effect of such a sentence on that condition and on any treatment which may be available for it.

22.23 It may, therefore, be appropriate to include recommendations on the disposal of the case. In making recommendations for disposal the doctor should consider the longer-term, as well as immediate, consequences. Factors to be taken into account include:

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

[6] Criminal Justice Act 2003. http://www.legislation.gov.uk/ukpga/2003/44/contents

- whether the court may wish to make a hospital order subject to special restrictions
- whether, for restricted patients, the order should designate admission to a named unit within the hospital
- whether, in the event of the court concluding that a prison sentence is appropriate, the offender should initially be admitted to hospital by way of a hospital direction under section 45A and a limitation direction which will subject the patient to special restrictions, and
- whether a community order with a mental health treatment requirement may be appropriate.

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

Restrictions, hospital orders and hospital directions

22.25 Where a part 3 patient (medically disorderd offender) is made subject to special restrictions ('restricted patients'), the court, or the Secretary of State for Justice in some circumstances may specify that the person be detained in a named unit within a hospital. This is to ensure an appropriate level of security.

22.26 A named hospital unit can be any part of a hospital which is treated as a separate unit. The hospital managers of the hospital will define the boundaries of the hospital however it will be for the court (or the Secretary of State for Justice, as the case may be) to confirm the unit or hospital covered by the detention authority in each case where it makes use of the power. When transferring a prisoner to hospital with a restriction direction attached, the Secretary of State for Justice may direct that the patient be detained in a specific hospital unit. This will normally be to a named ward to prevent patients being moved to lower levels of security within a hospital without the Secretary of State for Justice's agreement. Admission to a named unit will mean that the consent of the Secretary of State for Justice will be required for any leave of absence or transfer from the named unit, even if the transfer is to the same level of security, or transfer is to another part of the same hospital or to another hospital. If however, the transfer involves no change to either the named unit or hospital prior agreement from the Secretary of State for Justice is not required. For example, if the detention authority covers a named hospital, to move patients between units within that hospital will not require Secretary of State for Justice permission. The mental health casework section (MHCS) should be informed of the move (see paragraph 14.18).

22.27 As noted above, the need to consider the longer-term implications of a recommended disposal is particularly important where an extended determinate sentence is indicated under the Criminal Justice Act 2003. Either a hospital order under section 37 with or without restrictions under section 41, or attachment of a hospital direction to the prison sentence under section 45A is available to the court. Discretion lies with the court. Further guidance on the use of section 45A is provided below.

22.28 A hospital order, with or without restrictions, diverts the offender from a custodial sentence to a hospital for treatment. There is no limit to the time a restricted hospital order is in force so that the period of detention will be determined by the need for treatment in hospital.

22.29 A hospital direction, under section 45A, by contrast, accompanies a prison sentence and means that from the start of the sentence the offender will be managed in hospital in the same way as a prisoner who has been transferred to hospital subject to special restrictions under sections 47 and 49 of the Act The responsible clinician can propose transfer to prison to the Secretary of State for Justice at any time before the prisoner's release date if, in their opinion, no longer requires treatment in hospital and/or no effective treatment can be given. For transfers at end of prison sentence see paragraph 22.68 below.

22.30 A prison healthcare centre is not a hospital within the meaning of the Act. The rules in part 4 of the Act about medical treatment of detained patients do not apply and treatment cannot be given there under the Act without the patient's consent (see chapter 4).

Availability of places

22.31 If the medical evidence is that the person needs treatment in hospital, but the doctor cannot identify a suitable facility where the person could be admitted immediately, they should seek advice from the clinical commissioning group (CCG) that is responsible for providing the person with primary medical services or the CCG in whose area the person is usually resident. Prison should not be regarded as the default option.

Transporting patients subject to part 3 of the Act

22.32 Patients who are detained under part 3 of the Act transported between secure units, courts or prison are the responsibility of the unit or prison sending the patient unless other arrangements negotiated. In certain circumstances (eg an emergency situation) a clinical commissioning group commissioned ambulance with appropriate escort may be required to transport the patient. Secure hospitals that hold patients under part 3 of the Act and prisons should have their own security

protocols for transfer of patients subject to part 3 of the Act. All agencies involved in the transportation of patients should be mindful of the need to implement reasonable adjustments in arrangements to cater for the individual needs of the patient. Further information on the transport of patients generally is included at chapter 17.

22.33 A child or young person subject to part 3 should be transferred under local escort and bed watch policies. They should be transported in 'usual transport' (eg a car) unless in an emergency or otherwise agreed when an ambulance should be used.

22.34 It may be necessary for patients subject to part 3 of the Act to be subject to mechanical restraint for the purposes of ensuring a safe transfer (see paragraphs 26.88 – 26.90).

Transport to and from court

22.35 For patients remanded to hospital under sections 35 or 36 of the Act, or subject to a hospital order or an interim hospital order, the court has the power to direct who is to be responsible for transporting the defendant from the court to the receiving hospital. This direction should be based on individual need and there should be contingency planning and measurable outcomes in place to ensure that people do not have to return to the holding prison. Monitoring of this process should be logged. In practice, when remand orders are first made, patients are usually returned to the holding prison briefly using the escort provision commissioned for court to prison journeys, and arrangements are then made to admit them and make arrangements for transporting them to hospital within the statutory period. Secure hospitals that hold patients under part 3 of the Act and prisons should have their own security protocols for transfer of patients subject to part 3 of the Act.

22.36 When a patient has been admitted on remand or is subject to an interim hospital order under section 38 of the Act, it is the responsibility of the hospital to return the patient to court as required. The court should give adequate notice of hearings. The hospital should liaise with the court in plenty of time to confirm the arrangements for escorting the patient to and from the court. 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 appropriately qualified staff to do this taking into account the age of the patient and any disability. The assistance of the police may be requested, if necessary. If possible, and having regard to the needs of the patient, medical or nursing staff should remain with the patient on court premises, even though legal accountability while the patient is detained for hearings, remains with the court. For restricted patients attendance at court will require the consent of the Secretary of State for Justice. For those patients who have been transferred under section 48 of the Act, permission to attend court will be provided in writing on initial admission. For other patients who are required to attend court, prior approval must be sought.

22.37 It may be possible in some circumstances, and with permission from the Tribunal or the Court, for a patient to attend a hearing by live video link. Clinical teams should seek advice from the relevant tribunal or court to establish whether this might be available.

22.38 For further guidance on transport of patients under the Act, see chapter 17.

Treatment without consent – patients remanded for report

22.39 The rules in part 4 of the Act about medical treatment of detained patients do not apply to patients remanded to hospital under section 35 for a report on their mental condition. As a result, treatment can be administered only with their consent, or, in the case of a person aged 16 or over who lacks capacity to consent, in accordance with the Mental Capacity Act 2005 (see chapter 13). For children under the age of 16, who are not competent to consent to the proposed treatment, it may be possible for a person with parental responsibility for the child to consent on their behalf. (Further guidance on the informal treatment of children and young people, including the factors to consider in determining whether parental consent can be relied upon, are set out in chapter 19.)

22.40 Where a patient remanded under section 35 is thought to be in need of medical treatment for mental disorder which cannot otherwise be given, the patient should be referred back to court by the clinician in charge of their care as soon as possible, with an appropriate recommendation and with an assessment of whether they are in a fit state to attend court.

22.41 If there is a delay in securing a court date, consideration should be given to whether the patient meets the criteria for detention under part 2 of the Act to enable compulsory treatment to be given. This will be concurrent with, and not a replacement for, the remand made by the court.

Transfer of prisoners to hospital

22.42 The need for inpatient treatment for a prisoner should be identified and acted upon quickly, and prison healthcare staff should make contact immediately with the NHS Commissioning Board. Responsible NHS commissioners should aim to ensure that transfers of prisoners with mental disorders are carried out within a timeframe equivalent to levels of care experienced by patients who are admitted to mental healthcare services from the community. Any unacceptable delays in transfer after identification of need should be actively monitored and investigated by the NHS Commissioning Board.

22.43 Prisoners with a diagnosis of mental disorder who have given informed consent to treatment can be considered for transfer to hospital for treatment if the prison environment is considered to be contributing to their disorder and alternative

provision is not available within the prison estate. An assessment of need and regular review should consider whether the prison healthcare centre or another prison setting is capable of providing for the prisoner's care if they are considered to be too unwell or vulnerable to return to residential wings. For those prisoners diagnosed with a personality disorder consideration should firstly be given to using the Offender Personality Disorder Pathway which aims to manage and treat such prisoners within the criminal justice system if possible. Prisoners with personality disorder will be assessed against a set criteria for inclusion in the strategy. A hospital placement should only be considered where it is the only option for treatment or management of the prisoner. Additionally, clinical teams should actively consider remission of the prisoner back to prison when appropriate, so that the prisoner can continue on the agreed pathway between clinicians and offender managers. For further information on patients with a personality disorder see chapter 21 and for people with a learning disability see chapter 20.

Children and young people in custody

22.44 It is recognised that the treatment of children and young people under the Act should be provided by specialist professionals; be appropriate for their age and clinical need and be planned and implemented effectively with minimum delay and disruption (see chapter 19).

22.45 The terminology surrounding children and young people may be very different. For example 'custody' and 'youth detention accommodation' have the same meaning as prison and the detention accommodation will comprise:

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

Medical assessment

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

22.47 A mental health assessment should be undertaken within three days of admission to a custodial setting. *The Manual for the Comprehensive Health Assessment Tool (CHAT): Young People in the Secure Estate June (version 3)* provides guidance on undertaking the assessment.[7]

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

22 Transfer from custody under the Act for children and young people

22.49 Relevant NHS commissioners must provide the courts with comprehensive information regarding CAMHS beds which are, or could be made, available for patients.

22.50 Details should be provided of multi-agency after-care arrangements for children on restricted orders that might be on Children Act 1989 arrangements (full care orders). The Ministry of Justice expects support and after-care to be provided by appropriate authorities in the event of return from a secure hospital to detention. The section 117 meeting provides an opportunity to ensure co-ordination.

22.51 Young people can become 'looked after children' if they become accommodated under section 20 of the Children Act 1989 or are the subject of a care order under section 31 of the 1989 Act or alternatively, for a period of their remand to youth detention accommodation or local authority accommodation under chapter 3, part 3 of the LASPO.

22.52 Courts are unable to use section 45A in respect of children and young people (those under the age of 21) as they are not subject to a term of imprisonment.

Restricted patients

22.53 The Secretary of State for Justice has certain obligations with regard to the management of patients who are subject to restrictions (restricted patients) under the Act. The mental health casework section (MHCS) of the Ministry of Justice, on behalf of the Secretary of State for Justice, carries out these functions. Requests in respect of restricted patients will be considered and processed as quickly as possible. Reference to 'restricted patients' is included in the above paragraphs where relevant. The paragraphs below provide brief summaries of the key stages of a restricted patient's progress which are subject to Secretary of State for Justice decisions. The information should be read in conjunction with the guidance

[7] Comprehensive Health Assessment Tool (CHAT): young people in the secure estate v3. Offender Health Research Network. 2013. http://www.ohrn.nhs.uk/OHRNResearch/CHATToolV3June2013.pdf

available on the Ministry of Justice website: http://www.justice.gov.uk/offenders/types-of-offender/mentally-disordered-offenders

22.54 Restricted patients are those who are subject to a hospital order with restrictions (sections 37 and 41 of the Act); a hospital and limitation direction (section 45A and section 45b); a transfer direction with a restriction order (section 47 (sentenced prisoners), or a transfer direction under section 48 (remand or civil prisoners and immigration detainees). In respect of transferred prisoners, the restrictions are applied via the order under section 49. A person charged with an offence before the Crown Court but found not guilty by reason of insanity, or found unfit to plead, may also receive a hospital and restriction order under sections 37 and 41. The restriction order carries no time limit so the patient will remain detained in hospital for as long as they require treatment. Where the patient is also subject to a prison sentence and the patient is a restricted patient by virtue of section 45A (a limitation direction) or section 49, the restriction will fall away on the date that the patient would be released from prison.

22.55 All decisions about restricted patients, including about community leave, transfer, remission or discharge are taken by the Secretary of State for Justice.

22.56 The First Tier Tribunal (Mental Health) has a statutory duty to review the detention of a restricted patient and order discharge if it is not satisfied that the criteria for detention under the Act are met. The Tribunal does not have the power to discharge transferred prisoners, but can decide whether the patient would be ready for discharge if they were not a prisoner, and can make a recommendation that they should be returned to prison or, if appropriate, that a referral should be made to the parole board (see chapter 12).

Community leave

22.57 Section 41(3)(c)(i) requires a responsible clinician to obtain consent from the Secretary of State for Justice before granting section 17 leave to a restricted patient.

22.58 The Secretary of State for Justice will often consent to programmes of leave which give responsible clinicians discretion as to leave arrangements. The expectation however is that the leave will be designed and conducted in such a way as to preserve public safety and, where appropriate, respect the feelings and fears of victims and others who may have been affected by the offences.

22.59 Leave request forms are provided on the Ministry of Justice website which outlines the information required, however the attachment of leave plans may also be useful. In the event that consent for leave is given, responsible clinicians should be aware that the Ministry of Justice may request additional reports on the restricted patient as considered necessary.

22.60 Should there be any concerns or doubts about the leave being taken, it should be suspended and MHCS informed.

Hospital transfers

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

22.62 The Secretary of State for Justice's role is to ensure that transfers between hospitals preserve public safety, and, where appropriate, respect the feelings and fears of victims and others who may have been affected by the offences. The Secretary of State for Justice will not agree to a transfer unless he is satisfied that the move will not put the public or victims at risk. The Secretary of State for Justice may also stipulate a specific hospital or unit when agreeing to the transfer of a patient and any movement outside this 'named' hospital or ward will require the permission of the Secretary of State for Justice.

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

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

22.64 Section 47 of the Act empowers the Secretary of State for Justice by warrant to direct the removal to and detention in hospital for treatment of a person who is serving a sentence of imprisonment. The 'transfer direction' may be made with or without restrictions under section 49 and if transferred to hospital by virtue of a transfer direction only, the patient is treated as if they were a civil patient and the Secretary of State for Justice will have no further role.

22.65 When prisoners have been transferred under section 47 and remain detained in hospital after their release date, they cease to be restricted patients but remain detained as if on a hospital order without restrictions. The responsible clinician's options under the Act are modified accordingly, and the patient may, for example, be discharged onto a community treatment order (CTO), guardianship or discharged.

22.66 Section 48 empowers the Secretary of State for Justice by warrant to direct the removal to and detention in hospital for treatment of certain offenders such as those on remand, civil prisoners and immigration detainees. Restrictions may also be added under section 49. Subsequent attendance at court will require Secretary of State for Justice consent and will usually be given at the time of admission. Should the patient be subsequently acquitted by the court or the legal proceedings discontinued, the section 48/49 restricted transfer direction will cease and the responsible clinician in charge of the patient's care must either discharge or consider detention under part 2 of the Act.[8]

22.67 Professionals should be aware that immigration detainees may be particularly vulnerable and may need additional support, including reasonable adjustments. Examples include the use of interpreters and an understanding of their culture, ethnicity or religion. Staff supporting these patients should be culturally competent.

22.68 Should a transfer request be made for a prisoner under sections 47 and 49 who is near the end of his or her sentence, the Secretary of State for Justice will apply heightened scrutiny to such a request to ensure that the criteria for transfer under the Act is satisfied and taking into account the potential lengthening of detention.

22.69 In exceptional circumstances, the Secretary of State for Justice may 'direct' a restricted patient's admission into hospital, outside of NHS commissioning arrangements. This is usually where it is critical that the patient receive treatment and identifying a suitable bed is difficult.

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

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

22.71 In cases where clinicians are of the view that the conditions for hospital treatment are met, they may want to consider advising the court of the availability of a disposal under section 45A. It is then for the court to decide whether the culpability of the offender is such that a section 45A direction is appropriate.

22.72 The intention of the hospital direction is to increase the flexibility of options when dealing with mentally disordered offenders and in particular enables courts to deal with some of the most difficult cases in a way that takes proper account of the offender's need for treatment, the demands of justice and the right of other people to be protected from harm.

[8] For further information see Reference Guide to the Mental Health Act 1983. Department of Health. 2015. https://www.gov.uk/government/publications/reference-guide-to-the-mental-health-act-1983

22.73 A hospital direction enables the court to impose a custodial sentence (determinate or indeterminate) whilst as the same time securing medical treatment without delay.

22.74 The granting of a hospital and limitation direction is a decision for the court and there can be no presumption that one will be made even if the evidence suggests that it is appropriate. A hospital and limitation direction may be imposed where it is considered that the offender, although suffering from a mental disorder, can be considered to be responsible, to a degree, for the offence. Generally, courts have adopted the test that there has to be a 'significant degree' of culpability for a hospital direction to be appropriate, although this test is not always applied.

22

Notional section 37 patients

22.75 For transferred determinate sentence offenders, restrictions added by the Secretary of State for Justice will cease on expiry of the custodial part of the sentence (ie the date the offender would have been released had he or she remained in prison). If the patient continues to require further treatment, they can remain detained within the hospital as if subject to an unrestricted section 37 hospital order. Patients detained under a hospital and limitation direction (under sections 45A and 45B of the Act) will fall into this category if they have reached the end of their sentence but still require treatment. These patients are all commonly referred to as 'notional section 37' patients.

22.76 All unrestricted patients, including 'notional section 37 patients' have been entirely diverted from the criminal justice system to the health system for treatment. Treatment is the purpose of their detention in hospital and the Secretary of State for Justice has no say in the patient's disposal. It should be noted that these patients may continue to present a risk to themselves and others. Decisions on granting community leave, movement through the hospital system and discharge will be taken by the responsible clinician and hospital managers. The Tribunal also has a statutory duty to discharge if not satisfied that the criteria for detention are met.

22.77 When a transferred offender becomes unrestricted, there is still a period when, if released, they will be subject to licence conditions and management by the National Probation Service. Hospitals should remain in contact with the offender manager and victim liaison officer therefore until the end of sentence.

Discharge of restricted patients

22.78 The Secretary of State for Justice may authorise the discharge of a restricted patient. The discharge will either be with conditions, a 'conditional discharge' or 'absolutely' in which case the restrictions will cease and there will be no further involvement of the Secretary of State for Justice. In addition the Tribunal has a statutory duty to discharge patients if not satisfied that the criteria for detention are met (see chapter 12). Reports recommending conditional discharge for part 3 patients convicted of serious crimes will be subject to additional scrutiny to ensure that full consideration has been given to the long-term care and supervision of the patient in the community and management of risks for the effective protection of the public. In addition to discussions with both the responsible clinician and other members of the clinical team, in certain circumstances the Secretary of State for Justice may commission an independent psychiatric report.

22.79 Conditionally discharged restricted patients will in most cases be subject to community supervision and be monitored by a clinical supervisor and a social supervisor, both of whom are required to submit reports, generally quarterly, to the Ministry of Justice detailing the patient's progress, current presentation and any concerns. These reports should be comprehensive including defining clearly any risks being presented by the patient either to themselves or others. They should also record unusual occurrences such as interactions with the police and where necessary these events should be investigated further by the appropriate supervisor and information shared with other relevant parties. Although there is a requirement for regular reports, if at any time clinical teams become concerned over a patient's behaviour or presentation, they should investigate those concerns and contact the Ministry of Justice straightaway. Similarly these reports will be closely scrutinised by the Ministry of Justice and where necessary, concerns will be raised with the relevant parties involved. See paragraphs 22.87 – 22.92 below in respect of restricted part 3 patients convicted of serious offences.

22.80 The Ministry of Justice does not stipulate the professionals who can undertake the role of social supervisor. Social supervisors should have received adequate professional development, be resourced to be able to produce prompt, accurate reports and raise any concerns with regard to the patient's behaviour in the community. Social supervisors will be allocated by local authorities, who will determine that their agreed social supervisors have the correct knowledge, expertise and skills to undertake this role, in line with the efficiency and equity principle.[9]

[9] For more information see Guidance for Social Supervisors. Ministry of Justice. Mental Health Casework Section. 2009. https://www.justice.gov.uk/downloads/offenders/mentally-disordered-offenders/guidance-for-social-supervisors-0909.pdf

Recall to hospital

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

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

- the decision on whether to recall will largely depend on the degree of danger posed by the patient, the gravity of the potential or actual risk and how imminent the risk is
- recall does not necessarily require any evidence of deterioration in the patient's mental state, but evidence is required that a 'change' has occurred since the discharge decision. This is so that the Secretary of State for Justice can be satisfied that recall is a proportionate and lawful action. Other than in an emergency, medical evidence will be required that the patient is currently mentally disordered
- recall will not be used to deal with anti-social or offending behaviour that is unconnected with the patient's mental disorder
- recall decisions always give precedence to public safety considerations. This may mean that the Secretary of State for Justice will decide to recall on public safety grounds even if the supervisors (see paragraphs 22.79 – 22.80) are of the view that recall would be counter-therapeutic for the patient
- recall will be considered to protect others from harm because of a combination of the patient's mental disorder and behaviour, including potential behaviour where there is evidence that indicates the imminent likelihood of risk behaviours
- in an emergency the Secretary of State for Justice may recall for assessment in the absence of fresh evidence as regards mental disorder
- the support for recall from the patient's social supervisor is important but not determinative and the Secretary of State for Justice can, satisfied that recall is necessary, make the decision to recall in the absence of any recommendation
- where however recall is recommended by at least one supervisor, then the expectation is that the patient should be recalled unless there are compelling reasons not to recall, and
- admission under sections 2 or 3 – if a restricted patient requires compulsory detention in hospital under the Act then recall will almost invariably be appropriate. The only circumstances where recall may not be indicated would be where discharge was imminent (within days rather than weeks), or where the admission is solely due to self-harm or suicide issues and the admission is likely to last less than a month.

22.83 Should recall be indicated, the clinical team should initially discuss their concerns with MHCS and identify a suitable bed at an appropriate security level for the patient to be admitted to. Once the arrangements are confirmed, MHCS will issue a Secretary of State for Justice warrant for the recall of a patient to a named hospital or unit.

22.84 The social supervisor requesting the recall will be advised by MHCS that the patient should be briefly informed of the Secretary of State for Justice's reasons for the recall at the time the recall is effected unless the patient is violent. The Secretary of State for Justice then expects full reasons to be communicated to the patient within 72 hours of re-admission.

Secretary of State 'direction'

22.85 In exceptional circumstances, the Secretary of State for Justice may 'direct' a restricted patient's admission into hospital, outside the NHS commissioning arrangements. This is usually where it is critical that the patient receive treatment and identifying a suitable bed is difficult.

Contacting the MHCS

22.86 Verbal authorisation can be given for recalls or transfers with warrants and written authorisations provided during office hours. The MHCS provides an on-call service between the hours of 17:00 to 09:00 and on weekends and bank holidays. The out of hours number (operated by the Home Office) is: 020 7035 4848, option 5.

Multi-agency public protection arrangements (MAPPA)

22.87 Under section 325(3) of the Criminal Justice Act 2003,[10] health services have a duty to co-operate with the MAPPA responsible authorities in assessing and managing the risk of MAPPA eligible mentally disordered offenders.

22.88 MAPPA are the framework of statutory arrangements operated by criminal justice and other agencies that seek to manage and reduce the risk presented by sexual and violent offenders in order that re-offending is reduced and the public are protected. This is done by the sharing of information and the establishment of a coordinated risk management plan that will allow offenders, including part 3 patients, to be effectively managed.

[10] Criminal Justice Act 2003. http://www.legislation.gov.uk/ukpga/2003/44/contents

22.89 There are three categories of offender eligible for MAPPA, all of which may come to the attention of health services as part 3 patients:

- Category 1 – registered sexual offenders
- Category 2 – violent offenders: offenders sentenced to imprisonment or detention for a period of 12 months or more, or subject under hospital orders following conviction for a violent offence at Schedule 15 of the Criminal Justice Act 2003. This category includes a small number of sexual offenders who do not qualify for registration and offenders disqualified from working with children, and
- Category 3 – other dangerous offenders: offenders who do not qualify under Categories 1 or 2 but who have been assessed as currently posing a risk of serious harm to themselves or others which requires active inter-agency management. The person must have been committed an offence or have received a formal caution.

22.90 MAPPA offenders can be managed at one of three levels based upon the level of multi-agency co-operation that is required to implement the offender's risk management plan effectively. Offenders move up and down levels as appropriate. The levels are:

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

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

22.92 Further guidance on MAPPA and the responsibilities of health providers is available at: https://www.gov.uk/government/publications/multi-agency-public-protection-arrangements-mappa—2

Related material

- Criminal Justice Act 2003. http://www.legislation.gov.uk/ukpga/2003/44/contents
- Guidance for Clinical Supervisors. Ministry of Justice. Mental Health Casework Section. 2009. http://www.justice.gov.uk/downloads/offenders/mentally-disordered-offenders/guidance-for-clinical-supervisors-0909.pdf
- Guidance for Social Supervisors. Ministry of Justice. Mental Health Casework Section. 2009. http://www.justice.gov.uk/downloads/offenders/mentally-disordered-offenders/guidance-for-social-supervisors-0909.pdf
- The Recall of Conditionally Discharged Restricted Patients. Ministry of Justice. Mental Health Casework Section. 2009. http://www.justice.gov.uk/downloads/offenders/mentally-disordered-offenders/recall-of-conditionally-discharged-restricted-patients.pdf
- Mental Health Casework Section Guidance – Section 17 leave. Ministry of Justice. Mental Health Casework Section. 2014. http://www.justice.gov.uk/downloads/offenders/mentally-disordered-offenders/mhcs-guidance-s17-leave.pdf
- Guidance with Multi-agency Public Protection Arrangements (MAPPA). Ministry of Justice. 2014. https://www.gov.uk/government/publications/multi-agency-public-protection-arrangements-mappa—2
- Procedure for the Transfer from Custody of Children and Young People under the Mental Health Act 1983 in England. Department of Health. 2011. https://www.gov.uk/government/publications/procedure-for-the-transfer-from-custody-of-children-and-young-people-under-the-mental-health-act-1983-in-england
- Comprehensive Health Assessment Tool (CHAT): Young People in the Secure Estate. Offender Health Research Network. 2013. http://www.ohrn.nhs.uk/OHRNResearch/CHATToolV3June2013.pdf

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22

Care, support and treatment in hospital

This group of chapters addresses issues related to the care and treatment of patients. Guidance is given on the application of the appropriate medical treatment test and the criteria for detention of a patient or a community treatment order (CTO).

Guidance is also given on medical treatment for mental disorder under the Act, including on certain treatments which are subject to special rules and procedures under the Act, on treatment for patients on a CTO who are not recalled to hospital and on the meaning of the 'clinician in charge of treatment', the role of second opinion approved doctors and physical healthcare. Treatment must be appropriate to a patient's condition and take account of their wishes.

All patients, including those who may present with behavioural disturbance, should receive treatment in a safe and therapeutic environment. Guidance is given to providers and professionals on the particular issues related to managing disturbed behaviour which may present a risk to the patient or to others. Any restrictive interventions (eg restraint, seclusion and segregation) must be undertaken only in a manner that is compliant with human rights.

Chapter 23 The appropriate medical treatment test

Chapter 24 Medical treatment

Chapter 25 Treatments subject to special rules and procedures

Chapter 26 Safe and therapeutic responses to behavioural disturbances

23 The appropriate medical treatment test

Why read this chapter?

23.1 This chapter provides guidance on the application of the appropriate medical treatment test and the criteria for detention or a community treatment order (CTO) under the Act. It includes guidance on appropriate treatment for people with dementia.

Purpose of medical treatment for mental disorder

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

23.3 In the Act, medical treatment for mental disorder means medical treatment which is for the purpose of alleviating, or preventing a worsening of, a mental disorder or one or more of its symptoms or manifestations.

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

23.5 Symptoms and manifestations include 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 should be remembered that not every thought or emotion or every aspect of the behaviour, of a patient suffering from mental disorder will be a manifestation of that disorder.

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

Appropriate medical treatment test

23.7 The Act requires appropriate medical treatment to be available to a patient in order to meet the criteria for section 3 detention or a CTO. Where the appropriate medical treatment test forms part of the criteria for detention, the medical treatment in question is treatment for mental disorder in the hospital in which the patient is to be detained. Where it is part of the criteria for a CTO it refers to the treatment for mental disorder that the person will be offered while on a CTO.

23.8 The appropriate medical treatment test must be applied to ensure that no one is detained (or remains detained) for treatment, or is on a CTO, unless medical treatment for their mental disorder is both appropriate and available.

23.9 In order to be deemed appropriate, medical treatment must be for the purpose of alleviating or preventing a worsening of the patient's mental disorder or its symptoms or manifestations. It must also be appropriate, having taken account of the nature and degree of the patient's mental disorder and all their particular circumstances, including cultural, ethnic and religious or belief considerations.

23.10 The appropriate medical treatment test requires a judgement about whether an appropriate treatment or package of treatment for mental disorder is available for the individual in question. It is not consistent with the least 'restrictive option and maximising independence' and 'purpose and effectiveness' guiding principles' to detain someone for treatment that is not actually available or may not become available until some future point in time.

Applying the appropriate medical treatment test

23.11 The test requires a balanced and holistic judgement as to whether, medical treatment to available to the patient is appropriate, given:

- the nature and degree of the patient's mental disorder, and
- all the other circumstances of the patient's case. In other words, both the clinical appropriateness of the treatment and its appropriateness more generally must be considered.

23.12 The other circumstances of a patient's case might, for example, include factors such as:

- the patient's physical health – how this might impact on the effectiveness of the available medical treatment for the patient's mental disorder and the impact that the treatment might have in return
- the patient's age

- any physical disabilities or sensory impairments the patient has
- the patient's culture and ethnicity
- the patient's gender, gender identity, sexual identity and sexual orientation
- the patient's religion or beliefs
- the location of the available treatment
- the implications of the treatment for the patient's family and social relationships, including their role as a parent (where applicable)
- its implications for the patient's education or work
- the consequences for the patient, and other people, if the patient does not receive the treatment available (for mentally disordered offenders about to be sentenced for an offence, the consequence will sometimes be a prison sentence), and
- the patient's views and wishes about what treatment works for them and what doesn't.

23.13 Medical treatment must always be an appropriate response to the patient's condition and situation and indeed wherever possible should be the most appropriate treatment available. It may be that a single medical treatment does not address every aspect of a patient's mental disorder.

23.14 Medical treatment must actually be available to the patient. It is not sufficient that appropriate treatment could theoretically be provided.

23.15 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.

23.16 Medical treatment which aims merely to prevent a disorder worsening is unlikely, in general, to be appropriate in cases where normal treatment approaches would aim (and be expected) to alleviate the patient's condition significantly. However, for some patients with persistent and severe mental disorders, management of the undesirable effects of their disorder may be the most that can realistically be hoped for.

23.17 Appropriate medical treatment does not have to involve medication or psychological therapy – although it very often will. There may be patients whose particular circumstances mean that treatment may be appropriate even though it consists only of nursing and specialist day-to-day care under the clinical supervision of an approved clinician in a safe and secure therapeutic environment with a structured regime.

23.18 Simply detaining someone, even in a hospital, does not constitute medical treatment.

23.19 A patient's attitude towards the proposed treatment may be relevant in determining whether the appropriate medical treatment test is met. An indication of unwillingness to co-operate with treatment generally, or with a specific aspect of treatment, does not make such treatment inappropriate.

23.20 In particular, psychological therapies and other forms of medical treatments which, to be effective, require the patient's co-operation are not automatically inappropriate simply because a patient does not currently wish to engage with them. Such treatments can potentially remain appropriate and available as long as it continues to be clinically suitable to offer them and they would be provided if the patient agreed to engage.

23.21 In determining whether the appropriate medical treatment test is met, those making the judgement must satisfy themselves that appropriate medical treatment is available for the time being, given the patient's condition and circumstances as they are currently understood. Determinations are time specific and may need to be reconsidered as the patient's condition changes or clinicians obtain a greater understanding of the patient's case.

Patients with dementia

23.22 Generally, treatment approaches for dementia differ according to the type of dementia the person has. People with dementia may take time to engage and develop motivation for treatment. People with dementia can benefit from approaches that do not involve drugs, eg reminiscence therapy or cognitive stimulation therapy. People with dementia may experience depression or anxiety and it may be appropriate to offer them antidepressant drugs and/or offered talking therapies.

23.23 Some people with dementia may display challenging behaviour (see chapter 20) because they are distressed, confused or in pain. The use of sedation or antipsychotic medication may not be appropriate in these circumstances and alternative intervention or treatment could be deemed more appropriate.

Related material

- Quality Standard for Supporting People to Live Well with Dementia. National Institute for Health and Care Excellence quality standard 30. https://www.nice.org.uk/guidance/qs30
- Dementia Pathway. National Institute for Health and Care Excellence. http://pathways.nice.org.uk/pathways/dementia

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24 Medical treatment

Why read this chapter?

24.1 This chapter gives guidance on medical treatment for mental disorder under the Act, especially treatment given without patients' consent. It also gives guidance on promoting good physical healthcare for patients subject to the Act.

24.2 Treatment under the Act must be appropriate to the patient's mental health condition and take account of the person's wishes or feelings and advance decisions. The chapter provides guidance about appropriate treatment; treatments to which special rules and procedures apply; the treatment of detained patients and patients under community treatment orders (CTOs); and on issues of capacity and consent. It gives guidance on treatment plans, explaining their importance, and provides a summary of the treatment of incapacitated patients and the interface between the Act and the Mental Capacity Act (MCA).

Definitions

24.3 In the Act, 'medical treatment' includes nursing, psychological intervention and specialist mental health habilitation, rehabilitation and care.

24.4 The Act defines medical treatment for mental disorder as medical treatment which is for the purpose of alleviating or preventing a worsening of a mental disorder or one or more of its symptoms or manifestations.

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

Appropriate treatment

24.6 All treatment provided should be appropriate to the patient's mental health condition and take account of any advance decisions made by the person and any wishes or feelings they have expressed in advance of treatment. The practicalities of how the treatment is to be delivered, and how outcomes will be monitored should be considered.

24.7 Where reasonably practicable, treatment should be based on a strong evidence-base. Professionals should ensure that any treatment is compliant with the current guidelines and standards about what is appropriate treatment. Examples include, National Institute for Health and Care Excellence (NICE)/Social Care Institute for

Excellence (SCIE) guidelines, NICE quality standards and Department of Health Care Programme Approach (CPA) guidance. In the case of medications that are used to treat mental disorder, particular care is required when prescribing medications that exceed the maximum dosage listed in the British National Formulary (BNF) or where multiple medications are used to treat a patient.[1]

Treatments to which special rules and procedures apply

24.8 Section 57 (treatments requiring consent or a second opinion), section 58 (treatments requiring consent or a second opinion) and section 58A of the Act electro-convulsive therapy (ECT) set out types of medical treatment for mental disorder to which special rules and procedures apply, including, in many cases, the need for a certificate from a second opinion appointed doctor (SOAD) approving the treatment.

24.9 Guidance on sections 57, 58 and 58A is given in chapter 25, but in summary the treatments involved are as in the figure below.

Figure 10: Summary of treatments covered by sections 57, 58 and 58A

Section	Forms of treatment covered
Section 57	Neurosurgery for mental disorder Surgical implantation of hormones to reduce male sex drive
Section 58	Medication after an initial three-month period, except medication administered as part of ECT
Section 58A	ECT and medication administered as part of ECT

Note: it is possible that other forms of treatment may be added to any of these sections by regulations.

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

24.10 Part 4 of the Act deals mainly with the treatment of people who are liable to be detained in hospital, including patients who have been recalled to hospital from CTOs and conditional discharge. They are referred to in this chapter as 'detained patients'.

[1] The British National Formulary is available at: https://www.medicinescomplete.com/about/subscribe.htm
See also CR190. Consensus statement on high-dose antipsychotic medication. Royal College of Psychiatrists. 2014. http://www.rcpsych.ac.uk/usefulresources/publications/collegereports/cr/cr190.aspx

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

Figure 11: Meaning of detained patients in this chapter

In this chapter 'detained patients' means:	Exceptions
Patients who are liable to be detained in hospital under any section of the Act (including those who are not actually detained, such as patients who are on leave of absence or absent without leave).	• Patients detained on the basis of an emergency application under section 4 unless or until the second medical recommendation is received • Patients held in hospital under the holding powers in section 5 • Patients remanded to hospital for a report on their mental condition under section 35 • Patients detained in hospital as a place of safety under section 135 or 136 • Patients temporarily detained in hospital as a place of safety under section 37 or 45A, pending admission to the hospital named in their hospital order or hospital direction • Restricted patients who have been conditionally discharged (unless or until they are recalled to hospital) • Qualifying patients within the meaning of section 22 who have remained in custody for six months or longer in total.
Patients on CTOs who have been recalled to hospital	
Restricted patients who have been conditionally discharged and recalled to hospital	

24.12 Unless section 57, section 58 or 58A apply, section 63 of the Act (treatment not requiring consent) means that detained patients may be given medical treatment for any kind for mental disorder, whether they:

- consent to it, or
- have not consented to it,

but the treatment must be given by or under the direction of the approved clinician in charge of the treatment in question.

24.13 If sections 57, 58 or 58A apply, detained patients may be given the treatment only if the rules in those sections are followed (see chapter 25).

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

24.14 Part 4A of the Act sets out different rules for treatment for patients on CTOs who have not been recalled to hospital by their responsible clinician. This includes patients on CTOs who are in hospital without having been recalled (eg if they have been admitted to hospital voluntarily).

24.15 For convenience, this chapter refers to patients on CTOs who have not been recalled to hospital (ie admitted to hospital voluntarily) as 'part 4A patients'.

24.16 The rules for part 4A patients differ depending on whether or not they have the capacity to consent to or refuse the treatment in question. Except where otherwise stated, references in the paragraphs below to a person who lacks capacity to consent to or refuse treatment includes patients aged under 16 who lack the competence to consent to or refuse treatment (see paragraph 24.18 and chapter 19).

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

24.18 For part 4A patients, aged 18 and over, who lack the capacity to consent to or refuse a treatment, it may be given if someone who has lasting power of attorney (an attorney) or a Court of Protection appointed deputy consents on their behalf. Similarly it may be given in the case of those aged 16 and over if a deputy consents to the treatment on their behalf.

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

- in the case of a patient aged 18 or over, the treatment would be contrary to a valid and applicable advance decision made by the patient (see chapter 9)
- in the case of a patient aged 18 or over, the treatment would be against the decision of someone with the authority under the MCA 2005 to refuse it on the patient's behalf (an attorney, a deputy or the Court of Protection), or
- in the case of a patient aged 16 or over, the treatment would be against the decision of a deputy who has authority to refuse it on the patient's behalf, or force needs to be used in order to administer the treatment and the patient objects to the treatment.

24.20 In this last case, force means the actual use of physical force on the patient. Where force needs to be used, it is up to the person proposing to give the treatment to decide whether a patient objects to the treatment. The question is simply whether the patient objects – the reasonableness (or unreasonableness) of the objection is irrelevant. In any situation where force is used, if it amounts to a restrictive intervention then the provisions within chapter 26 apply and particular note should be taken of paragraphs 26.36 – 26.44.

24.21 In deciding whether patients object to treatment, all the relevant evidence should be taken into account, so far as it reasonably can be. In many cases, patients will be perfectly able to state their objection, either verbally or by their dissenting behaviour. In other cases, especially where patients are unable to communicate (or only able to communicate to a limited extent), clinicians will need to consider the patient's behaviour, wishes, feelings, views, beliefs and values, both present and past, so far as they can be ascertained.

24.22 If there is reason to think that a patient would object, if able to do so, then the patient should be taken to be objecting. Occasionally, it may be that the patient's behaviour initially suggests an objection to being treated, but is in fact not directed at the treatment at all. In that case the patient would not be taken to be objecting.

24.23 In addition to the requirements described in paragraphs 24.17 – 24.22 (the Act calls these the 'authority' to give treatment), the Act also refers to the 'certificate requirement' that applies to certain treatments that can only be given if they have either been: approved by a SOAD on a 'part 4A certificate'; or certified by the approved clinician in charge of the patient's treatment on a 'part 4A consent certificate', if the patient has capacity (or competence, for patients under 16) to consent to the treatment and has done so. Broadly speaking, the certificate requirement applies to any treatment for which a certificate would be necessary under section 58 or 58A of the Act were the patient detained instead (see chapter 25).

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

24.24 In an emergency, treatment can also be given to part 4A patients who lack capacity to consent to or refuse a treatment (and who have not been recalled to hospital) by anyone, whether or not they are acting under the direction of an approved clinician.

24.25 It is an emergency only if the treatment is immediately necessary to:

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

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

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

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

24.27 In addition, force may be used (whether or not the patient objects), provided that:

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

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

Treatment of other patients

24.29 The Act does not regulate treatment for any other patients, except that:

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

Capacity and consent

24.30 The Act frequently requires healthcare professionals to determine:

- whether a patient has the capacity to consent to or refuse a particular form of medical treatment, and
- if so, whether the patient does in fact consent.

The rules for answering these questions are the same as for any other patients.

Capacity to consent: people aged 16 or over

24.31 For people aged 16 or over, capacity to consent is defined by the MCA (see chapter 13). The principles of the MCA state (among other things) that:

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

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24.32 When taking decisions about patients under the Act, it should be remembered that:

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

Competence to consent to treatment – children under 16

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

Consent

24.34 Consent is the voluntary and continuing permission of a patient to be given a particular treatment, based on a sufficient knowledge of the purpose, nature, likely effects and risks of that treatment, including the likelihood of its success and any alternatives to it. Permission given under any unfair or undue pressure is not consent.

24.35 By definition, a person who lacks capacity is unable to consent or refuse treatment, even if they co-operate with the treatment or actively seek it.

24.36 It is the duty of everyone seeking consent to use reasonable care and skill, not only in giving information prior to seeking consent, but also in meeting the continuing obligation to provide the patient with sufficient information about the proposed treatment and alternatives to it.

24.37 The information which should be given should be related to the particular patient, the particular treatment and relevant clinical knowledge and practice. In every case, sufficient information should be given to the patient to ensure that they understand in broad terms the nature, likely effects and all significant possible adverse outcomes of that treatment, including the likelihood of its success and any alternatives to it. A record should be kept of information provided to patients.

24.38 Patients should be invited to ask questions and professionals should answer fully, frankly and truthfully. If a patient asks about a risk, they should always be given an honest answer. There may sometimes be a compelling reason, in the patient's interests, for not disclosing certain information. A professional who chooses not to disclose information should be prepared to justify the decision. A professional who chooses not to answer a patient's question should make this clear to the patient so that the patient knows where they stand. A record should be kept of any decision not to disclose information, and the reasons for that decision.

24.39 Patients should be told that their consent to treatment can be withdrawn at any time. Where patients withdraw their consent (or are considering withdrawing it), they should be given a clear explanation of the likely consequences of not receiving the treatment and (where relevant) the circumstances in which the treatment may be given without their consent under the Act. A record should be kept of the information provided to patients.

Treatment without consent – general points

24.40 To give time to develop a treatment programme suitable for the patient's needs, the Act allows treatment to be given in the initial three month period starting the day on which any form of medication for mental disorder was first administered to the patient during the current period in which the patient is liable to be detained under the Act.

24.41 During this time, the patient's consent should still be sought before any medication is administered, wherever practicable. The patient's consent, refusal to consent, or a lack of capacity to give consent should be recorded in the case notes. If a person has capacity to consent, but such consent is not forthcoming or is withdrawn during this period, the clinician in charge of the treatment must consider carefully whether to proceed in the absence of consent, to give alternative treatment or stop treatment.

24.42 Clinicians authorising or administering treatment without consent under the Act are performing a function of a public nature and must therefore comply with the Human Rights Act (HRA) 1998, which gives effect in the UK to certain rights and freedoms guaranteed under the European Convention on Human Rights (ECHR).

24.43 In particular, the following should be noted:

- compulsory administration of treatment which would otherwise require consent is invariably an infringement of article 8 of the ECHR (respect for family and private life). However, it may be justified where it is in accordance with law (in this case the procedures in the Act) and where it is proportionate to a legitimate aim (in this case, the reduction of the risk posed by a person's mental disorder and the improvement of their health)
- compulsory treatment is capable of being inhuman treatment (or in extreme cases even torture) contrary to article 3 of the ECHR, if its effect on the person concerned reaches a sufficient level of severity. But the European Court of Human Rights has said that a measure which is convincingly shown to be of medical necessity from the point of view of established principles of medicine cannot in principle be regarded as inhuman and degrading.

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

Treatment plans

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

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

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

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

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

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

24.51 Discussion with carers is particularly important where carers will themselves be providing care to the patient while the plan is in force. Plans should not be based on any assumptions about the willingness or ability of carers to support patients, unless those assumptions have been discussed and agreed with the carers. Carers have an important role to play in maintaining the patient's contact with home and community life and providing emotional support when the patient is detained. In some cases carers' willingness and ability to contribute to the provision of care may be dependent on additional support and they should be reminded of possible sources of such support and their entitlement to a carer's assessment by the local authority.

24.52 For children and young people, subject to the normal considerations of patient confidentiality, the plan should similarly be discussed with the people who have parental responsibility for them. For further information on confidentiality and sharing information concerning children and young people, paragraphs 19.14 – 19.16.

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

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

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

Figure 12: Medical treatment of patients subject to the Mental Health Act – exceptions to the normal rules on treatment and consent in the MCA

Situation	Exceptions to the normal rules in the MCA
Section 57 treatment (neurosurgery for mental disorder etc)	The MCA may not be used to give anyone treatment to which section 57 applies (see chapter 25 for guidance on section 57).
Section 58 treatment (medication after an initial three month period, except ECT-related medication)	The MCA may not be used to give anyone treatment to which section 58 applies (see chapter 25 for guidance on section 58).
Section 58A treatment (ECT and related medication)	The MCA may not be used to give detained patients (as defined in paragraphs 24.10 – 24.11) ECT and any other treatment to which section 58A applies.
Treatment regulated by part 4 of the Act for detained patients	The MCA may not be used to give detained patients (as defined in this chapter) any other medical treatment for mental disorder. Treatment regulated by part 4 of the Act at the time of the proposed treatment must be given in accordance with part 4 of the Act instead (see paragraphs 24.10 – 24.13).
Treatment for patients on CTOs who have not been recalled to hospital (part 4A patients)	The MCA may not generally be used to give these CTO patients any medical treatment for mental disorder, but attorneys, deputies and the Court of Protection may consent to such treatment on behalf of these CTO patients.
Advance decisions to refuse treatment (as defined in the MCA)	Where the Act allows treatment to be given against the wishes of a patient who has capacity to consent, it also allows treatment to be given despite the existence of a valid and applicable advance decision made under the MCA (see chapter 9). But note that, except in emergencies: • treatment to which section 58A applies cannot be given contrary to a valid and applicable advance decision, and • treatment cannot be given to CTO patients who have not been recalled to hospital (part 4A patients) contrary to a valid and applicable advance decision.
Patients who have attorneys or court-appointed deputies under the MCA with authority to take decisions on their behalf about their medical treatment	Attorneys and deputies (acting within the scope of their authority under the MCA) may not: • consent to treatment to which section 57 or 58 applies on behalf of any patient • consent to treatment to which section 58A applies – but note that (except in emergencies) they may refuse it on a patient's behalf, or • consent to or refuse any other treatment on behalf of detained patients (as defined in paragraphs 24.10 – 24.11). But note that attorneys and deputies may: • consent to treatment on behalf of CTO patients who have not been recalled to hospital (part 4A patients), even if treatment is to be given forcibly, and • except in emergencies, refuse treatment on behalf of those patients.

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

Court of Protection and other courts

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

Figure 13: Summary of when medical treatment for mental disorder may be given under the Act

Type of patient (and relevant part of the Act)	When treatment can be given	Notes (for further detail see chapter 24)
Detained patients (part 4) – see definition in paragraphs 24.10 – 24.13	If sections 57, 58 or 58A apply, treatment may be given only in accordance with those sections. Otherwise, treatment may be given: • with the patient's consent, and • without the patient's consent under section 63, if the treatment is by or under the direction of the approved clinician in charge.	Neurosurgery for mental disorder and other treatments to which section 57 applies cannot be given without the patient's consent and must always be approved by a SOAD. ECT and other treatments to which section 58A applies cannot be given to a patient who has capacity to consent but refuses to do so. They can only be given to patients who lack capacity (or who are under 18) if approved by a SOAD. Medication to which section 58 apply can be given without the patient's consent, but only with the approval of a SOAD. Sections 57, 58 and 58A do not apply in emergencies, where treatment is defined in section 62 as immediately necessary (see paragraphs 25.37 – 25.42).
CTO patients who have not been recalled to hospital (part 4A patients)	If section 57 applies, treatment can be given only with the patient's consent and if the other rules in section 57 are followed. Otherwise, if the patient has capacity to consent to or refuse treatment, treatment may be given only with the patient's consent. Or, if the patient lacks capacity to consent, treatment may be given: • with the consent of an attorney, deputy or the Court of Protection • without anyone's consent, provided that (i) the treatment is given by or under the direction of the approved clinician in charge of the patient's case, (ii) it is not inconsistent with a valid and applicable advance decision, or a decision of an attorney,	Unless it is an emergency, if treatment is one to which section 58 or 58A would apply if the person was liable to be detained, the treatment has to either be: approved by a SOAD on a part 4A certificate; or certified by the approved clinician in charge of the patient's treatment on a part 4A consent certificate, if the patient has capacity (or competence, for patients under 16) to consent to the treatment and has done so.

Type of patient (and relevant part of the Act)	When treatment can be given	Notes (for further detail see chapter 24)
	deputy or Court of Protection, and either (iii) no force needs to be used, or (iv) force does need to be used but the patient does not object, or • in an emergency only, if the treatment is (i) immediately necessary and (ii) if force is to be used, the treatment is needed to protect the patient from harm and any force used is proportionate to the risk of harm.	
Other patients	Treatment is not regulated by the Act, except that: • where section 57 applies, patients can be given treatment only if they consent • and the other rules in section 57 are followed, and • patients under 18 cannot be given ECT or other treatments to which section 58A applies, unless they consent and the treatment is approved by a SOAD. (Sections 57 and 58A do not apply in emergencies.)	

Promoting good physical health

24.57 Commissioners and providers should ensure that patients with a mental disorder receive physical healthcare that is equivalent to that received by people without a mental disorder. The physical needs of patients should be assessed routinely alongside their psychological needs. Commissioners need to ensure that long term physical health conditions are not undiagnosed or untreated, and that patients receive regular oral health and sensory assessments and, as required, referral.

24.58 Patients detained under the Act are at particular risk of comorbidities.[1] Commissioners should build into their procurement outcomes the requirement for physical health checks, physical healthcare planning and reporting arrangements that include evidence that physical health issues have been routinely considered for every individual patient they have commissioned a service for. Providers should deliver services that consider and address the physical health needs of their population. This would include practices in place to routinely screen for and provide interventions for high risk health conditions such as heart disease and diabetes and attention to care planning that had a focus on reducing common risk factors (eg smoking, poor diet and physical inactivity).

[1] Comorbidities Framework: a framework of principles for system-wide action. Department of Health, Public Health England and NHS England. 2014. https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/307143/Comorbidities_framework.pdf

24.59 Good nutrition and access to dietary advice is essential for healthy outcomes. Providers should ensure that they are compliant with current requirements on food, diet and nutrition, as set out in the NHS Standard Contract and compliance monitored via annual patient-led assessments of the care environment (PLACE) assessments.

24.60 Every provider should have a food and drink strategy (see annex B) that covers:

- the nutrition and hydration needs of patients
- healthier eating for the whole hospital community, and
- sustainable procurement of food and catering services.

24.61 Patients should have their nutritional state assessed on admission and at regular intervals thereafter, using an accredited screening tool. Providers should offer food and drink that meets the needs of all their patients (eg high density food for frail and underweight patients, and healthier food for those whose needs are more akin to the general population). Where necessary, support should be given to patients who need help to eat, or who wish to take action to improve their diet. Food that meets religious, cultural or personal preference should be available.[2]

24.62 Providers should ensure that all patients have sufficient opportunities to undertake sufficient physical and other meaningful activity to support their physical and mental health.

Related material

- Mental Capacity Act 2005. http://www.legislation.gov.uk/ukpga/2005/9/contents
- Mental Capacity Act 2005. Code of Practice. Department for Constitutional Affairs (now Ministry of Justice). 2007. https://www.gov.uk/government/publications/mental-capacity-act-code-of-practice
- Comorbidities Framework: a framework of principles for system-wide action. Department of Health, Public Health England and NHS England. 2014. https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/307143/Comorbidities_framework.pdf
- The Hospital Food Standards Panel's report on standards for food and drink in NHS hospitals. Department of Health. 2014. https://www.gov.uk/government/publications/establishing-food-standards-for-nhs-hospitals

This material does not form part of the Code. It is provided for assistance only.

[2] The Hospital Food Standards Panel's report on standards for food and drink in NHS hospitals. Department of Health. 2014. https://www.gov.uk/government/publications/establishing-food-standards-for-nhs-hospitals

25 Treatments subject to special rules and procedures

Why read this chapter?

25.1 This chapter gives guidance on the special rules and procedures in the Act for certain types of medical treatment for mental disorder.

25.2 This chapter provides guidance on the 'clinician in charge of treatment' and the treatments under section 57, or 58, or 58A of the Act. Guidance is given on second opinion approved doctor (SOAD) certificates and a summary of the circumstances in which certificates cease to authorise treatment, even though they have not been withdrawn is provided, is provided.

Definitions

25.3 In this chapter:

- 'detained patients' means the same as in chapter 24 (see paragraphs 24.10 – 24.13)
- 'SOAD' means a second opinion approved doctor appointed by the care quality commission (CQC) to approve certain forms of treatment
- 'SOAD certificate' means a certificate issued by a SOAD approving treatment for a particular patient
- 'part 4A patient' means a patient on a community treatment order (CTO) who has not been recalled to hospital
- 'part 4A certificate' means a SOAD certificate issued under part 4A of the Act in respect of the treatment of a patient on a CTO
- 'part 4A consent certificate' means a certificate issued by the approved 'clinician in charge of treatment' in respect of a patient on a CTO who has capacity (or competence, if under 16) to consent to or refuse a treatment, and consents to the treatment.

Clinician in charge of treatment

25.4 This chapter frequently refers to the 'clinician in charge of treatment'. This means the clinician in charge of the particular treatment in question for a patient, who need not be the same as the responsible clinician who is in charge of a patient's case overall.

25.5 In many cases, for detained patients and patients on a CTO the clinician in charge of treatment must be an approved clinician, as set out in the following table.

Figure 14: Summary of when the person in charge of treatment under the Act must be an approved clinician

Type of patient	When the clinician in charge of the treatment must be an approved clinician
Detained patients	When the treatment is being: • given without the patient's consent • given with the patient's consent, on the basis of a certificate issued under section 58 or, in relation to a patient over 18 a certificate issued under section 58A, by an approved clinician (rather than a SOAD) – see paragraphs 25.14 and 25.21 below, or • continued with the consent of a community patient who has been recalled to hospital (including one whose CTO has then been revoked) to avoid serious suffering to the patient, pending compliance with section 58 – see paragraph 25.33.
Part 4A patients	When the treatment is being: • given by that clinician or under the direction of that clinician to a patient who lacks capacity to consent to or refuse it and without the consent of an attorney, deputy or the Court of Protection – see paragraph 25.27 below. (Unless it is immediately necessary and being given under section 64G – see paragraphs 24.24 – 24.25), or • given to a patient who has capacity to consent and has done so, on the basis of a part 4A consent certificate issued by the approved clinician in charge of the person's treatment – see paragraph 25.33 below.

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

Treatments requiring consent and a second opinion under section 57

25.7 Section 57 applies to neurosurgery for mental disorder, to surgical implantation of hormones to reduce male sex drive and other treatments as specified by the Secretary of State. It applies to all patients, whether or not they are otherwise subject to the Act.

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

- the patient consents to the treatment
- a SOAD (and two other people appointed by the CQC) certify that the patient has the capacity to consent[1] to the treatment and has done so, and
- the SOAD also certifies that it is appropriate for the treatment to be given to the patient.

25.9 A decision to administer treatments to which section 57 applies requires particularly careful consideration, given their significance and sensitivity. Hospitals proposing to offer such treatments are strongly encouraged to agree with the CQC the procedures which will be followed to implement the requirements of section 57.

25.10 Before asking the CQC to put in hand the process of issuing a certificate, referring professionals should personally satisfy themselves that the patient is capable of giving valid consent and is willing to consent. The restrictions and procedures imposed by section 57 should be explained to the patient, and it should be made clear to the patient that their willingness to receive treatment does not necessarily mean that the treatment will be given.

Treatments requiring consent or a second opinion under section 58

25.11 Section 58 applies to the administration of medication for mental disorder. But it only applies once three months ('the three-month period') have passed from the day on which any form of medication for mental disorder was first administered to the patient during the current period in which the patient is liable to be detained under the Act.

25.12 For these purposes, the three-month period continues even if the section under which the patient is detained changes or if the patient has withdrawn consent for the treatment. It also includes any time the patient has spent on a CTO. The three-month period is broken if a part 2 patient is discharged without becoming a CTO patient or if the patient is placed under guardianship, or upon the conditional discharge of a restricted patient.

25.13 Section 58 does not apply to medication administered as part of electro-convulsive therapy (ECT). That is covered by section 58A instead (see paragraphs 25.19 – 25.25).

[1] Here and in section 58 and 58A, the Act refers to the patient being 'capable of understanding the nature, purpose and likely effects' of the treatment. For all practical purposes this can be understood to mean the same as the test of whether the patient has the capacity to consent (or, if under 16, the competence to do so).

25.14 Section 58 applies only to detained patients. They cannot be given medication to which section 58 applies unless:

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

25.15 Hospital managers should ensure that systems are in place to remind both the clinician in charge of the medication and the patient at least four weeks before the expiry of the three-month period.

25.16 Warning systems must be capable of dealing with the possibility that a patient may become a CTO patient, and may also have their CTO revoked, during the three-month period. A patient's move between detention and CTO does not change the date on which the three-month period expires.

25.17 Where approved clinicians certify the treatment of a patient who consents, they should not rely on the certificate as the only record of their reasons for believing that the patient has consented to the treatment. A record of their discussion with the patient including any capacity assessment, should be made in the patient's notes as normal.

25.18 Certificates under this section must clearly set out the specific forms of treatment to which they apply. All the relevant drugs should be listed, including medication to be given 'as required' (prn), either by name or by the classes described in the British National Formulary (BNF). If drugs are specified by class, the certificate should state clearly the number of drugs authorised in each class, and whether any drugs within the class are excluded. The maximum dosage and route of administration should be clearly indicated for each drug or category of drugs proposed. This can exceed the dosages listed in the BNF, but particular care is required in these cases.[2]

Electro-convulsive therapy under section 58A

25.19 Section 58A applies to ECT and to medication administered as part of ECT. It applies to detained patients and to all patients aged under 18 (whether or not they are detained).

[2] The British National Formulary is available at: https://www.medicinescomplete.com/about/subscribe.htm; See also CR190. Consensus statement on high-dose antipsychotic medication. Royal College of Psychiatrists. 2014. http://www.rcpsych.ac.uk/usefulresources/publications/collegereports/cr/cr190.aspx

25.20 The key differences from section 58 are that:

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

25.21 A patient who is consenting may not be given treatment under section 58A unless the clinician in charge, or a SOAD, has certified that the patient has the capacity to consent and has done so. If the patient is under 18, only a SOAD may give the certificate, and the SOAD must also certify that the treatment is appropriate.

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

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

25.23 In all cases, SOADs should indicate on the certificate the maximum number of administrations of ECT which it approves.

25.24 For children and young people under 18, a SOAD certificate by itself is not sufficient to authorise the treatment, unless they are detained. Clinicians must also have the patient's own consent or some other legal authority, just as they would if section 58A did not exist (see paragraphs 19.80 – 19.88).

25.25 Whether or not section 58A applies, patients of all ages who are to be treated with ECT should be given written information before their treatment starts which helps them to understand and remember, both during and after the course of ECT, the advice given about its nature, purpose and likely effects.

CTO patients not recalled to hospital – part 4A certificates and part 4A consent certificates for section 58 and 58A type treatment

25.26 Compulsory treatment cannot be given to a patient on a CTO who has not been recalled (referred to in this chapter as a 'part 4A patient') and who has capacity (or competence, for patients under 16) to consent to or refuse a treatment, and who refuses the treatment (unless it is immediately necessary and being given under section 64G – see paragraphs 25.24 – 25.25). Refusal to consent to treatment in itself does not justify a recall to hospital and fuller consideration of the patient's presentation and circumstances is required when considering whether a recall to hospital is warranted (see chapter 29).

25.27 In addition to rules governing treatment of CTO patients described in chapter 29, there are specific rules regarding the certification of certain treatment given to part 4A patients:

- 'section 58 type treatment' – treatment to which section 58 would apply if the patient were detained. Ie medication after an initial three-month period, and
- 'section 58A type treatment' – ECT and other types of treatment to which section 58A applies.

25.28 In the case of a part 4A patient who lacks capacity (or competence, if under 16) to consent to treatment, a SOAD must certify that the treatment is appropriate (a part 4A certificate).

25.29 In the case of a part 4A patient who has capacity (or, if under 16, is competent) to consent to the treatment and has consented, the approved clinician in charge of the patient's treatment must certify that the patient has capacity/competence and has consented (a part 4A consent certificate).

25.30 In the case of patients aged under 18, regardless of capacity to consent, ECT can only be authorised by a part 4A certificate (ie not by a part 4A consent certificate).

25.31 Neither a part 4A certificate nor a part 4A consent certificate is required for section 58 type treatment to be given:

- where less than three months have passed since the patient was first given the treatment during an unbroken period of detention and discharge onto a CTO (or an unbroken succession of periods of detention and CTO), or
- during the first month following a patient's discharge from detention onto a CTO (even if the three-month period referred to in section 58 has already expired or expires during that first month)

- if the criteria under section 64G are met for emergency treatment in the community of patients lacking capacity or competence, or
- it is immediately necessary and the patient has capacity to consent to it and has consented, or their donee or deputy or the Court of Protection has consented on the patient's behalf (see chapter 7).

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

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

25.33 In general, CTO patients recalled to hospital are subject to sections 58 and 58A in the same way as other detained patients. But there are exceptions, as follows:

- a certificate under section 58 is not needed for medication if less than one month has passed since the patient was discharged from hospital and became a CTO patient (see paragraph 25.31 above)
- a certificate is not needed under either section 58 or 58A if a part 4A certificate or part 4A consent certificate has been issued
- a certificate is not needed under either section 58 or 58A if the treatment in question is explicitly authorised for administration on recall on the patient's SOAD issued part 4A certificate, and
- treatment that was already being given on the basis of a part 4A certificate may be continued, even though it is not authorised for administration on recall, if the approved clinician in charge of the treatment considers that discontinuing it would cause the patient serious suffering. It may only be continued pending compliance with section 58 or 58A (as applicable) – in other words while steps are taken to obtain a new certificate.

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

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

25.36 The exceptions to the requirement to have a certificate under section 58 or 58A set out in paragraph 25.31 continue to apply if the patient's CTO is revoked, but only while steps are taken to comply with section 58 (where relevant). Responsible clinicians should ensure that steps are in hand to obtain a new SOAD certificate under section 58 or 58A, if one is needed, as soon as they revoke a CTO.

Urgent cases where certificates are not required (sections 62, 64B, 64C and 64E)

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

25.38 This applies only if the treatment in question is immediately necessary to:

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

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

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

25.41 Urgent treatment under these sections can continue only for as long as it remains immediately necessary. If it is no longer immediately necessary, the normal requirements for certificates apply. Although certificates are not required where treatment is immediately necessary, the other requirements of parts 4 and 4A of the Act still apply. The treatment is not necessarily allowed just because no certificate is required.

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

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

SOAD certificates

25.43 If a SOAD certificate is required, the clinician in charge of the treatment in question has the personal responsibility of ensuring that a request is made to the CQC for a SOAD to visit.

25.44 Clinicians should not normally request a visit from a SOAD in order to obtain a certificate which they could issue themselves confirming that a patient has consented to treatment. They should request a visit for that purpose only if they are genuinely unable to determine for themselves whether the patient has the capacity to consent or whether the patient is in fact consenting.

Arranging and preparing for SOAD visits

25.45 SOADs will visit detained patients in hospital. For CTO patients, hospital managers should ensure that arrangements are made for the SOAD to see the patient at a mutually agreed place, eg at an outpatient clinic or somewhere that the patient might visit regularly.

25.46 Attending hospital for examination by a SOAD is a condition of all CTOs. If CTO patients fail to attend when asked to do so, they may be recalled to hospital for the examination, if necessary, but this should only ever be a last resort (see paragraph 29.45).

25.47 The treatment proposal for the patient, together with notes of any relevant multi-disciplinary discussion on which it was based, must be given to the SOAD before or at the time of the visit. If a part 4A certificate is being requested, the proposal should clearly indicate which (if any) treatments it is proposed should be authorised in the case of the patient's recall to hospital.

25.48 During a visit, SOADs should interview the patient in private if possible. Others may attend if the patient and the SOAD wish, or if it is thought that the SOAD would be at significant risk of physical harm from the patient (and the SOAD agrees).

25.49 Hospital managers are responsible for ensuring that people whom the SOAD wishes to meet (including the clinician in charge of the treatment) are available in person at the time the SOAD visits.

25.50 SOADs have a right of access to records, without the patient's consent if necessary, and may ask hospital managers to provide the clinical notes to help inform their decision. Managers are responsible for ensuring that such requests can be fulfilled promptly.

25.51 Where the proposed treatment includes medication, the SOAD's attention should be drawn specifically to any recent review of the patient's treatment, including the rationale for using medication, and what other forms of treatment have been tried or considered. Clinicians should consider seeking a review by a specialist mental health pharmacist before seeking a SOAD certificate, particularly if the patient's medication regimen is complex or unusual.

25.52 Approved clinicians should ensure that SOADs are informed if the hospital knows that the patient has an attorney or deputy who is authorised under the MCA to make decisions on the patient's behalf about medical treatment. Details of any relevant advance decisions, or advance statements of views, wishes or feelings, should already be recorded in the patient's notes. If they are not, they should be drawn to the SOAD's attention.

Statutory consultees

25.53 SOADs are required to consult two people ('statutory consultees') before issuing certificates approving treatment.[3] Where section 57, 58 or 58A applies, one of the statutory consultees must be a nurse; the other must not be either a nurse or a medical doctor. Both must have been professionally concerned with the patient's medical treatment, and neither may be the clinician in charge of the proposed treatment or the responsible clinician. Where a SOAD is considering giving a part 4A certificate, at least one of the statutory consultees must not be a medical doctor (but need not be a nurse), and neither may be the clinician in charge of the proposed treatment or the responsible clinician (if the patient has one).

25.54 The Act does not specify who the statutory consultees should be, but they should be people whose knowledge of the patient and the patient's treatment can inform the SOAD when making decisions as to the patient's capacity to consent to or refuse treatment and the appropriateness of the proposed treatment, and will commonly be members of the wider multi-disciplinary team. People who may be particularly well placed to act as statutory consultees are those who have detailed and/or up-to-date knowledge of the patient. For part 4A certificates, it is permissible for one of the two consultees to be a medical doctor, but that person cannot be the responsible clinician; typically a general practitioner (GP) may be consulted.

[3] For part 4 certificates, see sections 57(3), 58(4), 58A(6) and 64H(3).

25.55 The statutory consultees whom the SOAD proposes to consult should consider whether they are sufficiently concerned professionally with the patient's care to fulfil the function. If not, or if a consultee feels that someone else is better placed to fulfil the function, they should make this known to the clinician in charge of the treatment and to the SOAD in good time.

25.56 Statutory consultees may expect a private discussion with the SOAD and to be listened to with consideration. Issues that the consultees may be asked about include, but are not limited to:

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

25.57 If the SOAD wishes to speak to the statutory consultees face-to-face, the hospital managers should ensure that the SOAD is able to do so.

25.58 SOADs should make a record of their consultation with statutory consultees, which will become part of the patient notes.

25.59 SOADs should, where appropriate, consult a wider range of people who are concerned with the patient's care than those required by the Act. That might include the patient's GP, nearest relative, family and carers, and any independent mental health advocate or other advocate representing the patient.

The SOAD's decision and reasons

25.60 The SOAD's role is to provide an additional safeguard to protect the patient's rights, primarily by deciding whether certain treatments are appropriate and issuing certificates accordingly. Although appointed by the commission, SOADs act as independent professionals and must reach their own judgement about whether the proposed treatment is appropriate.

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

25.62 SOADs should, in particular:

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

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

25.64 A certificate may be acted on even though the SOAD's reasons have yet to be received. If there is no pressing need for treatment to begin immediately, it is preferable to wait until the reasons are received, especially if the patient is likely to be unhappy with the decision.

25.65 When giving reasons, SOADs will need to indicate whether, in their view, disclosure of the reasons to the patient would be likely to cause serious harm to the patient's physical or mental health or to that of any other person. The responsible clinician should take into account this view when deciding whether or not to disclose the reasons to the patient. The expectation is that in the overwhelming majority of cases the patient should be able to see the SOAD's reasons.

25.66 It is the personal responsibility of the clinician in charge of the treatment to communicate the results of the SOAD visit to the patient. This need not wait until any separate statement of reasons has been received from the SOAD. But when a separate statement is received from the SOAD, the patient should be given the opportunity to see it as soon as possible, unless the clinician in charge of the treatment (or the SOAD) thinks that it would be likely to cause serious harm to the physical or mental health of the patient or any other person.

25.67 Documents provided by SOADs are a part of, and should be kept in, the patient's notes. The clinician in charge of the treatment should record their actions in providing patients with (or withholding) the reasons supplied by a SOAD.

25.68 Every attempt should be made by the clinician in charge of the treatment and the SOAD to reach agreement. A generally sound plan need not be rejected as a whole because of a minor disagreement about one aspect of it.

25.69 If SOADs are unable to agree with the clinician in charge of the treatment, they should inform the clinician personally as soon as possible. It is good practice for SOADs to give reasons for their disagreement.

25.70 Neither the SOAD nor the approved clinician should allow a disagreement in any way to prejudice the interests of the patient. If agreement cannot be reached, the position should be recorded in the patient's notes by the clinician in charge of the treatment in question, and the patient's responsible clinician (if different) should be informed.

25.71 The opinion given by the SOAD is the SOAD's personal responsibility. There can be no appeal to the CQC against the opinion.

Status of certificates under part 4 and part 4A

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

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

25.74 People administering the treatment (or directing its administration) should take reasonable steps to assure themselves that the treatment is, in fact, authorised by the certificate, given what is said in the certificate about the patient's capacity and willingness to consent (see paragraph 25.76).

25.75 Original signed certificates should be kept with the documents which authorise the patient's detention or CTO, and copies should be kept in the patient's notes. As a matter of good practice, a copy of the certificate relating to medication should be kept with the patient's medicine chart (if there is one) to minimise the risk of the patient being given treatment in contravention of the provisions of the Act.

Review of treatment and withdrawal of approval (sections 61 and 64H)

25.76 Although the Act does not require the validity of certificates to be reviewed after any particular period, it is good practice for the clinician in charge of the treatment to review them (in consultation with the responsible clinician, if different) at regular intervals.

25.77 The clinician in charge of any treatment given in accordance with a SOAD certificate must provide a written report on that treatment and the relevant patient's condition at any time if requested to do so by the CQC under sections 61 or 64H of the Act. This is in addition to the reports they are automatically required to provide periodically under those sections.[4] Copies of reports should be given to patients.

25.78 Under sections 61 and 64H, the CQC may also, at any time, direct that a certificate is no longer to approve either some or all of the treatments specified in it from a particular date.

25.79 However, where the CQC revokes approval in that way, treatment (or a course of treatment) which is already in progress may continue, pending a new certificate, if the clinician in charge of it considers that discontinuing it would cause the patient serious suffering (section 62 (2)).

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

Action where treatment is continued pending a new certificate

25.81 Where treatment is continued to avoid serious suffering pending compliance with a certificate requirement, the clinician in charge of the treatment should immediately take steps to ask for a SOAD visit. This applies both to cases where certificates have been withdrawn by the CQC and to cases where the treatment of CTO patients is being continued pending a new certificate following their recall to hospital (see paragraphs 25.33 and 25.36). If the SOAD visits and decides not to give a certificate for treatment which requires one, the treatment must end immediately.

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

[4] At the time of publication, the Care Quality Commission expects these reports to be submitted on form MHAC1 which it provides for this purpose.

Other circumstances when certificates cease to be effective

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

Figure 15: Circumstances in which certificates cease to authorise treatment, even though they have not been withdrawn

Type of certificate	Circumstances in which the certificate ceases to authorise treatment
Certificate issued by approved clinician under section 58 or 58A	The patient no longer consents to the treatment. The patient no longer has capacity to consent to the treatment. The patient stops (even if only temporarily) being either a detained patient (as defined in chapter 24) or a community patient who is not recalled to hospital. There is a permanent change in the approved clinician in charge of the patient's treatment.
SOAD certificate under section 57	The patient no longer consents to the treatment. The patient no longer has capacity to consent to the treatment. The SOAD specified a time limit on the approval of treatment, and the time limit has expired.
SOAD certificate under section 58 or 58A	The patient stops (even if only temporarily) being either a detained patient (as defined in chapter 24 or a community patient who is not recalled to hospital – except in the case of section 58A certificates for patients aged under 18. The SOAD specified a time limit on the approval of a course of treatment, and the time limit has expired. The certificate was given on the basis that the patient consented, but the patient no longer consents or has lost the capacity to consent. The certificate was given on the basis that the patient lacked capacity to consent, but the patient now has that capacity. Section 58 only: The certificate was given on the basis that the patient had capacity to consent but was refusing, and the patient is now either consenting or has lost the capacity to consent. Section 58A only: The certificate was given on the understanding that the treatment would not conflict with an advance decision to refuse treatment, but the person giving the treatment has since become aware that there is such a conflict. Section 58A only: The certificate was given on the understanding that the treatment would not conflict with a decision of an attorney, deputy or the Court of Protection, but the person giving the treatment has since become aware that there is such a conflict, or an attorney, deputy or the Court of Protection makes a new decision that the treatment should not be given.

Type of certificate	Circumstances in which the certificate ceases to authorise treatment
Part 4A certificate	The patient stops (even if only temporarily) being either a detained patient (as defined in chapter 24) or patient on a CTO. (But note that a part 4A certificate authorises section 58 type treatment for a patient whose CTO has been revoked only pending compliance with section 58 itself.) The certificate was given on the basis that the patient lacked capacity to consent to or refuse the treatment, but the patient now has that capacity and consents to the treatment. The SOAD specified a time limit on the approval of a course of treatment, and the time limit has expired.
Part 4A consent certificate	The patient stops (even if only temporarily) being either a detained patient (as defined in chapter 24) or patient on a CTO. (But note that a part 4A consent certificate authorises section 58 type treatment for a patient whose CTO has been revoked only pending compliance with section 58 itself.) There is a permanent change in the approved clinician in charge of the patient's treatment. The certificate was given on the basis that the patient consented, but the patient no longer consents or has lost the capacity to consent.

25.84 In all the circumstances listed in the table, treatment cannot be continued while a new certificate is obtained, unless no certificate is needed because the treatment is immediately necessary (see paragraphs 25.37 – 25.42) and, in respect of CTO patients not recalled to hospital, the treatment is given under section 64G.

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

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

Related material

- CR190 Consensus Statement on High-dose Antipsychotic Medication. Royal College of Psychiatrists. 2006. http://www.rcpsych.ac.uk/usefulresources/publications/collegereports/cr/cr190.aspx
- For further information and advice please contact the British National Formulary, British Medical Association and/or the Royal Pharmaceutical Society of Great Britain.

This material does not form part of the Code. It is provided for assistance only.

26 Safe and therapeutic responses to disturbed behaviour

Why read this chapter?

26.1 A safe and therapeutic culture should be provided for all people receiving treatment for a mental disorder including those who may present with behavioural disturbance.

26.2 This chapter provides guidance for providers, professionals and practitioners on how to manage people with disturbed behaviour which may present a particular risk to themselves or to others, including those charged with their care. It requires providers to have restrictive intervention reduction programmes and policies on related matters. The chapter makes clear that restrictive interventions such as: enhanced observation, physical restraint, mechanical restraint, rapid tranquillisation, seclusion and long-term segregation, should only be used in a way that respects human rights. It provides guidance on individualised assessments, as well as care plans or treatment plans which include primary, secondary and tertiary strategies (in some services such care plans are referred to as positive behavioural support (PBS) plans). It provides a definition of restrictive intervention and gives guidance on particular types of restrictive interventions. Guidance is also given on the particular needs of children and young people and on the importance of appropriate staff training.

26.3 Except where otherwise stated, this guidance applies to all people receiving treatment for a mental disorder in a hospital and who are liable to present with behavioural disturbances, regardless of their age and whether or not they are detained under the Act.

Restrictive intervention reduction programmes

26.4 Providers who treat people who are liable to present with behavioural disturbances should focus primarily on providing a positive and therapeutic culture. This culture should aim at preventing behavioural disturbances, early recognition, and de-escalation (see paragraphs 26.16 – 26.26).

26.5 Providers should have governance arrangements in place that enable them to demonstrate that they have taken all reasonable steps to prevent the misuse and misapplication of restrictive interventions. When restrictive interventions are unavoidable, providers should have a robust approach to ensuring that they are used in the safest possible manner. All mental health providers therefore should have in place a regularly reviewed and updated restrictive intervention reduction programme.

26.6 Restrictive intervention reduction programmes are overarching, multi-component action plans which aim to reduce the use of restrictive interventions. They should

demonstrate organisational commitment to restrictive intervention reduction at a senior level, how the use of data relating to restrictive interventions will inform service developments, continuing professional development for staff, how models of service which are known to be effective in reducing restrictive interventions are embedded into care pathways, how service users are engaged in service planning and evaluation and how lessons are learned following the use of restrictive interventions. They should ensure accountability for continual improvements in service quality through the delivery of positive and proactive care. They should also include improvement goals and identify who is responsible for progressing the different parts of the plan. A key indicator that a plan is being delivered well will be a reduction in the use of restrictive interventions. Other indicators include reduction of injuries as a result of restrictive interventions, improved patient satisfaction and reduced complaints.

Provider policies

26.7 Restrictive interventions may be required in health and social care settings as part of a broader therapeutic programme. When they are required, they should be planned, evidence based, lawful, in the patient's interests, proportionate and dignified. In order to ensure that this is the case, each provider should have one or more policies that guide the day-to-day operation of services ('provider policies'), which should include guidance on:

- assessments of risks and support needs (see paragraphs 26.8 - 26.15)
- the use of positive behaviour support plans (or equivalent) (as described in paragraph 26.15)
- how the risks associated with restrictive interventions can be minimised; in particular, an assessment of their potential to cause harm to the physical, emotional and psychological wellbeing of patients and how providers will take account of a patient's individual vulnerabilities to harm (such as unique needs associated with physical/emotional immaturity, older age, disability, poor physical health, pregnancy, past history of traumatic abuse etc)
- how restrictive interventions which are used by the provider, should be authorised, initiated, applied, reviewed and discontinued, as well as how the patient should be supported throughout the duration of the application of the restrictive intervention (see paragraphs 26.62 – 26.158)
- local recording and reporting mechanisms around the use of restrictive interventions
- post-incident analysis/debrief (see paragraphs 26.147 – 26.152), and
- workforce development, including training requirements relating to the application of restrictive interventions, which are underpinned by their therapeutic intent (see paragraphs 26.175 – 26.177).

Individualised assessments

26.8 People suffering from a mental disorder should, on admission to hospital, be assessed for immediate and potential risks of behavioural disturbance. Staff should be alert to risks that may not be immediately apparent, such as self-neglect. Assessments should take account of the person's history of such behaviours, their history of experiencing personal trauma, their presenting mental and physical state and their current social circumstances.

26.9 While previous history is an important factor in assessing current risk, staff should not assume that a previous history of behavioural disturbance means that a person will necessarily behave in the same way in the future.

26.10 Care should be taken to ensure that negative and stigmatising judgements about certain diagnoses, behaviours or personal characteristics do not obscure a rigorous assessment of the degree of risk which may be presented, or the potential benefits of appropriate treatment to people who are assessed as liable to present with behavioural disturbance. Providers should consider the accuracy of assessments of risks as part of routine audit arrangements and put training in place to learn from any inappropriate risk judgements. Cultural awareness is particularly important in understanding behaviour and responding appropriately; assessments should be carried out in a way that takes account of any cultural issues.

26.11 Assessments of behavioural presentation are important in understanding an individual's needs. These should take account of the individual's social and physical environment and the broader context against which behavioural disturbance occurs. There may be times where an individual feels angry for reasons not associated with their mental disorder and this may be expressed as behavioural disturbance. Assessments should seek to understand behaviour in its broader context and not presume it to be a manifestation of a mental disorder.

26.12 Assessments should consider the views of patients and their families, carers and advocates about why an individual might be behaving in a particular way, including any historical accounts of behaviour and possible reasons for that behaviour. This is particularly important because they can provide useful insights regarding individual responses to behavioural that have been tried in the past.

26.13 The results of the assessment should guide the development and implementation of effective, personalised and enduring systems of support that meet an individual's needs, promote recovery and enhance quality of life outcomes for the individual and others who care and support them.

26.14 When concluded, assessments should describe behaviours of concern, identify factors which predict their occurrence, and describe the functions that behaviours serve or the outcomes they achieve for the individual. These assessments should inform the patient's care programme approach (CPA) care plan and/or positive behaviour support plans (or equivalent) (see paragraphs 26.18 – 26.27).

Factors which may contribute to behavioural disturbance and which should be considered within assessments include:

- poorly treated symptoms of mental disorder
- unmet social, emotional or health needs
- excessive stimulation, noise and general disruption
- excessive heating, overcrowding and restricted access to external space
- boredom, lack of constructive things to do, insufficient environmental stimulation
- lack of clear communication by staff with patients
- the excessive or unreasonable application of demands and rules
- lack of positive social interaction
- restricted or unpredictable access to preferred items and activities
- patients feeling that others (whether staff, friends and/or families) are not concerned with their subjective anxieties and concerns
- exposure to situations that mirror past traumatic experiences
- a sense of personal disempowerment
- emotional distress, eg following bereavement
- frustrations associated with being in a restricted and controlling environment
- antagonism, aggression or provocation on the part of others
- inconsistent care
- difficulties with communication
- the influence of alcohol or drugs
- a state of confusion, and
- physical illness.

Primary, secondary and tertiary strategies

26.15 Staff should ensure that patients who are assessed as being liable to present with behavioural disturbance have a care or treatment plan which includes primary preventative strategies, secondary preventative strategies and tertiary strategies (see paragraphs 34.2 – 34.5). In some services such a care or treatment plan is referred to as a positive behaviour support plan. These individualised care plans, should be available and kept up to date, and include the following elements:

- primary preventative strategies aim to enhance a patient's quality of life and meet their unique needs, thereby reducing the likelihood of behavioural disturbances (see paragraphs 26.19 – 26.22)
- secondary preventative strategies focus on recognition of early signs of impending behavioural disturbance and how to respond to them in order to encourage the patient to be calm (including on de-escalation, see paragraphs 26.23 – 26.26), and

- tertiary strategies guide the responses of staff and carers when there is a behavioural disturbance. Responses should be individualised and wide ranging, if appropriate, possibly including continued attempts to de-escalate the situation, summoning assistance, removing sources of environmental stress or removing potential targets for aggression from the area. Where it can reasonably be predicted on the basis of risk assessment, that the use of restrictive interventions may be a necessary and proportionate response to behavioural disturbance, there should be clear instruction on their pre-planned use. Instructions should ensure that any proposed restrictive interventions are used in such a way as to minimise distress and risk of harm to the patient.

26.16 Patients and their families should be as fully involved as possible in developing and reviewing positive behaviour support plans (or equivalents). Patients eligible for support from an independent mental health advocate (IMHA) should be reminded that an IMHA can support them in presenting their views and discussing their positive behaviour support plan (or equivalent). The preparation of positive behaviour support plans (or equivalents) also provides an important opportunity to record the wishes and preferences of families and carers and the involvement they may wish to have in the management of behavioural disturbances. For example, on occasion, family members may wish to be notified if the patient is becoming anxious and to contribute to efforts to de-escalate the situation by speaking to the individual on the phone. People must consent to the involvement of families or advocates if they have capacity to give or refuse such consent.

26.17 Positive behaviour support plans (or equivalent) should take account of disabilities, a patient's level of cognitive functioning, the impact of age in terms of physiological and emotional maturity, the patient's ethnicity, culture, religion or belief, gender, gender identity and sexual identity. They should maximise privacy and dignity (see chapter 8 and paragraphs 1.13 – 1.14).

Meeting needs

Primary preventative strategies

26.18 Behavioural disturbance can be minimised by promoting a supportive and therapeutic culture within the care environment. Unless an individual is subject to specific justifiable restrictions (eg for security reasons), primary preventative strategies should typically include the following, depending on the individual's assessed needs:

A: The care environment:

- providing predictable access to preferred items and activities
- avoiding excessive levels of environmental stimulation
- organising environments to provide for different needs, for example, quiet rooms, recreation rooms, single-sex areas and access to open spaces and fresh air

- giving each patient a defined personal space and a safe place to keep their possessions
- ensuring an appropriate number and mix of staff to meet the needs of the patient population
- ensuring that reasonable adjustments can be made to the care environment to support people whose needs are not routinely catered for, for example, sensory impairments, and
- avoiding demands associated with compliance with service-based routines and adherence to 'blanket rules' (see paragraphs 1.6, 8.5 – 8.15).

B: Engaging with individuals and their families:

- ensuring that individuals are able to meet visitors safely in private and convivial environments, as well as to maintain private communication by telephone, post and electronic media, respecting the wishes of patients and their visitors
- engaging individuals, supporting them to make choices about their care and treatment and keeping them fully informed, and communicating in a manner that ensures the individual can understand what is happening and why
- involving individuals in the identification of their own trigger factors and early warning signs of behavioural disturbance and in how staff should respond to them
- engaging individuals in all aspects of care and support planning
- ensuring that meetings to discuss an individual's care occur in a format, location and at a time of day that promotes engagement of patients, families, carers and advocates
- with the individual's consent (if they have the capacity to give or refuse such consent), involving their nearest relative, family, carers, advocates and others who know them and their preferences in all aspects of care and treatment planning, and
- promptly informing patients, families, carers and advocates of any significant developments in relation to the individual's care and treatment, wherever practicable and subject to the patient's wishes and confidentiality issues.

C: Care and support:

- opportunity for individuals to be involved in decisions about an activity and therapy programme that is relevant to their identified needs, including evening and weekend activities
- delivering individualised patient-centred care which takes account of each person's unique circumstances, their background, priorities, aspirations and preferences
- supporting individuals to develop or learn new skills and abilities by which to better meet their own needs

- developing a therapeutic relationship between each patient and care workers, including a named key worker or nurse identified as the patient's primary contact at the service
- providing training for staff in the management of behavioural disturbance, including alternatives to restrictive interventions, desirable staff attitudes and values, and training in the implementation of models of care including positive behavioural support plans
- ensuring that individuals' complaints procedures are accessible and available and that concerns are dealt with quickly and fairly
- ensuring that physical and mental health needs are holistically assessed and that the person is supported to access the appropriate treatments, and
- developing alternative coping strategies in response to known predictors of behavioural disturbance.

26.19 People who are identified as being at risk of presenting with behavioural disturbance should be given the opportunity to have their wishes and feelings recorded in an advance statement, if they have the capacity to do so. Guidance on advance statements of wishes and feelings can be found in chapter 9.

26.20 Whilst some psychological treatments or programmes may impose restrictions on normal day-to-day activities (eg restricting access to favoured activities or incentives so that they are available only as incentives or behavioural reinforcers), such restrictions should not be imposed across the service, or be used to punish or humiliate. This means that service providers should avoid blanket restrictions that apply to all patients; interventions should always be individualised, and subject to discussion and review by the whole clinical team. The individual's consent to the intervention should always be sought where the individual has capacity to consent or refuse the intervention, even if a refusal may be overridden (eg because it is part of the compulsory treatment the individual may be given under the Act).

26.21 Restrictions associated with such programmes should be reasonable and proportionate to the risks associated with the behaviour being addressed and consistent with the guiding principles of the Code (and the Mental Capacity Act (MCA), where it applies). Access to leave, food and drink, fresh air, shelter, warmth, a comfortable environment, exercise, confidentiality or reasonable privacy should never be restricted or used as a 'reward' or 'privilege' dependant on 'desired' behaviours.

26.22 Psychological treatments with the goal of behavioural change should only be used under the direct supervision of a suitably trained and competent professional, and should be monitored regularly for impact.

26.23 Provider policies should encourage patients to avoid staying in their bedrooms for prolonged periods during the daytime. Therapeutic interventions and a range of engaging activities should be available and people should not be locked out of their bedrooms in an attempt to restrict their freedom of movement.

Secondary preventative strategies

26.24 De-escalation is a secondary preventative strategy. It involves the gradual resolution of a potentially violent or aggressive situation where an individual begins to show signs of agitation and/or arousal that may indicate an impending episode of behavioural disturbance.

26.25 De-escalation strategies promote relaxation, eg through the use of verbal and physical expressions of empathy and alliance. They should be tailored to individual needs and should typically involve establishing rapport and the need for mutual co-operation, demonstrating compassion, negotiating realistic options, asking open questions, demonstrating concern and attentiveness, using empathic and non-judgemental listening, distracting, redirecting the individual into alternate pleasurable activities, removing sources of excessive environmental stimulation and being sensitive to non-verbal communication.

26.26 Staff should liaise with individuals and those who know them well, and take into account clinical assessments, to identify individualised de-escalation approaches which should be recorded as secondary preventative strategies in the individual's positive behaviour support plan (or equivalent). In some instances it may be feasible for families to contribute to de-escalation approaches, eg, by speaking to their relative on the telephone (see paragraph 26.16).

26.27 Staff should ensure that they do not exacerbate behavioural disturbance, eg by dismissing genuine concerns or failing to act as agreed in response to requests, or through the individual experiencing unreasonable or repeated delays in having their needs met. Where such failures are unavoidable, every effort should be made to explain the circumstances of the failure to the individual and to involve them in any plans to redress the failure.

Enhanced observation

26.28 Staff should know the location of all patients for whom they are responsible in a hospital ward or service. It is not necessary to routinely keep patients who are not considered to present a serious risk of harm to themselves or others within sight.

26.29 Research suggests that most attempted suicides are discovered and prevented by staff checking on patients, particularly in the more private areas of wards. For individuals assessed as being at risk of suicide or serious self-harm, a significant preventive mechanism is for nursing staff to be caringly vigilant and inquisitive. For such individuals, staff should have a thorough knowledge of the patient and have a clear plan in relation to monitoring and supervision. Unusual circumstances and noises should be investigated.

26.30 There may be times when enhanced levels of observation are required for the short-term management of behavioural disturbance or during periods of distress to prevent suicide or serious self-harm. Enhanced observation is a therapeutic intervention with the aim of reducing the factors which contribute to increased risk and promoting recovery. It should focus on engaging the person therapeutically and enabling them to address their difficulties constructively (eg through sitting, chatting, encouraging/supporting people to participate in activities, to relax, to talk about any concerns etc).

26.31 Enhanced observation may be provided on an intermittent basis with staff engaging with patients and observing their condition at irregular and unpredictable intervals of between 15 and 30 minutes. High use of intermittent observation on wards has been shown to be associated with low levels of self-harm and has been shown to be tolerated by most patients.

26.32 Alternatively enhanced observation may be provided on a continuous basis with the individual remaining either within eyesight of staff or, for the most serious degrees of risk, within arm's length. Continuous observation should be carried out when intermittent observation is seen as insufficient to safely manage risks.

26.33 Provider policies should cover the use of enhanced observation and include:

- which staff (profession and grade) are best placed to carry out enhanced observation and under what circumstances it might be appropriate to delegate this duty to another member of the team
- how the selection of a staff member to undertake enhanced observation should take account of the individual's characteristics and circumstances (including factors such as ethnicity, sexual identity, age and gender)
- how enhanced observation can be undertaken in a way which minimises the likelihood of individuals perceiving the intervention to be coercive, and
- how observation can be carried out in a way that respects the individual's privacy as far as practicable and minimises any distress. In particular, provider policies should outline how an individual's dignity can be maximised without compromising safety when individuals are in a state of undress, such as when using the toilet, bathing, showering, dressing etc (see chapter 8).

26.34 Staff should balance the potentially distressing effect on the individual of increased levels of observation, particularly if these are proposed for many hours or days, against the identified risk of self-injury or behavioural disturbance. Levels of observation and risk should be regularly reviewed and a record made of decisions agreed in relation to increasing or decreasing the observation.

26.35 If an individual under long-term enhanced observation is also being prevented from having contact with anyone outside the area in which they are confined, then this will amount to either seclusion or long-term segregation which should comply with paragraphs 26.103 – 26.160.

Restrictive interventions

26.36 Restrictive interventions are deliberate acts on the part of other person(s) that restrict a patient's movement, liberty and/or freedom to act independently in order to:

- take immediate control of a dangerous situation where there is a real possibility of harm to the person or others if no action is undertaken, and
- end or reduce significantly the danger to the patient or others.

Restrictive interventions should not be used to punish or for the sole intention of inflicting pain, suffering or humiliation.

26.37 Where a person restricts a patient's movement, or uses (or threatens to use) force then that should:

- be used for no longer than necessary to prevent harm to the person or to others
- be a proportionate response to that harm, and
- be the least restrictive option.

26.38 Where risk assessments identify that restrictive interventions may be needed, their implementation should be planned in advance and recorded as tertiary strategies within the positive behaviour support plans (or equivalent) (paragraph 26.15 – 26.17).

26.39 On other occasions, behavioural disturbance may not have been predicted by risk assessments. In such cases emergency management of the situation and the use of restrictive interventions should be based on clinical judgement which take account of relevant best practice guidance (such as those published by the National Institute for Health and Care Excellence (NICE)) and all available knowledge of the patient's circumstances.

26.40 The most common reasons for needing to consider the use of restrictive interventions are:

- physical assault by the patient
- dangerous, threatening or destructive behaviour
- self-harm or risk of physical injury by accident
- extreme and prolonged over-activity that is likely to lead to physical exhaustion, or
- attempts to escape or abscond (where the patient is detained under the Act or deprived of their liberty under the MCA).

26.41 Restrictive interventions should be used in a way that minimises any risk to the patient's health and safety and that causes the minimum interference to their autonomy, privacy and dignity, while being sufficient to protect the patient and other people. The patient's freedom should be contained or limited for no longer than is necessary. Unless there are cogent reasons for doing so, staff must not cause deliberate pain to a patient in an attempt to force compliance with their instructions (for example, to mitigate an immediate risk to life).

26.42 The choice and nature of restrictive intervention will depend on various factors, but should be guided by:

- the patient's wishes and feelings, if known (eg by an advance statement)
- what is necessary to meet the needs of the individual based on a current assessment and their history
- the patient's age and any individual physical or emotional vulnerabilities that increase the risk of trauma arising from specific forms of restrictive intervention
- whether a particular form of restrictive intervention would be likely to cause distress, humiliation or fear
- obligations to others affected by the behavioural disturbance
- responsibilities to protect other patients, visitors and staff, and
- the availability of resources in the environment of care.

26.43 Where an individual has a history of abuse, restrictive interventions of any nature can trigger responses to previous traumatic experiences. Responses may be extreme and may include symptoms such as flashbacks, hallucinations, dissociation, aggression, self-injury and depression. Where patients have an identified history of trauma it will be particularly useful to obtain their recorded wishes about restrictive interventions. Patients' preferences in terms of the gender of staff carrying out such interventions should be sought and respected.

26.44 Providers should work with local police services to establish clear local protocols about the circumstances when, very exceptionally, the police may be called to manage patient behaviour within a health or care setting. In these cases, mental health professionals continue to be responsible for the health and safety of the person. Health staff should be alert to the risk of any respiratory or cardiac distress and continue to monitor the patient's physical and psychological wellbeing.

Respecting human rights

26.45 Any use of restrictive interventions must be compliant with the Human Rights Act 1998 (HRA), which gives effect in the UK to certain rights and freedoms guaranteed under the European Convention on Human Rights (ECHR).

26.46 Services and their staff should help all patients to understand the legal authority for any proposed action and their rights (especially their right to leave a hospital if they are not detained there). Informal patients should, in particular, be informed of the existence of holding powers.

26.47 No restrictive intervention should be used unless it is medically necessary to do so in all the circumstances of the case. Action that is not medically necessary may well breach a patient's rights under article 3, which prohibits inhuman or degrading treatment.

26.48 Article 8 of the ECHR protects the right to respect for private and family life. A restrictive intervention that does not meet the minimum level of severity for article 3 may nevertheless breach a patient's article 8 rights if it has a sufficiently adverse effect on the patient's private life, including their moral and physical integrity.

26.49 Restrictions that alone, or in combination, deprive a patient of their liberty without lawful authority will breach article 5 of the ECHR (the right to liberty). There is a deprivation of liberty in circumstances where a person is under continuous control and supervision and is not free to leave and lacks capacity to consent to the proposed interventions giving rise to the deprivation of liberty. However, the precise scope of the term 'deprivation of liberty' is not fixed and develops over time in accordance with European Court of Human Rights case law and UK case law on article 5.

26.50 Unless a patient is detained under the Act or is subject to a deprivation of liberty authorisation or Court of Protection order under the MCA, providers and their staff must be careful to ensure that the use of restrictive interventions does not impose restrictions which amount to a deprivation of liberty.

26.51 Examples of restrictions that could indicate there is a deprivation of liberty include:

- informal patients being prevented from leaving a hospital
- informal patients being told that they will be detained under the Act if they do not comply with requests of staff, or
- informal patients being kept in circumstances amounting to seclusion without their consent.

Children and young people under 18

26.52 In the case of children and young people under the age of 18, the use of restrictive interventions may require modification to take account of their developmental status. The legal context within which restrictive interventions are used with children and young people is different from adults; key aspects of this are explored in the following paragraphs. For further information on children and young people more generally, see chapter 19.

26.53 Service providers should ensure that staff involved in the care of children and young people who exhibit behavioural disturbance are able to employ a variety of skills and strategies that enable them to provide appropriate help and support. In most cases restrictive interventions will only be used if they form part of the positive behaviour support plan (or equivalent) and have therefore been developed with input from the child or young person and their family.

26.54 Staff should always ensure that restrictive interventions are used only after having due regard to the individual's age and having taken full account of their physical, emotional and psychological maturity.

26.55 When antipsychotic medication is used to sedate a child or young person, special consideration should be given to risks relating to their developing central nervous system, especially when the medication is given to children or adolescents who do not have a diagnosed psychosis.

26.56 The size and physical vulnerability of children and young people should be taken into account when considering physical restraint. Physical restraint should be used with caution when it involves children and young people because in most cases their musculoskeletal systems are immature which elevates the risk of injury.

26.57 Seclusion can be a traumatic experience for any individual but can have particularly adverse implications for the emotional development of a child or young person. This should be taken into consideration in any decision to seclude a child or young person. Careful assessment of the potential effects of seclusion by a trained child and adolescent clinician is required, especially for those children and adolescents with histories of trauma and abuse, where other strategies to de-escalate behaviours may be more appropriate than the use of seclusion.

26.58 In children and young people's services where 'time-out' processes are used, provider policies should differentiate between time-out and seclusion. Time-out is a specific behaviour change strategy which should be delivered as part of a behavioural programme. Time-out might include: preventing a child or young person from being involved in activities which reinforce a behaviour of concern until the behaviour stops; asking them to leave an activity and return when they feel ready to be involved and stop the behaviour; or accompanying the child or young person to another setting and preventing them from engaging in the activity they were participating in for a set period of time. If time-out processes have the features of seclusion, this should be treated as seclusion and comply with the requirements of the Code.

26.59 Restrictive interventions must only be used with great caution on children and young people who are not detained under the Act. As noted in paragraphs 26.73 and 26.106, if there are indications that the use of restrictive interventions (particularly physical restraint or seclusion) might become necessary, consideration should be given to whether formal detention under the Act is appropriate. A person with parental responsibility can consent to the use of restrictive interventions where

a child lacks competence or a young person lacks the capacity to consent, but only if the decision falls within the 'scope of parental responsibility' (see paragraphs 19.38 – 19.43).

26.60 For young people aged 16 or 17 who are not detained under the Act and who lack capacity to consent to the proposed interventions, the use of restrictive interventions in the young person's best interests will not be unlawful if they meet the requirements in section 6 of the MCA and do not amount to a deprivation of liberty (see paragraph 26.49).

26.61 Staff having care of children and young people should be aware that under section 3(5) of the Children Act 1989 they may do 'what is reasonable in all the circumstances of the case for the purpose of safeguarding or promoting the child's welfare'. Whether an intervention is reasonable or not will depend, among other things, upon the urgency and gravity of what is required. This might allow action to be taken to prevent a child from harming him/herself, however it would not allow restrictive interventions that are not proportionate and would not authorise actions that amounted to a deprivation of liberty.

Procedures for the safe use of restrictive interventions

26.62 Provider polices concerning the use of restrictive interventions and their implementation should be kept under ongoing review in order to ensure consistency with current national policy, best practice guidance and evidence. Restrictive interventions should never be employed to deliberately punish or humiliate, and staff should not cause deliberate pain to a person in an attempt to force compliance with their instructions except in the most exceptional circumstances to mitigate an immediate risk to life.

26.63 Any initial attempt to manage an acute behavioural disturbance should, as far as the situation allows, be non-restrictive. For example, assistance might be sought using an emergency alarm system or by verbally summoning assistance. A single member of staff should assume control of the incident. Where possible, the patient should be asked to stop the behaviour. An individual's communication needs should be taken into account including those arising from sensory impairments, learning disability, autism spectrum disorders, or an individual for whom English is not their first language. Where possible, an explanation should be given of the consequences of refusing the request from staff to stop the behaviour. The explanation should be provided calmly and every attempt should be made to avoid the explanation being perceived by the patient as a threat.

26.64 The nature and manner of application of any restrictive intervention, the reason(s) for its use and the consequences or outcome, should be recorded in an open and transparent manner.

26.65 Staff should only use methods of restrictive interventions for which they have received training. Training records should record precisely the techniques for which a member of staff has received training.

26.66 Verbal de-escalation should continue throughout a restrictive intervention. Negotiations should focus on establishing rapport, demonstrating concern, helping the patient to relax, and reducing the patient's level of agitation.

26.67 Whenever restrictive interventions are being used, provider's policies should make provision for the timely attendance of a doctor in response to staff requests concerning a psychiatric emergency whether in relation to medication, restraint or seclusion.

26.68 Where a behavioural disturbance occurs and a restrictive intervention has been used, family members should be informed in accordance with any prior agreements (see paragraph 26.16).

Physical restraint

26.69 Physical restraint refers to any direct physical contact where the intention is to prevent, restrict, or subdue movement of the body (or part of the body) of another person.

26.70 Patients should not be deliberately restrained in a way that impacts on their airway, breathing or circulation. The mouth and/or nose should never be covered and there should be no pressure to the neck region, rib cage and/or abdomen. Unless there are cogent reasons for doing so, there must be no planned or intentional restraint of a person in a prone position (whereby they are forcibly laid on their front) on any surface, not just the floor.

26.71 Full account should be taken of the individual's age, physical and emotional maturity, health status, cognitive functioning and any disability or sensory impairment, which may confer additional risks to the individual's health, safety and wellbeing in the face of exposure to physical restraint. Throughout any period of physical restraint:

- a member of staff should monitor the individual's airway and physical condition to minimise the potential of harm or injury. Observations, including vital clinical indicators such as pulse, respiration and complexion (with special attention for pallor/discolouration), should be conducted and recorded. Staff should be trained so that they are competent to interpret these vital signs
- emergency resuscitation devices should be readily available in the area where restraint is taking place, and
- a member of staff should take the lead in caring for other patients and moving them away from the area of disturbance.

26.72 Where physical restraint has been used, staff should record the decision and the reasons for it, including details about how the intervention was implemented and the patient's response.

26.73 If an individual is not detained under the Act, but physical restraint of any form is necessary, consideration should be given to whether the criteria in sections 5 and 6 of the MCA apply (restraint to be used in respect of people aged 16 and over who lack capacity) and/or whether detention under the Act is appropriate (subject to the criteria being met).[1]

26.74 Provider policies concerning the use of physical restraint should be kept under ongoing review in order to ensure consistency with national policy and best practice.

Mechanical restraint

26.75 Mechanical restraint is a form of restrictive intervention that refers to the use of a device to prevent, restrict or subdue movement of a person's body, or part of the body, for the primary purpose of behavioural control.

26.76 Mechanical restraint should only be used exceptionally, where other forms of restriction cannot be safely employed. It should be used in line with the principle of least restrictive option and should not be an unplanned response to an emergency situation. Mechanical restraint should never be used instead of adequate staffing.

26.77 The use of mechanical restraint should be approved following multi-disciplinary consultation (which should include an IMHA where the patient has one – see chapter 6). The nature of the multi-disciplinary team should be defined in a provider's policies. Provision for the use of mechanical restraint should be recorded as a tertiary strategy in the positive behaviour support plan (or equivalent). This plan should detail the circumstances which might warrant mechanical restraint, the type of device to be applied, how continued attempts should be made to de-escalate the situation and any special measures that are required to reduce the likelihood of physical or emotional trauma resulting.

26.78 Where the agreed provisions for the use of mechanical restraint in positive behaviour support plans (or equivalent) allow a nurse or other professional to authorise the actual use of mechanical restraint, then that professional should notify, without delay, the responsible clinician or duty doctor (or equivalent).

26.79 Staff applying mechanical restraint devices should have appropriate training in their application and use.

26.80 An individual who is mechanically restrained should remain under continuous observation throughout. It may be necessary for the individual to remain at arm's length.

[1] Mental Capacity Act 2005. Code of Practice. Department for Constitutional Affairs (now Ministry of Justice). 2007. https://www.gov.uk/government/publications/mental-capacity-act-code-of-practice

26.81 The individual should be reviewed by a nurse every fifteen minutes for the duration of the period of mechanical restraint.

26.82 The individual should have a medical review by a registered medical practitioner at least one hour after the beginning of mechanical restraint. Subsequently there should be ongoing medical reviews at least every four hours by a registered medical practitioner. Local policies should determine which of their registered medical practitioners should undertake medical reviews. Reviews should be undertaken more frequently if requested by nursing staff. Reviews should ensure that the individual is as comfortable as possible and should include a full evaluation of the patient's physical and mental health condition.

26.83 Procedures should be in place to enable nursing staff to summon a doctor to conduct a medical review ahead of the next scheduled review if they have concerns about the patient's condition.

26.84 The patient's clinical record should provide details of the rationale for the decision to mechanically restrain them, the medical and psychiatric assessment, the patient's condition at the beginning of mechanical restraint, the response to mechanical restraint and the outcomes of the medical reviews.

26.85 Mechanical restraint which involves tying an individual (using tape or a part of the individual's garments) to some part of a building or its fixtures should never be used.

26.86 If, exceptionally, a belt (or similar device) is applied to an individual's body to secure their arms or wrists and the resulting degree of immobility prevents their ability to leave an area (such as where they are unable to reach or operate door handles), this will amount to either seclusion or long-term segregation. The individual should be afforded safeguards regarding associated observation and monitoring, review procedures and care plans to ensure that their privacy and dignity are preserved. Such devices should never be used as an alternative to (or in addition to) seclusion because a suitable safe environment in which to undertake seclusion is not available.

26.87 There may be circumstances where mechanical restraint devices need to be used on a long-term basis, such as to limit self-injurious frequent and intense behaviour (in which case the requirement for post-incident review in paragraph 26.167 does not apply). This will be rare and encountered with small numbers of patients who have severe cognitive impairments, where devices such as arm splints or cushioned helmets may be required to safeguard an individual from the hazardous consequences of their behaviour. In such cases, tertiary strategies within positive behaviour support plans (or equivalent) should aim to provide brief recurrent periods when restraints can be removed. The positive behaviour support plan (or equivalent) may also allow for less frequent medical and nursing reviews provided that the whole clinical team, the patient's family, carers and advocates are in agreement.

Patients subject to a Ministry of Justice Order

26.88 There may be occasions when the use of mechanical restraint (including handcuffs) is required for security purposes when transferring prisoners into a healthcare setting. Guidance for prison and health staff to develop local procedures for the safe management of prisoners at hospital was agreed in a concordat between the National Offender Management Service (NOMS) and the NHS Counter Fraud and Security Service, which forms part of the National Security Framework (Note: Since 2011 NHS Counter Fraud and Security Management Services have been under the auspices of NHS Protect).[2]

26.89 Similarly, there may be occasions where mechanical restraint (including handcuffs) may be used for security purposes for the transfer of restricted patients in secure settings to non-secure settings. The use of mechanical restraint in these circumstances should be informed by an assessment of the risks posed by the patient, as well as their presenting physical and mental condition and the need to maximise their dignity. Escorting staff should alert medical staff to any identified risks if restraints were to be removed; however, if requested by medical staff, they should be removed whilst medical treatment is carried out.

26.90 On occasion, in high-risk cases, the Secretary of State for Justice will make permission for a restricted patient to leave hospital conditional on the use of restraint. Staff should discuss any concerns about this with Mental Health Casework Section (see paragraph 22.86 for contact details).

Rapid tranquillisation

26.91 Rapid tranquillisation refers to the use of medication to calm or lightly sedate an individual to reduce the risk of harm to self or others and to reduce agitation and aggression. This may provide an important opportunity for a thorough psychiatric examination to take place. Prescribers should aim to ensure that the degree of sedation arising from rapid tranquillisation does not compromise the patient's capacity to understand and respond to what is said to them.

26.92 Rapid tranquillisation may also be used to manage acute behavioural disturbance, though this should be a very short-term strategy designed solely to reduce immediate risk and is distinct from treating any underlying mental illness.

26.93 Rapid tranquillisation should only be used where a patient is highly aroused, agitated, overactive and aggressive, or is making serious threats or gestures towards others, or is being destructive to their surroundings, when other therapeutic interventions have failed to contain the behaviour.

[2] Concordat between the National Offender Management Service and NHS Counter Fraud and Security Management Service. Prisoner Escort and Bedwatch Function. Ministry of Justice National Offender Management Service. 2010.

26.94 Rapid tranquillisation includes the use of both intra-muscular injections and oral medication. Oral medication should always be considered before any injections.

26.95 Rapid tranquillisation should be prescribed in accordance with evidence-based practice guidelines such as those published by NICE [3] and in a manner that is consistent with General Medical Council's good practice in prescribing and managing medicines. It must be in line with legal requirements (in respect of patients subject to the Act, the rules concerning treatment and emergency treatment powers under the Act) (see chapter 24).

26.96 Staff prescribing rapid tranquilisation should note any physical observations and monitoring needed following administration and make that clear to staff caring for the patient.

26.97 Where a prescription indicates a choice of administration routes for rapid tranquillisation (eg oral or intramuscular injection), the person prescribing the medication should list factors which should be considered in deciding which route to use under any reasonably foreseeable circumstances.

26.98 Where rapid tranquilisation in the form of an intramuscular injection is needed, the person prescribing the injection should state the preferred injection site, having taken full account of the need to avoid prone restraint (ie where the person is forcibly laid on their front).

26.99 Physical restraint may, on occasion, need to be used to administer rapid tranquillisation by intramuscular injection to an unwilling patient, where the patient may lawfully be treated without consent. It must not be used unless there is such legal authority, whether under the Act (see provisions for treatment in chapter 24), the MCA or otherwise. Rapid tranquillisation must not be used to treat an informal patient who has the capacity to refuse treatment and who has done so.

26.100 The use of restraint to administer treatment in non-emergency circumstances should be avoided wherever possible, but may sometimes be necessary, especially if an emergency situation would be likely to occur if the treatment were not administered. The decision to use restraint should be discussed first with the clinical team and should be properly documented and justified in the patient's notes.

26.101 Following the administration of rapid tranquillisation, the patient's condition and progress should be closely monitored. Subsequent records should indicate the reason for the use of rapid tranquillisation and provide a full account of both its efficacy and any adverse effects observed or reported by the patient.

26.102 Rapid tranquillisation should never be used to manage patients as a substitute for adequate staffing.

[3] Violence: the short-term management of disturbed/violent behaviour in in-patient psychiatric settings and emergency departments. National Institute of Clinical Excellence. 2005. http://www.nice.org.uk/guidance/cg25/resources/cg25-violence-full-guideline3

Seclusion

26.103 Seclusion refers to the supervised confinement and isolation of a patient, away from other patients, in an area from which the patient is prevented from leaving, where it is of immediate necessity for the purpose of the containment of severe behavioural disturbance which is likely to cause harm to others.

26.104 If a patient is confined in any way that meets the definition above, even if they have agreed to or requested such confinement, they have been secluded and the use of any local or alternative terms (such as 'therapeutic isolation') or the conditions of the immediate environment do not change the fact that the patient has been secluded. It is essential that they are afforded the procedural safeguards of the Code.

26.105 Seclusion should only be undertaken in a room or suite of rooms that have been specifically designed and designated for the purposes of seclusion and which serves no other function on the ward. Seclusion does not include locking people in their rooms at night in accordance with the High Security Psychiatric Services (Arrangements for Safety and Security) Directions 2013.[4]

26.106 Seclusion should only be used in hospitals and in relation to patients detained under the Act. If an emergency situation arises involving an informal patient and, as a last resort, seclusion is necessary to prevent harm to others, then an assessment for an emergency application for detention under the Act should be undertaken immediately.

26.107 Seclusion should not be used as a punishment or a threat, or because of a shortage of staff. It should not form part of a treatment programme.

26.108 Seclusion should never be used solely as a means of managing self-harming behaviour. Where the patient poses a risk of self-harm as well as harm to others, seclusion should be used only when the professionals involved are satisfied that the need to protect other people outweighs any increased risk to the patient's health or safety arising from their own self-harm and that any such risk can be properly managed.

26.109 The following factors should be taken into account in the design of rooms or areas where seclusion is to be carried out:

- the room should allow for communication with the patient when the patient is in the room and the door is locked, eg via an intercom
- rooms should include limited furnishings which should include a bed, pillow, mattress and blanket or covering
- there should be no apparent safety hazards

[4] The High Security Psychiatric Services (Arrangements for Safety and Security) Directions. 2013. https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/268545/HSH_Directions_Signed__2_.pdf

- rooms should have robust, reinforced window(s) that provide natural light (where possible the window should be positioned to enable a view outside)
- rooms should have externally controlled lighting, including a main light and subdued lighting for night time
- rooms should have robust door(s) which open outwards
- rooms should have externally controlled heating and/or air conditioning, which enables those observing the patient to monitor the room temperature
- rooms should not have blind spots and alternate viewing panels should be available where required
- a clock should always be visible to the patient from within the room, and
- rooms should have access to toilet and washing facilities.

26.110 Provider policies should include detailed guidance on the use of seclusion and should be consistent with the guiding principles of the Code. (See chapter 1.) The policy should:

- ensure the physical and emotional safety and wellbeing of the patient
- ensure that the patient receives the care and support rendered necessary by their seclusion both during and after it has taken place
- designate a suitable environment that takes account of the patient's dignity and physical wellbeing
- set out the roles and responsibilities of staff, and
- set requirements for recording, monitoring and reviewing the use of seclusion and any follow-up action.

26.111 In order to ensure that seclusion measures have a minimal impact on a patient's autonomy, seclusion should be applied flexibly and in the least restrictive manner possible, considering the patient's circumstances. Where seclusion is used for prolonged periods then, subject to suitable risk assessments, flexibility may include allowing patients to receive visitors, facilitating brief periods of access to secure outside areas or allowing meals to be taken in general areas of the ward. The possibility of facilitating such flexibility should be considered during any review of the ongoing need for seclusion. Particularly with prolonged seclusion, it can be difficult to judge when the need for seclusion has ended. This flexibility can provide a means of evaluating the patient's mood and degree of agitation under a lesser degree of restriction, without terminating the seclusion episode.

Procedure for seclusion

26.112 The following procedure should be incorporated into the provider's policy on seclusion.

Figure 16: Procedure for seclusion

Overview of seclusion and monitoring process	
• If not authorised by a psychiatrist, there must be a medical review within one hour or without delay if the individual is not known or there is a significant change from their usual presentation	Paragraphs 26.116 and 26.127
• Seclusion area to be within constant sight and sound of staff member	Paragraphs 26.118 – 26.121
• Documented report by person monitoring every 15 minutes	Paragraphs 26.123 – 26.124
• Nursing reviews by two nurses every two hours throughout seclusion	Paragraphs 26.132-26.134
• Continuing medical reviews every four hours until the first [internal] multi-disciplinary team	Paragraphs 26.129
• First (internal) multi-disciplinary team as soon as is practicable	Paragraphs 26.135 – 26.138
• Independent multi-disciplinary team after eight hours consecutive or 12 hours intermittent seclusion (within a 48 hour period)	Paragraphs 26.139 – 26.141
• Following first (internal) multi-disciplinary team continuing medical reviews at least twice daily (one by the responsible clinician)	Paragraph 26.130

Authorising seclusion

Figure 17: Authorising seclusion

Seclusion may be authorised by either:	Additional considerations
A psychiatrist	if the psychiatrist who authorises seclusion is neither the patient's responsible clinician (RC) nor an approved clinician (AC), the RC or duty doctor (or equivalent) should be informed of seclusion as soon as practicable.
An approved clinician who is not a doctor	provider policies should determine the appropriateness of using ACs who are not doctors to authorise seclusion the patient's RC or duty doctor (or equivalent) should be informed of seclusion as soon as practicable.
The professional in charge (eg a nurse) of a ward	the patient's RC or duty doctor (or equivalent) must be informed of seclusion as soon as practicable.

Commencing seclusion

26.113 Staff may decide what a patient can take into the seclusion area. The patient should never be deprived of clothing when in seclusion (see paragraphs 26.161 – 26.166).

26.114 The person authorising seclusion (see Authorising seclusion table) should have seen the patient immediately prior to the commencement of seclusion.

26.115 When a patient is placed in seclusion, the start time of the seclusion should be recorded in the seclusion record (see paragraph 26.149).

26.116 If seclusion was authorised by an approved clinician who is not a doctor, or by the professional in charge of the ward, the responsible clinician or duty doctor (or equivalent) should attend to undertake the first medical review (see paragraph 26.128) within one hour of the beginning of seclusion. If the patient is newly admitted, not well known to the staff, or there has been a significant change in the patient's physical, mental state and/or behavioural presentation, this medical review should take place without delay. Where seclusion has been authorised by a psychiatrist, whether or not they are the patient's responsible clinician or an approved clinician, the first medical review will be the review that they undertook immediately before authorising seclusion (meaning that a medical review within one hour of seclusion is not necessary).

26.117 Where it has been agreed in a positive behaviour support plan (or equivalent) that family members will be notified of significant behavioural disturbances and the use of restrictive interventions, this should take place as agreed in the plan (see paragraph 26.15).

Observation during seclusion

26.118 A suitably skilled professional should as a minimum be readily available within sight and sound of the seclusion area at all times throughout the patient's period of seclusion.

26.119 The professional should have the means to summon urgent assistance from other staff at any point.

26.120 Consideration should be given to whether a male or female person should carry out ongoing observations; this may be informed by consideration of a patient's trauma history.

26.121 The aim of observation is to safeguard the patient, monitor their condition and behaviour and to identify the earliest time at which seclusion can end.

26.122 For patients who have received sedation, a skilled professional will need to be outside the door at all times.

26.123 A record of the patient's behaviour should be made at least every 15 minutes (see paragraph 26.149).

26.124 The record made should include, where applicable: the patient's appearance, what they are doing and saying, their mood, their level of awareness and any evidence of physical ill health especially with regard to their breathing, pallor or cyanosis.

26.125 Where a patient appears to be asleep in seclusion, the person observing the patient should be alert to and assess the level of consciousness and respirations of the patient as appropriate.

Seclusion reviews

26.126 A series of review processes should be instigated when a patient is secluded. These include the multi-disciplinary team (MDT), nursing, medical and independent MDT reviews. All reviews provide an opportunity to determine whether seclusion needs to continue or should be stopped, as well as to review the patient's mental and physical state. Where agreed (see paragraph 26.16), family members should be advised of the outcomes of reviews.

Medical reviews

26.127 For the purposes of medical reviews, where the responsible clinician is not immediately available, eg outside of normal working hours, local policies should make provision for a 'duty doctor' to deputise for the responsible clinician. The policy should also identify which of their doctors are competent to carry out a medical review (see paragraph 26.133). Whenever the duty doctor is not an approved clinician, they should at all times have access to an on-call docter who is an approved clinician.

26.128 The first medical review should:

- if seclusion was authorised either by an approved clinician, who is not a doctor or the professional in charge of the ward, be undertaken by the responsible clinician or duty doctor (or equivalent) within one hour of the commencement of seclusion, or
- if seclusion was authorised by a consultant psychiatrist (whether or not they are the patient's responsible clinician or an approved clinician), be the review that they undertook immediately before seclusion was authorised.

26.129 If it is agreed that seclusion needs to continue, a seclusion care plan (see paragraph 26.147) should be agreed and prepared, which should identify how the patient's presenting and ongoing needs whilst in seclusion can continue to be met.

26.130 Subsequent medical reviews should be undertaken by either the responsible clinician, a doctor who is an approved clinician, or a duty doctor (see paragraph 26.127).

26.131 Continuing four-hourly medical reviews of secluded patients should be carried out until the first (internal) MDT has taken place including in the evenings, night time, on weekends and bank holidays. A provider's policy may allow different review arrangements to be applied when patients in seclusion are asleep.

26.132 Following the first internal MDT review, further medical reviews should continue at least twice in every 24-hour period. At least one of these should be carried out by the patient's responsible clinician (local arrangements for out-of-hours cover may provide for an alternative approved clinician to cover these responsible clinician reviews.

26.133 Medical reviews provide the opportunity to evaluate and amend seclusion care plans, as appropriate (see paragraph 26.147). They should be carried out in person and should include, where appropriate:

- a review of the patient's physical and psychiatric health
- an assessment of adverse effects of medication
- a review of the observations required
- a reassessment of medication prescribed
- an assessment of the risk posed by the patient to others
- an assessment of any risk to the patient from deliberate or accidental self-harm, and
- an assessment of the need for continuing seclusion, and whether it is possible for seclusion measures to be applied more flexibly or in a less restrictive manner.

Nursing reviews

26.134 Nursing reviews of the secluded patient should take place at least every two hours following the commencement of seclusion. These should be undertaken by two individuals who are registered nurses, and at least one of whom should not have been involved directly in the decision to seclude.

26.135 In the event of concerns regarding the patient's condition, this should be immediately brought to the attention of the patient's responsible clinician or duty doctor.

26.136 When patients in seclusion are asleep, provider policies may allow reviews to be undertaken in accordance with a revised schedule which should be recorded in the seclusion care plan (see paragraph 26.147) in order to avoid waking the patient.

MDT reviews

26.137 The first internal MDT seclusion review should be held as soon as is practicable.

26.138 Appropriate membership of the MDT review meetings should be determined by provider policies. Membership would likely include the responsible clinician, a doctor who is an approved clinician, or an approved clinician who is not a doctor but who has appropriate expertise, the senior nurse on the ward, and staff from other disciplines who would normally be involved in patient reviews.

26.139 At weekends and overnight, membership of the initial MDT review may be limited to medical and nursing staff, in which case the on-call senior site manager (or equivalent) should also be involved. Further MDT reviews should take place once in every 24-hour period of continuous seclusion.

26.140 Where seclusion continues, these reviews should evaluate and make amendments, as appropriate, to the seclusion care plan (see paragraph 26.147).

Independent MDT review

26.141 An independent MDT review should be promptly undertaken where a patient has either been secluded for eight hours consecutively or for 12 hours intermittently during a 48-hour period.

26.142 Appropriate membership of the meeting should be determined by provider policies, but as a minimum they should include a doctor who is an approved clinician, or an approved clinician who is not a doctor a nurse and other professionals who were not involved in the incident which led to the seclusion and an IMHA (in cases where the patient has one). It is good practice for the independent MDT to consult those involved in the original decision.

26.143 If it is agreed that seclusion needs to continue, the review should evaluate and make recommendations, as appropriate, for amendments to the seclusion care plan (see paragraph 26.147).

Ending seclusion

26.144 Seclusion should immediately end when a MDT review, a medical review or the independent MDT review determines it is no longer warranted. Alternatively where the professional in charge of the ward feels that seclusion is no longer warranted, seclusion may end following consultation with the patient's responsible clinician or duty doctor. This consultation may take place in person or by telephone.

26.145 Seclusion ends when a patient is allowed free and unrestricted access to the normal ward environment or transfers or returns to conditions of long-term segregation.

26.146 Opening a door for toilet and food breaks or medical review does not constitute the end of a period of seclusion.

Further guidance on seclusion

26.147 A seclusion care plan should set out how the individual care needs of the patient will be met whilst the patient is in seclusion and record the steps that should be taken in order to bring the need for seclusion to an end as quickly as possible. As a minimum the seclusion care plan should include:

- a statement of clinical needs (including any physical or mental health problems), risks and treatment objectives
- a plan as to how needs are to be met, how de-escalation attempts will continue and how risks will be managed
- details of bedding and clothing to be provided
- details as to how the patient's dietary needs are to be provided for, and
- details of any family or carer contact/communication which will maintained during the period of seclusion in accordance with paragraph 26.16.

26.148 Wherever possible, the patient should be supported to contribute to the seclusion care plan and steps should be taken to ensure that the patient is aware of what they need to do for the seclusion to come to an end. In view of the potentially traumatising effect of seclusion, care plans should provide details of the support that will be provided when the seclusion comes to an end.

26.149 The seclusion record format should be determined by providers' policies on seclusion. Different providers may use different systems, which may be electronic or paper-based (or a combination of both); in any case they should meet recognised professional record keeping standards. The seclusion record should provide the following details:

- who authorised the seclusion
- the date and time of commencement of seclusion
- the reason(s) for seclusion
- what the patient took into the seclusion room
- if and when a family member, carer and/or advocate was informed of the use of seclusion
- 15 minute recordings by the person undertaking continuous direct observation

- details of who undertook scheduled nursing reviews, their assessment, and a record of the patient's condition and recommendations
- details of who undertook scheduled medical reviews, their assessment and a record of the patient's condition and recommendations
- details of who undertook the independent MDT review, their assessment and a record of the patient's condition and recommendations
- details of who undertook the scheduled MDT reviews, their assessment and a record of the patient's condition and recommendations
- the date and time seclusion ended, and
- details of who determined that seclusion should come to an end.

Long-term segregation

26.150 Long-term segregation refers to a situation where, in order to reduce a sustained risk of harm posed by the patient to others, which is a constant feature of their presentation, a multi-disciplinary review and a representative from the responsible commissioning authority determines that a patient should not be allowed to mix freely with other patients on the ward or unit on a long-term basis. In such cases, it should have been determined that the risk of harm to others would not be ameliorated by a short period of seclusion combined with any other form of treatment. The clinical judgement is that, if the patient were allowed to mix freely in the general ward environment, other patients or staff would continue to be exposed to a high likelihood of serious injury or harm over a prolonged period of time. Where consideration is being given to long-term segregation, wherever appropriate, the views of the person's family and carers should be elicited and taken into account. The multi-disciplinary review should include an IMHA in cases where a patient has one.

26.151 It is permissible to manage this small number of patients by ensuring that their contact with the general ward population is limited. The environment should be no more restrictive than is necessary. This means it should be as homely and personalised as risk considerations allow. Facilities which are used to accommodate patients in conditions of long-term segregation should be configured to allow the patient to access a number of areas including, as a minimum, bathroom facilities, a bedroom and relaxing lounge area. Patients should also be able to access secure outdoor areas and a range activities of interest and relevance to the person.

26.152 Patients should not be isolated from contact with staff (indeed it is highly likely they should be supported through enhanced observation) or deprived of access to therapeutic interventions. Treatment plans should aim to end long-term segregation.

26.153 The local safeguarding team should be made aware of any patient being supported in longer term segregation.

26.154 Staff supporting patients who are long-term segregated should make written records on their condition on at least an hourly basis.

26.155 The patient's situation should be formally reviewed by an approved clinician who may or not be a doctor at least once in any 24-hour period and at least weekly by the full MDT. The composition of the MDT should be decided by the provider's policy on long-term segregation, but should include the patient's responsible clinician and an IMHA where appropriate. Provider's policies should provide for periodic reviews by a senior professional who is not involved with the case. The outcome of all reviews and the reasons for continued segregation should be recorded and the responsible commissioning authority should be informed of the outcome).

26.156 Where long-term segregation continues for three months or longer, regular three monthly reviews of the patient's circumstances and care should be undertaken by an external hospital. This should include discussion with the patient's IMHA (where appropriate) and commissioner.

26.157 The patient's treatment plan should clearly state the reasons why long-term segregation is required. In these cases, the way that the patient's situation is reviewed needs to reflect the specific nature of their management plan. The purpose of a review is to determine whether the ongoing risks have reduced sufficiently to allow the patient to be integrated into the wider ward community and to check on their general health and welfare. The decision to end long-term segregation should be taken by the MDT (including consultation with the patient's IMHA where appropriate), following a thorough risk assessment and observations from staff of the patient's presentation during close monitoring of the patient in the company of others.

26.158 The patient's care plan should outline how they are to be made aware of what is required of them so that the period of long-term segregation can be brought to an end.

26.159 Where successive MDT reviews determine that segregation continues to be required, more information should be available to demonstrate its necessity and explain why the patient cannot be supported in a less restrictive manner.

26.160 At times of acute behavioural disturbance where there is a need to contain an immediate risk of harm to others, there may be a need to transfer the person, for a short period of time, to a physical area that is more secure and restrictive and which has been designed for the purpose of seclusion. In such a situation, the procedure for seclusion in the Code should be followed with regards to authorising and commencing seclusion, observation, seclusion reviews and ending seclusion.

Deprivation of access to normal daytime clothing

26.161 Individuals should never be deprived of appropriate clothing with the intention of restricting their freedom of movement, neither should they be deprived of other aids necessary for their daily living.

26.162 It may be appropriate, in a small number of instances, for individuals to be asked to wear special tear-proof clothing, such a decision should be authorised by the patient's responsible clinician. An MDT should undertake an individualised risk assessment before this decision is taken. (Local policy should determine the appropriate complexion of the MDT.) This is particularly likely to be the case where the risk of shredded clothing being used to self-harm or attempt suicide has been assessed and is considered to be very high.

26.163 Tear-proof clothing should never be a first-line response to such risks and should never be used as a substitute for enhanced levels of support and observation. The requirement to wear tear-proof clothing should never be a blanket rule within a service.

26.164 Any tear-proof clothing should fit the person so as to preserve their dignity. It should not be demeaning or stigmatising, and should, where possible, meet any specific cultural or religious requirements.

26.165 Any requirement that an individual should wear tear-proof clothing should be proportionate to the assessed risk and documented evidence should show that it is used only as long as absolutely necessary. As soon as the risk is assessed to have diminished, consideration should be given by nursing staff or the MDT team to a return to usual clothing. This will require ongoing dynamic risk assessment.

26.166 Positive behaviour support plans (or equivalents) should detail primary preventative strategies that will aim to avoid the ongoing need for such restrictions. The patients should be told what they need to do so that they can wear their usual and preferred clothing.

Following acute behavioural disturbance

26.167 Following any episode of acute behavioural disturbance that has led to the use of a restrictive intervention, a post-incident review or debrief should be undertaken so that involved parties, including patients, have appropriate support and there is opportunity for organisational learning. It is important that patients are helped to understand what has happened and why. Patients with limited verbal communication skills may need support to participate in the post incident review or de-briefing.

26.168 Where a patient is not able to participate in debriefing, methods for assessing the effects of any intervention on their behaviour, emotions and clinical presentation should be fully explored as part of their assessment(s) and recorded in their positive behaviour support plan (or equivalent).

26.169 If the patient is able and agrees to discuss the incident which led to the use of a restrictive intervention, their understanding and experience of the incident should be explored. The patient should be given a choice as to who they would like to discuss their experience with, wherever possible. Attempts by staff to simply justify decisions to use a restrictive intervention may be counterproductive; the aim is to use empathic therapeutic relationships to explore what aspects of the intervention helped, didn't help and might be done differently in future.

26.170 Patients' accounts of the incident and their feelings, anxieties or concerns following the restrictive intervention should be recorded in their notes. Positive behaviour support plans (or equivalent) should be reviewed and updated as necessary. Patients should be reminded that they can record their future wishes and feelings about which restrictive interventions (or any other aspect of treatment and care that has been raised by the incident) they would or would not like to be used in an advance statement (see chapter 9).

26.171 If patients wish to formally raise a concern they should be reminded of how to access the local complaints system and independent advocacy services. Patients should also be made aware of how and where to find an accessible version of the hospital policy on restrictive interventions. The hospital's safeguarding lead should be informed whenever a patient raises concerns about restrictive interventions. Patients who need alternative support (eg alternative format, additional explanation) should be offered this support to access and use the complaints procedure.

26.172 There should be arrangements to support patients (and others) who have suffered serious assaults in hospital including, where appropriate, the involvement of the police.

Community treatment order patients and patients subject to guardianship

26.173 As is the case for hospital patients, a positive behavioural support planning (or equivalent) framework should be used in relation to those patients on a community treatment order (CTO), guardianship or leave, who present with behavioural disturbance. Positive behaviour support plans (or equivalents) should be developed as part of the patient's care plan. *Positive and Proactive Care*[5] gives further guidance. Seclusion and long-term segregation should not be used for patients on a CTO, guardianship or who are on leave, with the exception of patients who are on section 17 leave to another hospital.

[5] Positive and Proactive Care: reducing the need for physical interventions. Department of Health. 2014. https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/300293/JRA_DoH_Guidance_on_RP_web_accessible.pdf

26.174 Neither a CTO nor guardianship gives anyone the right to treat the patient without their consent to the treatment, if they have capacity to consent to or refuse that treatment. Restrictive interventions that give rise to deprivations of liberty go beyond what can be authorised by the conditions of the patient's CTO or conditions of guardianship. If there are indications that the use of any such restrictive interventions may become necessary, this should prompt consideration as to whether the community patient should be recalled to hospital or the guardianship patient should be detained under the Act, or whether a deprivation of liberty authorisation or deprivation of liberty order can be sought under the MCA.

Training

26.175 All hospitals should have a policy on workforce development and training for staff who may be exposed to aggression or violence in their work or who may need to become involved in the application of restrictive interventions. The policy should specify who will receive what level of training (based on training needs analysis) and how often they will be trained. The policy should require training to be delivered during the induction period of new staff members or as soon as is practicably possible.

26.176 All staff who support people who are liable to present with behavioural disturbance should be competent in physical monitoring and emergency resuscitation techniques to ensure the safety of patients following administration of rapid tranquillisation and during periods of physical restraint or seclusion.

26.177 All clinical staff who undertake training in the recognition, prevention and management of violence and aggression and associated physical restraint should attend periodic refresher or update education and training programmes.

Security assessments

26.178 To manage levels of risk appropriately, the therapeutic environment should be managed carefully through the delivery of a range of security measures. A number of levels of secure care currently exist to manage increasing levels of risk to others. Currently these consist of high, medium and low secure services, each of which provides a range of physical, procedural and relational security measures to ensure effective treatment and care whilst providing for the safety of the individual and others including other patients, staff and the general public. Physical security includes the fences, locks, personal alarms and so on that keep people safe. Procedural security refers to the policies and procedures in place to maintain safety and security. Relational security is the knowledge and understanding that staff have of a patient and of the environment, and the translation of that information into appropriate responses and care. The balance between these three dynamics often shifts, requiring services to change the way in which they meet the needs of a particular patient group or situation. It is essential that all three are in place at all times. Psychiatric intensive care units (PICUs) may also provide care in locked environments where assessments of risk should also consider any need for appropriate security measures.

26.179 Assessments should consider the level of security (physical, procedural and relational) required to mitigate risks. The application of security measures should aim to promote a safe and therapeutic environment, whilst pro-actively encouraging independence, responsibility and recovery. The use of security should therefore be based on the risk needs of the individual, be as least restrictive as possible, and imposed only when risks have been identified. Only patients who require a combination of enhanced procedural, physical and relational security should be placed in secure services.

Related material

- Violence: the short-term management of disturbed/violent behaviour in in-patient psychiatric settings and emergency departments. National Institute of Clinical Excellence. 2005. http://www.nice.org.uk/guidance/cg25/resources/cg25-violence-full-guideline3
- Positive and Proactive Care: reducing the need for restrictive interventions. Department of Health. 2014. https://www.gov.uk/government/publications/positive-and-proactive-care-reducing-restrictive-interventions
- Meeting Needs and Reducing Distress: guidance on the prevention and management of clinically related challenging behaviour in NHS settings. Department of Health, NHS Protect. 2013. http://www.nhsbsa.nhs.uk/Documents/SecurityManagement/Meeting_needs_and_reducing_distress.pdf
- A Positive and Proactive Workforce: a guide to workforce development for commissioners and employers seeking to minimise the use of restrictive practices in social care and health. Skills for Health and Skills for Care. 2014. http://www.skillsforhealth.org.uk/component/docman/doc_download/2423-a-positive-and-proactive-workforce.html
- The Maudsley Prescribing Guidelines in Psychiatry. Taylor, D., Paton, C. and Kapur, S. 2012.
- The Legal Aspects of the Care and Treatment of Children and Young People with Mental Disorder. National Institute for Mental Health in England. 2009. http://egret.psychol.cam.ac.uk/medicine/legal/children_young_people_with_mental_disorder_2009.pdf
- Adult Acute Mental Health Units: planning and design manual. Department of Health. 2011. https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/147864/HBN_03-01_Final.pdf
- Good Practice in Prescribing and Managing Medicines and Devices. General Medical Council. 2013. http://www.gmc-uk.org/Prescribing_Guidance__2013__50955425.pdf
- The High Security Psychiatric Services (Arrangements for Safety and Security) Directions. 2013. https://www.gov.uk/government/publications/high-security-psychiatric-services-directions

- Concordat between the National Offender Management Service and NHS Counter Fraud and Security Management Service. Prisoner Escort and Bedwatch Function. Ministry of Justice, National Offender Management Service. 2010.

This material does not form part of the Code. It is provided for assistance only.

Leaving hospital

Patients may leave hospital under a variety of circumstances including being fully discharged, on short-term leave or to receive care and treatment in the community under guardianship or a community treatment order (CTO). This group of chapters gives guidance on the power to grant leave of absence, long-term leave, escorted leave, leave to reside in other hospitals and recall from leave, and short-term leave for restricted patients. Hospital managers should have policies outlining the actions necessary in cases where a patient is absent without leave and guidance is given about matters that should be covered by such polices.

CTOs may be used to allow suitable patients to leave hospital and to be treated in the community and guidance is given about the use of CTOs and patients for whom they are suitable. Guidance is also given about the purpose of guardianship and the responsibilities of local authorities. A choice may need to be made between guardianship, leave of absence or a CTO and guidance is given about how to make such a choice and on renewal or extension and on discharge.

Clinical commissioning groups and local authorities have a duty to provide after-care to particular patients detained for hospital treatment. Guidance is given on this after-care duty and also on the care programme approach which is an overarching system for co-ordinating the care of people with mental disorders.

Chapter 27 Leave of absence
Chapter 28 Absence without leave
Chapter 29 Community treatment orders
Chapter 30 Guardianship
Chapter 31 Guardianship, leave of absence or CTO
Chapter 32 Detention and CTO: renewal, extension and discharge
Chapter 33 After-care
Chapter 34 Care programme approach

27 Leave of absence

Why read this chapter?

27.1 Patients detained in hospital have the right to leave hospital lawfully only if they have leave of absence from their responsible clinician under section 17 of the Act.

27.2 This chapter gives guidance on who has the power to grant leave of absence, short- and long-term leave, escorted leave, leave to reside in other hospitals, and recall from leave. It also draws attention to differences when considering leave of absence, including short-term leave for restricted patients.[1]

General points

27.3 In general, while patients are detained in a hospital they can leave lawfully – even for a very short period – only if they are given leave of absence by their responsible clinician under section 17 of the Act.[2]

27.4 Responsible clinicians cannot grant leave of absence from hospital to patients who have been remanded to hospital under sections 35 or 36 of the Act or who are subject to interim hospital orders under section 38.

27.5 Except for certain restricted patients (see paragraphs 27.39 – 27.42 and 22.53 – 22.60) no formal procedure is required to allow patients to move within a hospital or its grounds. Such 'ground leave' within a hospital may be encouraged or, where necessary, restricted, as part of each patient's care plan.

27.6 Any proposal to grant leave to a restricted patient has to be approved by the Secretary of State for Justice, who should be given as much notice as possible and full details of the proposed leave. For further information on restricted patients see also paragraphs 27.39 – 27.42, 27.53 – 27.60, and the Ministry of Justice website.[3]

27.7 What constitutes a particular hospital for the purpose of leave is a matter of fact which can be determined only in the light of the particular case. Where one building, or set of buildings, includes accommodation under the management of different bodies (eg two different NHS trusts), the accommodation used by each body should be treated as forming separate hospitals. Facilities and grounds shared by both can be regarded as part of both hospitals.

[1] For patients in high security hospitals, this chapter should be read in conjunction with The High Security Psychiatric Services (Arrangements for Safety and Security) Directions. 2013, and Guidance on The High Security Psychiatric Services (Arrangements for Safety and Security) Directions. 2013. https://www.gov.uk/government/publications/high-security-psychiatric-services-directions

[2] Patients will lawfully be absent from hospital if they are being transferred or taken to another place under the Act, or under another piece of legislation. This would include, eg patients being transferred to another hospital under section 19 of the Act, or patients who are required to attend court.

[3] http://www.justice.gov.uk/

Power to grant leave

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

27.9 Responsible clinicians may grant leave for specific occasions or for specific or indefinite periods of time. They may make leave subject to any conditions which they consider necessary in the interests of the patient or for the protection of other people.

27.10 Leave of absence can be an important part of a detained patient's care plan, but can also be a time of risk. When considering and planning leave of absence, responsible clinicians 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 the patient's recovery
- balance these benefits against any risks that the leave may pose for the protection of other people (either generally or particular people)
- consider any conditions which should be attached to the leave, eg requiring the patient not to visit particular places or persons
- be aware of any child protection and child welfare issues in granting leave
- take account of the patient's wishes, and those of carers, friends and others who may be involved in any planned leave of absence
- consider what support the patient would require during their leave of absence and whether it can be provided
- ensure that any community services which will need to provide support for the patient during the leave are involved in the planning of the leave, and that they know the leave dates and times and any conditions placed on the patient during their leave
- ensure that the patient is aware of any contingency plans put in place for their support, including what they should do if they think they need to return to hospital early
- liaise with any relevant agencies, eg the sex offender management unit (SOMU)
- undertake a risk assessment and put in place any necessary safeguards, and
- (in the case of part 3 patients – see chapters 22 and 40) consider whether there are any issues relating to victims which impact on whether leave should be granted and the conditions to which it should be subject.

27.11 Leave should normally be of short duration and not normally more than seven days. When considering whether to grant leave of absence for more than seven consecutive days, or extending leave so that the total period is more than seven consecutive days, responsible clinicians should also consider whether the patient should go onto a community treatment order (CTO) instead and, if required, consult any local agencies concerned with public protection. This does not apply to restricted patients, nor, in practice, to patients detained for assessment under section 2 of the Act, as they are not eligible to be placed on a CTO.

27.12 The option of using a CTO does not mean that the responsible clinician cannot use longer-term leave if that is the more suitable option, but the responsible clinician will need to be able to show that both options have been duly considered. Decisions should be explained to the patient and fully documented, including why the patient is not considered suitable for a CTO, and also guardianship or discharge.

27.13 Leave for more than seven days may be used to assess a patient's suitability for discharge from detention. Guidance on factors to be considered when deciding between longer-term leave of absence, guardianship and a CTO is given in chapter 31.

27.14 Hospital managers cannot overrule a responsible clinician's decision to grant leave. The fact that a responsible clinician grants leave subject to certain conditions, eg residence at a hostel, does not oblige the hospital managers, or anyone else, to arrange or fund the particular placement or services the clinician has in mind. Responsible clinicians should not grant leave on such a basis without first taking steps to establish that the necessary services or accommodation (or both) are available and will be funded.

Short-term leave

27.15 Except where the agreement of the Secretary of State for Justice is required (in the case of restricted patients – see paragraphs 27.39 – 27.42), responsible clinicians may decide to authorise short-term local leave, which may be managed by other staff. For example, patients may be given leave for a shopping trip of two hours every week to a specific destination, with the decision on which particular two hours to be left to the discretion of the responsible nursing staff.

27.16 The parameters within which this discretion may be exercised should be clearly set out by the responsible clinician, eg the particular places to be visited, any restrictions on the time of day the leave can take place, and any circumstances in which the leave should not go ahead.

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

Longer periods of leave

27.18 Longer-term leave should be planned properly and, where possible, well in advance (see also paragraph 27.11). Patients should be fully involved in the decision and responsible clinicians should be satisfied that patients are likely to be able to manage outside the hospital. Subject to the normal considerations of patient confidentiality, carers and other relevant people should be consulted before leave is granted (especially where the patient is to reside with them). Relevant community services should be consulted.

27.19 If patients do not consent to carers or other people who would normally be involved in their care being consulted about their leave, responsible clinicians should reconsider whether or not it is safe and appropriate to grant leave.

27.20 As with short-term leave, responsible clinicians should specify any circumstances in which the leave should not go ahead – eg if the patient's health has considerably deteriorated since it was authorised.

27.21 This does not apply to restricted patients.

Recording leave

27.22 Hospital managers should establish a standardised system by which responsible clinicians can record the leave they authorise and specify the conditions attached to it. Copies of the authorisation should be given to the patient and to any carers, professionals and other people in the community who need to know. A copy should also be kept in the patient's notes. In case they fail to return from leave, an up-to-date description of the patient should be available in their notes. A photograph of the patient should also be included in their notes, if necessary with the patient's consent (or if the patient lacks capacity to decide whether to consent, a photograph is taken in accordance with the Mental Capacity Act (MCA)).

27.23 The outcome of leave – whether or not it went well, particular problems encountered, concerns raised or benefits achieved – should be recorded in patients' notes to inform future decision-making. Patients should be encouraged to contribute by giving their own views on their leave; some hospitals provide leave records specifically for this purpose.

Care and treatment while on leave

27.24 Responsible clinicians' responsibilities for their patients remain the same while the patients are on leave.

27.25 A patient who is granted leave under section 17 remains liable to be detained, and the rules in part 4 of the Act about their medical treatment continue to apply (see chapter 24). If it becomes necessary to administer treatment without the patient's consent, consideration should be given to whether it would be more appropriate to recall the patient to hospital (see paragraphs 27.32 – 27.36), although recall is not a legal requirement.

27.26 The duty on local authorities and clinical commissioning groups (or, in certain circumstances, NHS Commissioning Board (NHS England)) to provide after-care under section 117 of the Act for certain patients who have been discharged from detention also applies to those patients while they are on leave of absence (see chapter 33).

Escorted leave

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

27.28 Escorted leave to Northern Ireland is permitted under the Act – patients may be held in lawful custody by a constable or a person authorised in writing by the managers of the hospital. In Scotland, the Isle of Man or any of the Channel Islands escorted leave can only be granted if the local legislation allows such patients to be kept in custody while in that jurisdiction. If this is contemplated for a restricted patient seek advice from the Mental Health Casework Section of the Ministry of Justice.[4]

Accompanied leave

27.29 While it may often be appropriate to authorise leave subject to the condition that a patient is accompanied by a friend or relative (eg on a pre-arranged day out from the hospital), responsible clinicians should specify that the patient is to be in the legal custody of a friend or relative only if it is appropriate for that person to be legally responsible for the patient, and if that person understands and accepts the consequent responsibility.

[4] The Mental Health Casework Section can be contacted as follows: MHCSTeam1@noms.gsi.gov.uk (case letters A-Gile); MHCSTeam2@noms.gsi.gov.uk (case letters Gilf-Nev); MHCSTeam3@noms.gsi.gov.uk (case letters New-Z)

Leave to reside in other hospitals

27.30 Responsible clinicians may require patients, as a condition of leave, to reside at another hospital in England and Wales, and they may then be kept in the custody of staff of that hospital. Before authorising leave on this basis, responsible clinicians should consider whether it would be more appropriate to transfer the patient to the other hospital instead (see chapter 37).

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

Recall from leave

27.32 A responsible clinician (or, in the case of restricted patients, the Secretary of State) may revoke their patient's leave at any time if they consider it necessary in the interests of the patient's health or safety or for the protection of other people. Responsible clinicians must be satisfied that these criteria are met and should consider what effect being recalled may have on the patient. A refusal to take medication would not on its own be a reason for revocation, although it would almost always be a reason to consider revocation.

27.33 The responsible clinician must arrange for a notice in writing revoking the leave to be served on the patient or on the person who is for the time being in charge of the patient. Hospitals should always know the address of patients who are on leave of absence and of anyone with responsibility for them whilst on leave.

27.34 The reasons for recall should be fully explained to the patient and a record of the explanation included in the patient's notes.

27.35 A restricted patient's leave may be revoked either by the responsible clinician or by the Secretary of State for Justice. If a problem were to arise during a restricted patient's leave of absence the responsible clinician should immediately suspend the use of that leave and notify the Ministry of Justice who would then consider whether to revoke or rescind the leave or let the permission stand.

27.36 It is essential that carers (especially where the patient is residing with them while on leave) and professionals who support the patient while on leave should have easy access to the patient's responsible clinician if they feel consideration should be given to return of the patient before their leave is due to end.

Renewal of authority to detain

27.37 It is possible to renew a patient's detention while they are on leave if the criteria in section 20 of the Act are met (see chapter 32). Leave should not be used as an alternative to discharging the patient either completely or onto a CTO where that is appropriate. Chapter 31 gives further guidance on factors to consider when deciding between leave of absence and a CTO. This does not apply to restricted patients.

Patients who are in hospital but not detained

27.38 Patients who are not legally detained in hospital have the right to leave at any time. They cannot be required to ask permission to do so, but may be asked to inform staff when they wish to leave the ward.

Restricted patients

27.39 Any proposal to grant leave to a restricted patient has to be approved by the Secretary of State for Justice.

27.40 Where the courts or the Secretary of State have decided that restricted patients are to be detained in a particular unit of a hospital, those patients will require the Secretary of State's permission to take leave of absence to go to any other part of that hospital as well as outside the hospital.

27.41 For routine medical appointments or treatment, the Secretary of State's permission will be required. It is accepted that there will be times of acute medical emergency such as heart attack, stroke or penetrative wounds or burns where the patient requires emergency treatment. There may also be acute situations which, while not life threatening still require urgent treatment, eg fractures. In these situations, the responsible clinician may use their discretion, having due regard to the emergency or urgency being presented and the management of any risks, to have the patient taken to hospital. The Secretary of State should be informed as soon as possible that the patient has been taken to hospital, what risk management arrangements are in place, be kept informed of developments and notified when the patient has been returned to the secure hospital.

27.42 Further information and guidance on further types of short term section 17 leave, such as compassionate or holiday, can be found on the Ministry of Justice website.[5]

[5] Mental Health Casework Section Guidance – Section 17 Leave. Ministry of Justice. 2014. http://www.justice.gov.uk/downloads/offenders/mentally-disordered-offenders/mhcs-guidance-s17-leave.pdf

Related material

- Mental Health Casework Section Guidance – Section 17 leave. Ministry of Justice. Menatl Health Casework Section. 2014. http://www.justice.gov.uk/downloads/offenders/mentally-disordered-offenders/mhcs-guidance-s17-leave.pdf
- Guidance for Responsible Medical Officers – leave of absence for patients subject to restrictions. Ministry of Justice Mental Health Unit. 2007. http://www.mentalhealthlaw.co.uk/images/Leave-guidance-for-rmos
- The High Security Psychiatric Services (Arrangements for Safety and Security at Ashworth, Broadmoor and Rampton Hospitals) Directions. 2011. https://www.gov.uk/government/publications/the-high-security-psychiatric-services-arrangements-for-safety-and-security-at-ashworth-broadmoor-and-rampton-hospitals-directions-2011
- The High Security Psychiatric Services (Arrangements for Safety and Security) Directions. Department of Health. 2013. https://www.gov.uk/government/publications/high-security-psychiatric-services-directions
- Guidance on The High Security Psychiatric Services (Arrangements for Safety and Security) Directions. 2013. http://wwws.gov.uk/government/publications/high-security-psychiatric-services-directions

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28 Absence without leave

Why read this chapter?

28.1 This chapter provides guidance on action to be taken when patients are absent without leave (AWOL) or have otherwise absconded from legal custody under the Act, including on when patients are to be considered to be AWOL.

28.2 Hospital managers should have policies in place outlining actions necessary in this eventuality and guidance is provided about the matters that should be covered by such policies.

General points

28.3 Under section 18 of the Act, patients are considered to be AWOL in various circumstances, in particular when they:

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

Detained patients

28.4 Detained patients who are AWOL may be taken into custody and returned by an approved mental health professional (AMHP), any member of the hospital staff, any police officer, or anyone authorised in writing by the hospital managers.

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

28.6 Otherwise, responsibility for the safe return of patients rests with the detaining hospital. If the absconding patient is initially taken to another hospital, that hospital may, with the written authorisation of the managers of the detaining hospital, detain the patient while arrangements are made for their return. In these (and similar) cases people may take a faxed or scanned copy of a written authorisation as evidence that they have the necessary authority without waiting for the original.

Guardianship patients

28.7 Guardianship patients who are AWOL from the place they are required to live may be taken into custody by any member of the staff of a local authority, any person authorised in writing by the local authority or the private guardian (if there is one), or a police officer.

Patients on a CTO (community patients)

28.8 Community patients who are AWOL may be taken into custody and returned to the hospital to which they were recalled by an AMHP, a police officer, a member of staff of the hospital to which they have been recalled, or anyone authorised in writing by managers of that hospital or by the responsible clinician.

Other situations in which patients are in legal custody

28.9 In addition, there are various situations in which patients are considered to be in legal custody under the Act. These include, eg:

- the detention of patients in places of safety under section 135 or 136 (see chapter 16)
- the transport of patients to hospital (or elsewhere) under the Act, including patients being returned to hospital when they have gone AWOL (see chapter 17), and
- where patients' leave of absence is conditional on their being kept in custody by an escort (see chapter 27).

28.10 If patients who are in legal custody abscond, they may also be taken into custody and returned to the place they ought to be, in accordance with the Act.

Local policies

28.11 Hospital managers should ensure that there is a clear written policy about the action to be taken when a detained patient, or a patient on a CTO, goes missing. All relevant staff should be familiar with this policy. Hospital managers should agree their policy with other agencies – such as the police and ambulance services – as necessary.

28.12 Policies in relation to detained and CTO patients should include guidance about:

- the immediate action to be taken by any member of staff who becomes aware that a patient has gone missing, including a requirement that they immediately inform the professional in charge of the patient's ward (where applicable), who should in turn ensure that the patient's responsible clinician is informed
- the circumstances in which a search of a hospital and its grounds should be made
- the circumstances in which other local agencies with an interest, including the local authority, should be notified
- the circumstances in which the police should be informed, who is responsible for informing the police and the information they should be given (this should be in line with local arrangements agreed with the police)
- how and when other people, including the patient's nearest relative, should be informed (this should include guidance on informing people if there is good reason to think that they might be at risk as a result of the patient's absence)
- when and how an application should be made for a warrant under section 135(2) of the Act to allow the police to enter premises in order to remove a patient who is missing, and
- how (and by whom) patients are to be returned to the place where they ought to be, and who is responsible for organising any necessary transport (see chapter 17).

28.13 Local authorities should have equivalent policies for the action to be taken when they (or a private guardian) become aware that a guardianship patient is AWOL from the place where they are required to live.

28.14 The police should be asked to assist in returning a patient to hospital only if necessary. If the patient's location is known, the role of the police should, wherever possible, only be to assist a suitably qualified and experienced mental health professional in returning the patient to hospital.

28.15 The police should always be informed immediately if a patient is missing who is:

- considered to be particularly vulnerable
- considered to be dangerous, and/or
- subject to restrictions under part 3 of the Act (restricted patients) (see paragraphs 22.53 – 22.60).

28.16 There may also be other cases where, although the help of the police is not needed, a patient's history makes it desirable to inform the police that they are AWOL in the area.

28.17 Whenever the police are asked for help in returning a patient, they must be informed of the time limit for taking them into custody.

28.18 Where the police have been informed about a missing patient, they should be told immediately if the patient is found or returns.

28.19 Although every case should be considered on its merits, patient confidentiality will not usually be a barrier to providing basic information about a patient's absence to people – such as those the patient normally lives with or is likely to contact – who may be able to help with finding the patient.

28.20 Where a patient is missing for more than a few hours, their nearest relative should normally be informed (if they have not been already), subject to the normal considerations about involving nearest relatives (see paragraphs 4.32 – 4.37).

28.21 It is good practice when a patient returns after a substantial period of absence without leave always to re-examine the patient to establish whether they still meet the criteria for detention, a CTO or guardianship. Where patients (other than restricted patients) have been AWOL for more than 28 days, section 21B of the Act requires such an examination to take place within a week of the patient's return and the provision of a report that the criteria for continued detention or being subject to a CTO or guardianship are still met. Otherwise, the patient's detention, CTO or guardianship will end automatically.

28.22 Incidents in which patients go AWOL or abscond should be reviewed and analysed so that lessons for the future can be learned, including lessons about ways of identifying patients most at risk of going missing.

28.23 All instances of absence without leave should be recorded in the individual patient's notes. Where a patient has gone AWOL previously, it may be useful for the patient's care plan to include specific actions which experience suggests should be taken if that patient were to go missing again.

29 Community treatment orders

Why read this chapter?

29.1 The purpose of a community treatment order (CTO) is to allow suitable patients to be treated safely in the community rather than in hospital; this chapter gives guidance on CTOs. Hospital managers, approved mental health professionals and responsible clinicians should, in particular, note the guidance in this chapter.

29.2 This chapter provides guidance about the use of CTOs, patients for whom they are suitable, and providing and managing care planning and support in the community. Certain conditions may be attached to a CTO and information should be provided for patients and others about the CTO.

29.3 The chapter includes guidance on circumstances that might lead to recall to hospital and the procedure that should be followed and on revoking a CTO, reviewing a CTO and discharging patients from a CTO.

29.4 In accordance with the guiding principles, patients, and where appropriate, their families and carers should be fully involved in decisions, and treatment should be the least restrictive option and maximising independence.

Purpose of a CTO

29.5 The purpose of a CTO is to allow suitable patients to be safely treated in the community rather than under detention in hospital, and to provide a way to help prevent relapse and any harm – to the patient or to others – that this might cause. It is intended to help patients to maintain stable mental health outside hospital and to promote recovery. The principles, in particular, treating patients using the least restrictive option and maximising their independence; and purpose and effectiveness should always be considered when considering CTOs.

29.6 A CTO provides a framework for the management of patient care in the community and gives the responsible clinician the power to recall the patient to hospital for treatment if necessary.

29.7 For a discussion about when to decide on a CTO rather than either of the alternative community provisions available under the Act (guardianship and leave of absence under section 17 of the Act) see chapter 31. Chapter 31 also discusses when a deprivation of liberty authorisation (DoL authorisation) or Court of Protection order would be appropriate. When considering these options clinicians should take account of the available evidence as to their purpose and likely effectiveness for the patient in question.

Who can be discharged using a CTO?

29.8 Only patients who are detained in hospital for treatment under section 3 of the Act, or are unrestricted part 3 patients, can be considered for a CTO. Patients detained in hospital for assessment under section 2 of the Act are not eligible (see also paragraphs 19.26 – 19.30 on children and young people).

29.9 A CTO is an option only for patients who meet the criteria set out in the Act, which are that:

- the patient is suffering from a mental disorder of a nature or degree which makes it appropriate for them to receive medical treatment
- it is necessary for the patient's health or safety or for the protection of others that the patient should receive such treatment
- subject to the patient being liable to be recalled as mentioned below, such treatment can be provided without the patient continuing to be detained in a hospital
- it is necessary that the responsible clinician should be able to exercise the power under section 17E(1) of the Act to recall the patient to hospital, and
- appropriate medical treatment is available for the patient.

29.10 The decision as to whether a CTO is the right option for any patient is taken by the responsible clinician) and requires the agreement of an approved mental health professional (AMHP). The responsible clinician should consider the principles, in particular the least restrictive option and maximising independence principle. A CTO may be used only if it would not be possible to achieve the desired objectives for the patient's care and treatment without it. In particular, the responsible clinician should consider whether the power to recall the patient is necessary and whether the patient can be treated in the community without that power. Consultation at an early stage with the patient and those involved in the patient's care will be important, including family and carers.

29.11 In assessing the patient's suitability for a CTO, the responsible clinician must be satisfied that the patient requires medical treatment for mental disorder for their own health or safety or for the protection of others, and that appropriate treatment is, or would be, available for the patient in the community.

29.12 In making a decision to place the patient on a CTO the responsible clinician must assess what risk there would be of the patient's condition deteriorating after discharge, eg as a result of refusing or neglecting to receive treatment.

29.13 In assessing that risk the responsible clinician should take into consideration the patient's history of mental disorder, previous experience of contact with services and engagement with treatment. A tendency to fail to follow a treatment plan or to discontinue medication in the community, and then relapsing may suggest a risk justifying use of a CTO rather than discharge into community care.

29.14 Other relevant factors will vary, but are likely to include the patient's current mental state, the patient's capacity to make decisions about their care and treatment and attitude to treatment and risk of relapse, the circumstances into which the patient would be discharged, and the willingness and ability of family and/or carers to provide support (especially where aspects of the care plan depend on them).

29.15 Taken together, all these factors should help the responsible clinician to assess the risk of the patient's condition deteriorating significantly after discharge, and inform the decision as to whether continued detention, a CTO or discharge would be the right option for the patient at that particular time. The responsible clinician should consider the likelihood that a CTO will benefit the patient and take account of the patient's views about the use of a CTO.

29.16 A risk that the patient's condition will deteriorate is a significant consideration, but does not necessarily mean that the patient should be discharged onto a CTO rather than discharged. The responsible clinician must be satisfied that the risk of harm arising from the patient's disorder is sufficiently serious to justify having the power to recall the patient to hospital for treatment. CTOs should only be used when there is reasonable evidence to suggest that there will be benefits to the individual. Such evidence may include:

- a clear link between non concordance with medication and relapse sufficient to have a significant impact on wellbeing requiring treatment in hospital
- clear evidence that there is a positive response to medication without an undue burden of side effects
- evidence that the CTO will promote recovery, and
- evidence that recall may be necessary (rather than informal admission or reassessment under the Act).

29.17 Patients do not have to give formal consent to a CTO. But in practice, patients should be involved in decisions about the treatment to be provided in the community and how and where it is to be given, and be prepared to co-operate with the proposed treatment. The responsible clinician should inform the patient of the essential legal and factual grounds for the CTO and other information about the CTO (paragraphs 4.13 – 4.17) both orally and in writing.

29.18 The responsible clinician's decision to place a patient on a CTO should only ever be made on clinical grounds where the patient meets the criteria in section 17A of the Act.

Action upon Tribunal recommendation

29.19 When a detained patient makes an application to the Tribunal for discharge, the Tribunal may decide not to order discharge, but to recommend that the responsible clinician should consider a CTO. In that event, the responsible clinician should carry out the assessment of the patient's suitability in the usual way. It will be for the responsible clinician to decide whether or not a CTO is appropriate for that patient taking into account the factors outlined above. The responsible clinician should record the reasons for their decision.

Care planning and support in the community

29.20 Good care planning, in line with the care programme approach (CPA), (see chapter 34) will be essential to the success of a CTO. A care co-ordinator will need to be identified.

29.21 Patients on a CTO are entitled to after-care services under section 117 of the Act. The after-care arrangements should be drawn up as part of the normal care planning arrangements. The clinical commissioning group and local authority must continue to provide after-care services under section 117 for as long as the patient remains on a CTO (see also chapter 33).

Role of the AMHP

29.22 The AMHP must decide whether to agree with the patient's responsible clinician that the patient meets the criteria for a CTO, and (if so) whether a CTO is appropriate. The AMHP should meet with the patient before deciding whether to agree that the CTO should be made. Even if the criteria for a CTO are met, it does not mean that the patient must be discharged onto a CTO. In making that decision, the AMHP should consider the wider social context for the patient. Relevant factors may include any support networks the patient may have, the potential impact on the rest of the patient's family, and their need for support in providing care, and employment issues.

29.23 The AMHP should consider how the patient's social and cultural background may influence the family environment in which they will be living and the support structures potentially available. But no assumptions should be made on the basis of the patient's ethnicity or social or cultural background about what care and support can be provided by the family.

29.24 The Act does not specify who this AMHP should be. It may (but need not) be an AMHP who is already involved in the patient's care and treatment as part of the multi-disciplinary team. It can be an AMHP acting on behalf of any willing local authority, and local authorities may agree with each other and with hospital

managers the arrangements that are likely to be most convenient and best for patients. But if no other local authority is willing, responsibility for ensuring that an AMHP considers the case should lie with the local authority which would become responsible under section 117 for the patient's after-care if the patient were discharged.

29.25 If the AMHP does not agree with the responsible clinician that the patient should go onto a CTO, or if they do not agree with the conditions attached to the CTO, then the CTO cannot be made. A record of the AMHP's decision and the full reasons for it should be kept in the patient's notes. The responsible clinician should not approach another AMHP for an alternative view.

Making the CTO

29.26 If the responsible clinician and AMHP agree that the patient should be discharged onto a CTO, they should complete the relevant statutory form and send it to the hospital managers. The responsible clinician must specify on the form the date that the CTO is to be made. This date is the authority for a CTO to begin, and may be a short while after the date on which the form is signed, to allow time for arrangements to be put in place for the patient's discharge.

Conditions to be attached to the CTO

29.27 The CTO includes conditions with which the patient is required to comply. There are two conditions which must be included in all cases. Patients are required to make themselves available for medical examination:

- when needed for consideration of extension of the CTO, and
- if necessary, to allow a second opinion approved doctor (SOAD) to provide a part 4A certificate authorising treatment.

29.28 Responsible clinicians may also, with the AMHP's agreement and following discussions with the patient, set other conditions which are identified as being necessary or appropriate to:

- ensure that the patient receives medical treatment for mental disorder
- prevent a risk of harm to the patient's health or safety as a result of mental disorder, and
- protect other people from a similar risk of harm.

29.29 Conditions may be set for any or all of these purposes, but not for any other reason. The AMHP's agreement to the proposed conditions must be obtained before the CTO can be made.

29.30 In considering what conditions might be necessary or appropriate, the responsible clinician should always keep in view the patient's diverse needs and circumstances. The patient, and (subject to the normal considerations of patient confidentiality) any others with an interest such as a parent (and any others with parental responsibility) or carer, should be consulted.

29.31 The conditions must not deprive the patient of their liberty and should:

- be kept to a minimum number consistent with achieving their purpose
- restrict the patient's liberty as little as possible while being consistent with their care plan and recovery goal
- have a clear rationale, linked to one or more of the purposes in paragraph 29.28 above, and
- be clearly and precisely expressed, so that the patient can readily understand what is expected.

29.32 The nature of the conditions will depend on the patient's individual circumstances. They should be stated clearly having regard to the least restriction principle. Subject to paragraph 29.31, they might cover matters such as:

- where and when the patient is to receive treatment in the community
- where the patient is to live, and
- avoidance of known risk factors or high-risk situations relevant to the patient's mental disorder.

29.33 The reasons for any condition should be explained to the patient and others, as appropriate, (eg the patient's independent mental health advocate (IMHA), family and carers and, in the case of a child or young person, the person(s) with parental responsibility, see chapters 4, 5, 6 and 19 on children and young people) and recorded in the patient's notes. It will be important, if the CTO is to be successful, that the patient agrees to keep to the conditions, or to try to do so, and that patients have access to the help they need to be able to comply. It is helpful if families can have access to support so they can help the patient to comply. The patient should have a discharge CPA meeting and a copy of the care plan before they are discharged from hospital onto the CTO (see paragraphs 34.13 – 34.14 and 34.19).

Information for patients on a CTO and others

29.34 As soon as the decision is made to discharge a patient onto a CTO, the responsible clinician should inform the patient and others consulted of the decision, the conditions to be applied to the CTO, and the services which will be available for the patient in the community, including the continuing right to an IMHA (see chapter 6).

29.35 There is a duty on hospital managers to take steps to ensure that patients understand what a CTO means for them and their rights to apply for discharge. This includes giving patients information both orally and in writing and must be done as soon as practicable after the patient goes onto the CTO. Hospital managers' information policies should set out whether this information is to be provided by the responsible clinician, by another member of the professional team or by someone else. A copy of this information must be provided to the nearest relative (subject to the normal considerations about involving nearest relatives – see paragraphs 4.32 – 4.37) and should also be given to the carer, if different. (See also chapter 40 on information to be given to the victims of certain part 3 patients.)

Monitoring CTO patients

29.36 It will be important to maintain contact with a patient on a CTO and to monitor closely their mental health and wellbeing after they leave hospital. The type and scope of the arrangements will vary depending on the patient's needs and individual circumstances and the way in which local services are organised. All those involved will need to agree to the arrangements. Respective responsibilities should be clearly set out in the patient's care plan. The care co-ordinator would normally be responsible for co-ordinating the care plan, working with the responsible clinician (if they are different people), the team responsible for the patient's care, family carers and any others with an interest.

29.37 Appropriate action will need to be taken if the patient becomes unwell, engages in high-risk behaviour as a result of mental disorder or withdraws consent to treatment (or begins to object to it). The responsible clinician should consider, with the patient (and others where appropriate), the reasons for this and what the next steps should be. If the patient refuses crucial treatment, an urgent review of the situation will be needed, and recalling the patient to hospital will be an option if the risk justifies it. If suitable alternative treatment is available which would allow the patient to continue safely on a CTO and which the patient would accept, the responsible clinician should consider such treatment if this can be offered. If so, the treatment plan, and if necessary the conditions of the CTO, should be varied accordingly (note that a revised part 4A certificate may be required).

29.38 If the patient is not complying with any condition of the CTO the reasons for this will need to be properly investigated. Recall to hospital may need to be considered if it is no longer safe and appropriate for the patient to remain in the community. The conditions may need to be reviewed – eg if the patient's health has improved a particular condition may no longer be relevant or necessary. The responsible clinician may vary conditions as appropriate (see paragraphs 29.40 – 29.43 below). Changes may also be needed to the patient's care or treatment plan.

29.39 Alternatively, after review it may be concluded that the CTO is failing to promote recovery and then consideration needs to be given to discharging the CTO and taking a different approach.

Varying and suspending conditions

29.40 The responsible clinician has the power to vary the conditions of the patient's CTO, or to suspend any of them. The responsible clinician does not need to agree any variation or suspension with the AMHP. However, it would not be good practice to vary conditions which had recently been agreed with an AMHP without discussion with that AMHP. The responsible clinician should record the reasons for varying conditions in the patient's notes. A copy should also be placed with the care plan or its equivalent (see paragraphs 34.14, 34.15 and 34.19). Any variation in the conditions must be recorded on the relevant statutory form, which should be sent to the hospital managers.

29.41 A variation of the conditions might be appropriate where the patient's treatment needs or living circumstances have changed. Any condition no longer required should be removed.

29.42 Suspension of one or more of the conditions may be appropriate to allow for a temporary change in circumstances, eg the patient's temporary absence or a change in treatment regime. Suspending conditions may be a useful way to test whether they are still needed and could be part of a planned reduction of conditions leading to the patient's possible discharge from the CTO. The responsible clinician should record any decision to suspend conditions in the patient's notes, with reasons.

29.43 It will be important to discuss any proposed changes to the conditions with the patient and ensure that the patient, and anyone else affected by the changes such as their family and carers (where appropriate, and subject to the patient's right to confidentiality) knows that they are being consulted and why. As when the conditions were first set, the patient's views about the changes should be sought and considered before a change is made; and the responsible clinician should discuss with the patient whether they will be able to keep to any new or varied conditions. The patient and their nearest relative (where appropriate) should be informed of any changes to the conditions. Any help the patient needs to comply with them should be made available. Families and/or carers should be supported to help the patient (see paragraphs 10.10 – 10.13).

Responding to concerns raised by the patient's carer

29.44 Particular and prompt attention should be paid to carers when they raise a concern that the patient is not complying with the conditions or that the patient's mental health appears to be deteriorating. The team responsible for the patient needs to give due weight to those concerns and any requests made by the carers in deciding what action to take. Carers are typically in much more frequent contact with the patient than professionals, even under well-run care plans. Their concerns may prompt a review of how a CTO is working for that patient and whether the criteria for recall to hospital might be met or whether more support in the

community should be put in place. The managers of responsible hospitals should ensure that local protocols are in place to cover how concerns raised should be addressed and taken forward (see also paragraphs 10.3 – 10.6).

Recall to hospital

29.45 The recall power is intended to provide a means to respond to evidence of relapse or high-risk behaviour relating to mental disorder before the situation becomes critical and leads to the patient or other people being harmed. The need for recall might arise as a result of relapse, or by a change in the patient's circumstances giving rise to increased risk. The responsible clinician does not have to interview or examine the patient in person before deciding to recall them.

29.46 The responsible clinician may recall a patient on a CTO to hospital for treatment if:

- the patient needs to receive treatment for mental disorder in hospital (either as an in-patient or as an out-patient), or
- 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.

29.47 A patient may also be recalled to hospital if they break either of the mandatory conditions which must be included in all CTOs – that is, by failing to make themselves available for medical examination either to allow consideration of extension of the CTO or to allow a SOAD to give a part 4A certificate for proposed section 58 or section 58A treatment (see chapter 25). The patient must always be given the opportunity to comply with the condition before recall is considered, unless there is a risk of harm to their health or safety or to others. Before exercising the recall power for this reason, the responsible clinician should consider whether the patient has a valid reason for failing to comply, and should take any further action accordingly.

29.48 The responsible clinician must be satisfied that the criteria are met before using the recall power. Any action should be proportionate to the level of risk. For some patients, the risk arising from a failure to comply with treatment could indicate an immediate need for recall. In other cases, negotiation with the patient and (unless the patient objects or it is not reasonably practicable) the nearest relative, carers and, in the case of children and young people, person(s) with parental responsibility, may resolve the problem and so avert the need for recall.

29.49 The responsible clinician should consider in each case whether recalling the patient to hospital is justified in all the circumstances. For example, it might be sufficient to monitor a patient who has failed to comply with a condition to attend for treatment, before deciding whether the lack of treatment means that recall is necessary. A patient might agree to admission to hospital on a voluntary basis. Failure to comply

with a condition (apart from those relating to availability for medical examination, as above) does not in itself trigger recall. Only if the breach of a condition results in an increased risk of harm to the patient or to anyone else will recall be justified.

29.50 It might be necessary to recall a patient whose condition was deteriorating despite compliance with treatment, if the risk cannot be managed otherwise.

29.51 Recall to hospital for treatment should not become a regular or routine event for any patient on a CTO. If recall is being used frequently, the responsible clinician should review the patient's treatment plan to consider whether it could be made more acceptable to the patient, or whether, in the individual circumstances of the case, a CTO continues to be appropriate.

Procedure for recall to hospital

29.52 The responsible clinician has responsibility for co-ordinating the recall process, unless it has been agreed locally that someone else will do this. It will be important to ensure that the practical impact of recalling the patient on the patient's domestic circumstances is considered and managed. For example, wherever possible the responsible clinician should give the patient (or arrange for the patient to be given) oral reasons for the recall before it happens, taking into account any risks arising from giving notice of the recall. The family and carers involved in providing support to the patient should also be informed.

29.53 In every case the responsible clinician must complete a written notice of recall to hospital, which is effective only when served on the patient. A copy of this should be kept in the notes so as to be available to the on call team who may be required to follow-up the recall process. It is important that, wherever possible, the notice should be handed to the patient personally. Otherwise, the notice is served by delivery to the patient's usual or last known address (see paragraphs 29.55 – 29.56 below).

29.54 Once the recall notice has been served, the patient can, if necessary, be treated as absent without leave, and taken and transported to hospital (and a patient who leaves the hospital without permission can be returned there). The time at which the notice is deemed to be served will vary according to the method of delivery.

29.55 It will not usually be appropriate to post a notice of recall to the patient. This may, however, be an option if the patient has failed to attend for medical examination as required by the conditions of the CTO, despite having been requested to do so, when the need for the examination is not urgent (see paragraph 29.53 above). First class post should be used. The notice is deemed to be served on the second working day after posting, and it will be important to allow sufficient time for the patient to receive the notice before any action is taken to ensure compliance.

29.56 Where the need for recall is urgent, as will usually be the case, it will be important that there is certainty as to the timing of delivery of the notice. A notice handed to the patient is effective immediately. It may not be possible to achieve this if the patient's whereabouts are unknown, or if the patient is unavailable or simply refuses to accept the notice. In that event the notice should be delivered by hand to the patient's usual or last known address. The notice is then deemed to be served (even though it may not actually be received by the patient) on the day after it is delivered – that is, the day (which does not have to be a working day) beginning immediately after midnight following delivery.

29.57 If the patient's whereabouts are known but access to the patient cannot be obtained, it might be necessary to consider whether a warrant issued under section 135(2) is needed (see chapter 16).

29.58 The patient should be transported to hospital in the least restrictive manner possible. If appropriate, the patient might be accompanied by a family member, carer or friend (see chapter 17).

29.59 The responsible clinician should ensure that the hospital to which the patient is recalled is ready to receive the patient and to provide appropriate treatment. While recall must be to a hospital, the required treatment may then be given on an outpatient basis, if appropriate.

29.60 The hospital need not be the patient's responsible hospital (that is, the hospital where the patient was detained immediately before going onto a CTO) or under the same management as that hospital. A copy of the notice of recall, which provides the authority to detain the patient, should be sent to the managers of the hospital to which the patient is being recalled.

29.61 When the patient arrives at hospital after recall, the clinical team will need to assess the patient's condition, provide the necessary treatment and determine the next steps. The patient may be well enough to return to the community once treatment has been given, or may need a longer period of assessment or treatment in hospital. The patient may be detained in hospital for a maximum of 72 hours after recall to allow the responsible clinician to determine what should happen next. During this period the patient remains a CTO patient, even if they remain in hospital for one or more nights. The responsible clinician may allow the patient to leave the hospital at any time within the 72-hour period. Once 72 hours from the time of admission have elapsed, the patient must be allowed to leave if the responsible clinician has not revoked the CTO (see paragraphs 29.63 – 29.68 below). On leaving hospital the patient will remain on the CTO as before. Section 5(2) cannot be used to extend the 72-hour period.

29.62 In considering the options, the responsible clinician and the clinical team will need to consider whether a CTO remains the right option for that patient. They will also need to consider, with the patient, the nearest relative (subject to the normal considerations about involving nearest relatives), and any carers (and in the case of children and young people, those with parental responsibility), what changes might be needed to help to prevent the circumstances that led to recall from recurring. It may be that a variation in the conditions is required, or a change in the care plan (or both).

Revoking the CTO

29.63 If the patient requires inpatient treatment for longer than 72 hours after arrival at the hospital, the responsible clinician should consider revoking the CTO. The effect of revoking the CTO is that the patient will again be detained under the powers of the Act. The responsible clinician and an AMHP should reassess the patient before revoking their CTO. They must do so if necessary to satisfy themselves that the patient again needs to be admitted to hospital for medical treatment under the Act.

29.64 The CTO may be revoked if:

- the responsible clinician considers that the patient again needs to be admitted to hospital for medical treatment under the Act, or
- an AMHP agrees with that assessment, and also believes that it is appropriate to revoke the CTO.

29.65 In making the decision as to whether it is appropriate to revoke a CTO, the AMHP should consider the wider social context for the person concerned, in the same way as when making decisions about applications for admissions under the Act (see chapter 14).

29.66 As before, the AMHP carrying out this role may (but need not) be already involved in the patient's care and treatment, or can be an AMHP acting on behalf of any willing local authority. If no other local authority is willing, responsibility for ensuring that an AMHP considers the case should lie with the local authority which has been responsible for the patient's after-care.

29.67 If the AMHP does not agree that the CTO should be revoked, then the patient cannot be detained in hospital after the end of the maximum recall period of 72 hours. The patient will therefore remain on a CTO. A record of the AMHP's decision and the full reasons for it should be kept in the patient's notes. It would not be appropriate for the responsible clinician to approach another AMHP for an alternative view.

29.68 If the responsible clinician and the AMHP agree that the CTO should be revoked, they must complete the relevant statutory form for the revocation to take legal effect, and send it to the hospital managers. The responsible clinician or the AMHP must give the patient (or arrange for the patient to be given) oral reasons for revoking the CTO before it is revoked. The patient is then detained again under the powers of the Act exactly as before going onto a CTO, except that a new detention period of six months begins for the purposes of review and applications to the Tribunal (see also paragraph 25.36). Written reasons for the revocation should also be given to the patient and (where appropriate) their nearest relative. Hospital managers should notify the patient and (where appropriate) their nearest relative when they have referred the patient's case to the Tribunal (see paragraph 29.72).

Hospital managers' responsibilities

29.69 It is the responsibility of the hospital managers (see chapters 37 and 38) to ensure that no patient is detained following recall for longer than 72 hours unless the CTO is revoked. The relevant statutory form must be completed on the patient's arrival at hospital. Hospital managers should ensure arrangements are in place to monitor the patient's length of stay following the time of detention after recall, as recorded on the form, so that the maximum period of detention is not exceeded (see also paragraphs 4.10 – 4.18 on information for patients).

29.70 The hospital managers should also ensure that arrangements are in place to cover any necessary transfers of responsibility between responsible clinicians in the community and in hospital.

29.71 If a patient's CTO is revoked and the patient is detained in a hospital other than the one which was the responsible hospital at the time of recall, the hospital managers of the new hospital must send a copy of the revocation form to the managers of the original hospital.

29.72 The hospital managers have a duty to ensure that a patient whose CTO is revoked is referred to the Tribunal without delay.

Review of patient's CTOs

29.73 In addition to the statutory requirements in the Act for review of CTOs, it is good practice to review the patient's progress on their CTO as part of all reviews of the CPA care plan or its equivalent (see chapter 34).

29.74 Reviews should cover whether the CTO is meeting the patient's treatment needs and, if not, what action is necessary to address this. A patient who no longer satisfies all the criteria for being on a CTO must be discharged without delay.

Discharge from a CTO

29.75 It is very important that patients should not remain subject to a CTO once it is no longer necessary, ie if the answer to any of the following questions is 'no'.

- Is the patient still suffering from mental disorder?
- If so, is the disorder of a nature or degree which makes it appropriate for the patient to receive medical treatment?
- If so, is it necessary in the interests of the patient's health or safety or for the protection of other persons that the patient should receive such treatment?
- Is it still necessary for the responsible clinician to be able to exercise the power to recall the patient to hospital, if that is needed? (eg the longer a patient has been on a CTO without the need to exercise the power to recall them to hospital, the more important it will become to question whether this criterion is still satisfied, see paragraphs 32.11 – 32.16).

29.76 CTO patients may be discharged in the same way as detained patients, by the Tribunal, the hospital managers, or (for part 2 patients) the nearest relative. The responsible clinician may also discharge a CTO patient at any time and must do so if the patient no longer meets the criteria for a CTO. A patient's CTO should not simply be allowed to lapse.

29.77 The reasons for discharge should be explained to the patient, and any concerns on the part of the patient, the nearest relative or any carer (and in the case of children and young people, those with parental responsibility) should be considered and dealt with as far as possible. On discharge from a CTO, the team should ensure that any after-care services the patient continues to need under section 117 of the Act will be available (see chapter 33).

Related material

- Refocusing the Care Programme Approach: policy and positive practice guidance. Department of Health. 2008. http://webarchive.nationalarchives.gov.uk/20130107105354/http:/www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_083647

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30 Guardianship

Why read this chapter?

30.1 Guardianship enables patients to receive care outside hospital where it cannot be provide without the use of compulsory powers. This chapter provides guidance on guardianship, in particular, on the purpose of guardianship, assessing a patient for guardianship, the responsibilities of local authorities and the components of effective guardianship.

Purpose of guardianship

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

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

- they have the exclusive right to decide where a patient should live, taking precedence even over an attorney or deputy appointed under the Mental Capacity Act 2005 (MCA). The Court of Protection also lacks jurisdiction to determine a place of residence of a patient whilst that patient is subject to guardianship and there is a residence requirement in effect[1]
- they can require the patient to attend for treatment, work, training or education at specific times and places (but they cannot use force to take the patient there), and
- they can demand that a doctor, approved mental health professional (AMHP) or another relevant person has access to the patient at the place where the patient lives.

30.4 Guardianship therefore 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 should be part of the patient's overall care plan.

30.5 Guardianship must not be used to impose restrictions that amount to a deprivation of liberty.

30.6 Guardianship does not give anyone the right to treat the patient without their permission or to consent to treatment on their behalf.

30.7 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 take decisions about where a guardianship patient is to reside, or take any other decisions which conflict with decisions made by the guardian.

[1] C v Blackburn and Darwen Borough Council. 2011. EWHC 2231. http://www.bailii.org/ew/cases/EWHC/COP/2011/3321.html

Assessment for guardianship

30.8 An application for guardianship may be made, in relation to a person who is aged 16 or over and who is not a ward of court, on the grounds that:

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

30.9 Guardianship is most likely to be appropriate where:

- the patient is thought to be 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, and
- there is a particular need for someone to have the authority to decide where the patient should live or to insist that doctors, AMHPs or other people be given access to the patient.

30.10 As with applications for detention in hospital (see chapter 14), AMHPs and doctors making recommendations should consider whether the objectives of the proposed application could be achieved in another, less restrictive, way, without the use of guardianship.

30.11 Where patients lack capacity to make some or all important decisions concerning their own welfare, one potential alternative to guardianship will be to rely solely on the MCA – especially the protection from liability for actions taken in connection with care or treatment provided by section 5 of the MCA. While this is a factor to be taken into account, it will not by itself determine whether guardianship is necessary or unnecessary. AMHPs and doctors need to consider all the circumstances of the particular case.

30.12 Where an patient aged 16 or over is assessed as requiring residential care but lacks the capacity to make a decision about whether they wish to be placed there, guardianship is unlikely to be necessary where the move can properly, quickly and efficiently be carried out on the basis of:

- section 5 of the MCA or the decision of an attorney or deputy, and
- (where relevant) a deprivation of liberty authorisation (a DoL authorisation) (in relation to a patient aged 18 or over) or deprivation of liberty order (Court of Protection order) under the MCA.

30.13 But guardianship may still be appropriate in such cases if:

- there are other reasons – unconnected to the move to residential care – to think that the patient might benefit from the attention and authority of a guardian
- there is a particular need to have explicit statutory authority for the patient to be returned to the place where the patient is to live should they go absent, or
- it is thought to be important that decisions about where the patient is to live are placed in the hands of a single person or authority – eg where there have been long-running or particularly difficult disputes about where the person should live.

30.14 It will not always be best to use guardianship as the way of deciding where patients who lack capacity to decide for themselves must live. In cases which raise unusual issues, or where guardianship is being considered in the interests of the patient's welfare and there are finely balanced arguments about where the patient should live, it may be preferable instead to seek a best interests decision from the Court of Protection under the MCA.

30.15 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 be recalled to hospital (and the patient is eligible), a community treatment order (CTO) may be appropriate (see chapter 29).

Responsibilities of local authorities

30

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

- receiving, scrutinising and accepting or refusing applications for guardianship. Such arrangements should ensure that applications are properly but quickly dealt with
- monitoring the progress of each patient's guardianship, including steps to be taken to fulfil the authority's statutory obligations in relation to private guardians and to arrange visits to the patient
- ensuring the suitability of any proposed private guardian, and that they are able to understand and carry out their duties under the Act
- ensuring that patients under guardianship receive, both orally and in writing, information in accordance with regulations under the Act, including their right to have access to an independent mental health advocate (IMHA)
- ensuring that patients are aware of their right to apply to a Tribunal and that patients are given the name of someone who will give them necessary assistance, on behalf of the local authority, in making such an application
- authorising an approved clinician to be the patient's responsible clinician
- maintaining detailed records relating to guardianship patients

- ensuring that the need to continue guardianship is reviewed in the last two months of each period of guardianship in accordance with the Act, and
- discharging patients from guardianship as soon as it is no longer required.

30.17 Patients may be discharged from guardianship at any time by the local authority, the responsible clinician authorised by the local authority, or (in most cases) the patient's nearest relative.

30.18 Discharge decisions by local authorities may be taken only by:

- the local authority itself, or
- three or more members of the local authority, or
- a committee or subcommittee of the local authority authorised for that purpose.

Where decisions are taken by three or more local authority members (or a committee or sub-committee), all three people (or at least three of them, if there are more) must agree.

30.19 Local authorities may consider discharging patients from guardianship at any time, but must consider doing so when they receive a report from the patient's nominated medical attendant or responsible clinician renewing their guardianship under section 20 of the Act.

Components of effective guardianship

Care planning

30.20 An application for guardianship should be accompanied by a comprehensive care plan established on the basis of multi-disciplinary discussions in accordance with the care programme approach (or its equivalent).

30.21 The plan should identify the services needed by the patient and who will provide them. It should also indicate which of the powers that guardians have under the Act are necessary to achieve the plan. If none of the powers are required, guardianship should not be used.

30.22 Key elements of the plan are likely to be:

- suitable accommodation to help meet the patient's needs
- access to day care, education and training facilities, as appropriate
- effective co-operation and communication between all persons concerned in implementing the care plan
- (if there is to be a private guardian) support from the local authority for the guardian.

30.23 A private guardian should be prepared to advocate on behalf of the patient in relation to those agencies whose services are needed to carry out the care plan. So should a local authority which is itself the guardian.

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

30.25 Regulations require private guardians to appoint a doctor as the patient's nominated medical attendant. It is the nominated medical attendant who must examine the patient during the last two months of each period of guardianship and decide whether to make a report extending the patient's guardianship. (Where the patient's guardian is the local authority itself, this is done by the responsible clinician authorised by the local authority.)

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

30 Power to require a patient to live in a particular place

30.27 Guardians have the power to decide where patients should live. If patients leave the place they are required to live without the guardian's permission, they can be taken into legal custody and brought back there (see chapter 28).

30.28 This power can also be used to take patients for the first time to the place they are required to live, if patients do not (or, in practice, cannot) go there by themselves.

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

30.30 The power to take or return patients to the place they are required to live may be used, eg to discourage them from:

- living somewhere the guardian considers unsuitable
- breaking off contact with services
- leaving the area before proper arrangements can be made, and
- sleeping rough.

But it may not be used to restrict their freedom to come and go so much that they are effectively being detained.

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

30.32 If the person lacks the capacity to decide where to live, they may be deprived of their liberty if this is authorised separately by either (a) a DoL authorisation in respect of a hospital or care home placement if they are 18 or over; or (b) by a Court of Protection order made by the Court of Protection under the MCA in respect of other community settings if they are 16 or over. If it is appropriate for deprivation of liberty to be authorised under the MCA, the local authority should consider whether guardianship remains appropriate, bearing in mind the need to apply the least restrictive option and maximising independence principle (see paragraphs 1.2 – 1.6 and paragraphs 30.2 – 30.7).

Guardianship and hospital care

30.33 Guardianship does not restrict patients' access to hospital services on an informal basis. Patients who require treatment but do not need to be detained may be admitted informally in the same way as any other patient. This applies both to physical and mental healthcare.

30.34 Nor does guardianship prevent the deprivation of a person's liberty being authorised under the MCA, if the person needs to be detained in a hospital in their best interests in order to receive care and treatment. A DoL authorisation or Court of Protection order can be sought so long as:

- it would not be inconsistent with the guardian's decision about where the patient should live, and
- the person does not object to being kept in hospital for treatment for mental disorder or to receiving that treatment.[2]

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

30.36 Guardianship can remain in force if the patient is detained in hospital under section 2 or 4 of the Act for assessment, but it ends automatically if a patient is detained for treatment as a result of an application under section 3. Regulations also allow a patient to be transferred from guardianship to detention in hospital under section 3. The normal requirements for an application and medical recommendations must be met, and the transfer must be agreed by the local authority.

[2] In these circumstances, a DoL authorisation or Court of Protection order cannot be made because the person will be ineligible to be deprived of their liberty by the MCA: see paragraphs 12 and 17 of Schedule A1, read with paragraphs 2 (Case D), 3 and 5 of Schedule 1A, to the Mental Capacity Act 2005.

Patients who resist the authority of the guardian

30.37 If a patient consistently resists exercise by the guardian of any of their powers, it can normally be concluded that guardianship is not the most appropriate form of care for that person, and the guardianship should be discharged. The local authority should first consider whether a change of guardian – or change in the person who, in practice, exercises the local authority's powers as guardian – might be appropriate instead.

Guardianship orders under section 37

30.38 Guardianship may be used by courts as an alternative to hospital orders for offenders with mental disorders where the criteria set out in the Act are met. The court must first be satisfied that the local authority or named person is willing to act as guardian. In considering the appropriateness of the patient being received into their guardianship, local authorities should be guided by the same considerations as apply to applications for guardianship under part 2 of the Act.

30.39 The guidance in this chapter on components of effective guardianship applies to guardianship order patients in the same way as it applies to other guardianship patients. The main difference between applications for guardianship under part 2 of the Act and guardianship orders is that nearest relatives may not discharge patients from guardianship orders. Nearest relatives have rights to apply to the Tribunal instead (see paragraphs 12.6 – 12.9).

Related material

- Mental Capacity Act 2005. http://www.legislation.gov.uk/ukpga/2005/9/contents
- Mental Capacity Act 2005. Code of Practice. Department for Constitutional Affairs (now Ministry of Justice). 2007. https://www.gov.uk/government/publications/mental-capacity-act-code-of-practice
- Mental Capacity Act 2005: Deprivation of Liberty Safeguards – Code of Practice to supplement the main Mental Capacity Act 2005 Code of Practice. 2008. http:// webarchive.nationalarchives.gov.uk/20130107105354/http:/www.dh.gov.uk/en/ Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_085476

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31 Guardianship, leave of absence or CTO?

Why read this chapter?

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

Deciding between guardianship, leave of absence and CTO

31.2 There are three ways in which an unrestricted patient may be subject to the powers of the Act while living in the community: guardianship, leave of absence and CTO.

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

31.4 Leave of absence (section 17) is primarily intended to allow a patient detained under the Act to be temporarily absent from hospital where further in-patient treatment as a detained patient is still thought to be necessary. It is clearly suitable for short-term absences for a fixed period or specific purpose eg to allow visits to family and to trial living more independently (see also chapter 27).

31.5 Leave of absence may be useful in the longer term (more than seven consecutive days) where the clinical team wish to see how the patient manages outside hospital before making the decision to discharge. Leave for a longer period should also be for a specific purpose or a fixed period, and not normally more than one month. For most patients who are able to live in the community, a CTO should be considered a better option than longer-term leave for the ongoing management of their care. Reflecting this, whenever considering longer-term leave for a patient (that is, for more than seven consecutive days), the responsible clinician must first consider whether the patient should be discharged onto a CTO instead. Any decision to authorise section 17 leave for more than seven days on a second occasion should be fully documented, including why a CTO or discharge is not appropriate (see paragraph 27.14).

31.6 A CTO (section 17A) is used where it is necessary for the patient's health or safety or for the protection of others to continue to receive treatment after their discharge from hospital. It seeks to prevent the 'revolving door' scenario and the harm which could arise from relapse. It is a more structured system than leave of absence and has more safeguards for patients. A key feature of the CTO framework is that it is suitable only where there is no reason to think that the patient will need further treatment as a detained in-patient for the time being, but where the responsible clinician needs to be able to recall the patient to hospital if necessary (see chapter 29).

31.7 Some pointers to the use of the three options are given in the following figures:

Figure 18: CTO or longer-term leave of absence: relevant factors to consider

Factors suggesting longer-term leave	Factors suggesting a CTO
• Discharge from hospital is for a specific purpose or a fixed period. • The patient's discharge from hospital is deliberately on a 'trial' basis. • The patient is likely to need further in-patient treatment without their consent or compliance. • There is a serious risk of arrangements in the community breaking down or being unsatisfactory – more so than for a CTO.	• There is confidence that the patient is ready for discharge from hospital on an indefinite basis. • There are good reasons to expect that the patient will not need to be detained for the treatment they need to be given. • The patient appears prepared to consent or comply with the treatment they need – but risks as below mean that recall may be necessary. • The risk of arrangements in the community breaking down, or of the patient needing to be recalled to hospital for treatment, is sufficiently serious to justify a CTO, but not to the extent that it is very likely to happen.

Figure 19: CTO or guardianship: relevant factors to consider

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

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

31.8 Patients who are on a CTO or on leave, and who lack capacity to decide whether or not to consent to the arrangements required for their care or treatment, may occasionally need to be detained for further care or treatment for their mental disorder in circumstances in which recall to hospital for this purpose is not considered necessary. They might also need to be admitted to a care home or hospital because of physical health problems.

31.9 If they will be detained in a care home, a deprivation of liberty authorisation (DoL authorisation) or Court of Protection order under the Mental Capacity Act 2005 (MCA) must be obtained. Deprivation of liberty under the MCA can exist alongside a CTO or leave of absence, provided that there is no conflict with the conditions of the CTO or leave set by the patient's responsible clinician.[1]

31.10 If they will be detained in a hospital for further treatment for mental disorder (whether or not they will also receive treatment for physical health problems), they should be recalled to be treated under the Act. The MCA cannot be used to authorise the deprivation of their liberty.[2]

31.11 For guidance on the use of a DoL authorisation or Court of Protection order in relation to a patient who is subject to guardianship, see chapter 30 on guardianship.

[1] If it would conflict with the conditions of their CTO or leave, the person would be ineligible to be deprived of their liberty under the MCA: see paragraphs 12 and 17 of Schedule A1, read with paragraphs 2 (Cases B and C), 3 and 4 of Schedule 1A to the MCA.

[2] Patients who are on a CTO or on leave are ineligible to be deprived of their liberty under the MCA for the purpose of being detained in a hospital to receive medical treatment for mental disorder: see paragraphs 12 and 17 of Schedule A1, read with paragraphs 2 (Cases B and C) and 4 of Schedule 1A to the MCA.

32 Detention and CTO: renewal, extension and discharge

Why read this chapter?

32.1 A patient's detention or community treatment order (CTO) may by extended or renewed by the responsible clinician. This must be done before the period of detention or CTO expires. This chapter provides guidance on how the procedures in the Act for renewing detention and extending a CTO should be applied. It provides guidance on the role and responsibilities of the responsible clinician and the role of the patient's nearest relative. Guidance is given on a nearest relative's power of discharge and an illustrative standard letter for nearest relatives to use to discharge a patient is provided.

Detention: renewal, disharge or CTO

32.2 Before it expires, responsible clinicians must decide whether patients' current period of detention should be renewed. Responsible clinicians must examine the patient and decide within the two months leading up to the expiry of the patient's detention whether the criteria for renewing detention under section 20 of the Act are met and whether discharge is appropriate. The responsible clinician should discuss their decision with the patient. They must consult one or more other people who have been professionally concerned with the patient's medical treatment. The responsible clinician must make this decision on the basis of clinical factors only and should fully document the reasons for this decision in the report to the hospital managers.

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

Second professional

32.4 Before responsible clinicians can submit that report, they are required to obtain the written agreement of another professional ('the second professional') that the criteria are met. This second professional must be professionally concerned with the patient's treatment and must not belong to the same profession as the responsible clinician.

32.5 Apart from that, the Act does not say who the second professional should be. Hospital managers should have a local policy on the selection of the second professional. Policies should be based on the principle that the involvement of a second professional is intended to provide an additional safeguard for patients by ensuring that:

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

32.6 Accordingly, second professionals should:

- have sufficient experience and expertise to decide whether the patient's continued detention is necessary and lawful, but need not be approved clinicians (nor be qualified to be one)
- have been actively involved in the planning, management or delivery of the patient's treatment, and
- have had sufficient recent contact with the patient to be able to make an informed judgement about the patient's case.

32.7 Second professionals should satisfy themselves, in line with the local policies, that they have sufficient information on which to make the decision. Whether that requires a separate clinical interview or examination of the patient will depend on the nature of the contact that the second professional already has with the patient and on the other circumstances of the case. Responsible clinicians should ensure that the second professional is given enough notice to be able to interview or examine the patient if appropriate.

32.8 Before examining patients to decide whether to make a renewal report, responsible clinicians should identify and record who the second professional is to be. Hospital managers' policies may, if the hospital mangers wish, say that the identity of the second professional is to be decided or agreed by a third party – such as a senior clinician or manager – but the Act does not require that.

32.9 Unless there are exceptional circumstances, the decision of the identified second professional should be accepted, even if the responsible clinician does not agree with it, and documented in the patient's notes including the reasons for the disagreement. If, in exceptional circumstances, it is decided that the agreement of a different second professional should be sought, this should be fully documented and the decision should be drawn to the attention of the hospital managers if, as a result, a renewal report is made.

Not holding a review before detention expires

32.10 Detention should not continue if the authority for detention is not renewed because any such detention would be an unlawful deprivation of liberty, which is a breach of the patient's Article 5 ECHR right to liberty. Such cases are sometimes referred to as 'de-facto' detention. If, in exceptional cases, authority for detention is not renewed and the patient continues to be kept in circumstances which amount to a deprivation of liberty, the responsible clinician must notify the hospital managers immediately. The patient should then be immediately discharged or there must be lawful authority to continue to detain the patient, for example, in exercise of the holding powers in the Act. If necessary a new application for admission or assessment should then be made. This should be reported to the service commissioner and the Care Quality Commission as a serious incident. The hospital managers should ensure that a review is undertaken within one month to determine

why this has happened and what actions have been taken to resolve this and to ensure that it would not happen again in the future. (See also paragraph 38.50 in relation to what the hospital manager should do.)

Community treatment orders

32.11 All decisions should be taken in line with the least restrictive option and maximum independence principle, with guardianship or discharge being fully considered. Only responsible clinicians may extend the period of the CTO. To do so, responsible clinicians must examine their patient and decide, during the two months leading up to the day on which the patient's CTO is due to expire, whether the criteria for extending the CTO under section 20A of the Act are met. They must also consult one or more other people who have been professionally concerned with the patient's medical treatment.

32.12 The responsible clinician should also consult the wider multi-disciplinary team (MDT). Where appropriate, this should include the patient, nearest relative, the independent mental health advocate (IMHA) and/or other representative, family and carers, the local authority and clinical commissioning group responsible for the patient's after-care (chapter 33); and any other key service providers. Consultation should take place during a care programme approach (CPA) assessment and before the responsible clinician decides whether or not to extend the CTO.

32.13 When deciding whether to extend the period of a CTO the responsible clinician, second professional and AMHP should all consider carefully whether or not the criteria for extending the CTO are met and, if so, whether an extension is appropriate. For example, the longer patients have been on a CTO without the need to exercise the power to recall them to hospital, the more important it will become to question whether that criterion is still satisfied.

32.14 Where responsible clinicians are satisfied that the criteria for extending the patient's CTO are met, they must submit a report to that effect to the managers of the responsible hospital, clearly stating their reasons.

32.15 Before responsible clinicians can submit that report they must obtain the written agreement of an approved mental health professional (AMHP). Responsible clinicians should ensure that the AMHP is given enough notice to be able to interview the patient if appropriate.

32.16 This does not have to be the same AMHP who originally agreed that the patient should become a CTO patient. It may (but need not) be an AMHP who is already involved in the patient's care and treatment. It can be an AMHP acting on behalf of any willing local authority. If no other local authority is willing, responsibility for ensuring that an AMHP considers the case should lie with the local authority which is responsible under section 117 for the patient's after-care.

The responsible clinician's power of discharge

32.17 Section 23 of the Act allows responsible clinicians to discharge part 2 patients and unrestricted part 3 patients and all CTO patients by giving an order in writing.

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

32.19 A decision by a second professional not to agree to the renewal of detention does not bring a patient's current period of detention to an end before it is otherwise due to expire. Similarly, a decision by an AMHP not to agree to the extension of a patient's CTO does not end the existing period of CTO. In both cases, it would normally be a reason for responsible clinicians to review whether they should use their power to discharge the patient.

The nearest relative's power of discharge

32.20 Patients detained for assessment or treatment under part 2 of the Act may be discharged by their nearest relatives (see paragraphs 5.3 – 5.4). The hospital managers should ensure that the nearest relative is aware of this power and how to use it.

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

32.22 During that period, the patient's responsible clinician can block the discharge by issuing a 'barring report' stating that, if discharged, the patient is likely to act in a manner dangerous to themselves or others.

32.23 This question focuses on the probability of dangerous acts, such as causing serious physical injury or lasting psychological harm, not merely on the patient's general need for safety and others' general need for protection.

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

32.25 Hospital managers should offer nearest relatives any help they require, such as providing them with a standard letter to complete. The following letter illustrates what a standard letter might look like.

Illustrative standard letter for nearest relatives to use to discharge a patient

To the managers of [insert name and address of hospital in which the patient is detained, or (for a patient on a community treatment order) the responsible hospital.]

Order for discharge under section 23 of the Mental Health Act 1983

My name is [give your name] and my address is [give your address]

[Complete A, B or C below]

A. To the best of my knowledge and belief, I am the nearest relative (within the meaning of the Mental Health Act 1983) of [name of patient].

or

B. I have been authorised to exercise the functions of the nearest relative of [name of patient] by the county court.

or

C. I have been authorised to exercise the functions of the nearest relative of [name of patient] by that person's nearest relative.

I give you notice of my intention to discharge the person named above, and I order their discharge from [say when you want the patient discharged from detention or a community treatment order].

[Please note: you must leave at least 72 hours between when the hospital managers get this letter and when you want the patient discharged.

The time when:

- the notice is received by the hospital manager or an authorised person; or
- if the notice is sent by pre-paid post, the day service is deemed to have taken place [for first class post, service is deemed on the second business day following posting, and for second class post, service is deemed on the fourth business day following posting; or
- the notice is put into the internal mail system; and
- the time when you want the patient discharged.]

Signed ..... Date .....

Discharge by the hospital managers and the Tribunal

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

33 After-care

Why read this chapter?

33.1 Section 117 of the Act requires clinical commissioning groups and local authorities, in co-operation with voluntary agencies, to provide or arrange for the provision of after-care to particular patients detained in hospital for treatment who then cease to be detained. This chapter provides guidance on this duty of after-care. It should be read in conjunction with chapter 34 on the care programme approach. The guidance covers after-care planning and direct payments.

Mental health after-care

33.2 Section 117 of the Act requires clinical commissioning groups (CCGs) and local authorities, in co-operation with voluntary agencies, to provide or arrange for the provision of after-care to patients detained in hospital for treatment under section 3, 37, 45A, 47 or 48 of the Act who then cease to be detained. This includes patients granted leave of absence under section 17 and patients going on community treatment orders (CTOs). It applies to people of all ages, including children and young people.

33.3 After-care services mean services which have the purposes of meeting a need arising from or related to the patient's mental disorder and reducing the risk of a deterioration of the patient's mental condition (and, accordingly, reducing the risk of the patient requiring admission to hospital again for treatment for mental disorder.[1] Their ultimate aim is to maintain patients in the community, with as few restrictions as are necessary, wherever possible.

33.4 CCGs and local authorities should interpret the definition of after-care services broadly. For example, after-care can encompass healthcare, social care and employment services, supported accommodation and services to meet the person's wider social, cultural and spiritual needs, if these services meet a need that arises directly from or is related to the particular patient's mental disorder, and help to reduce the risk of a deterioration in the patient's mental condition.

33.5 After-care is a vital component in patients' overall treatment and care. As well as meeting their immediate needs for health and social care, after-care should aim to support them in regaining or enhancing their skills, or learning new skills, in order to cope with life outside hospital.

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

[1] The definition of 'after-care services' was inserted into section 117 by the Care Act 2014. http://www.legislation.gov.uk/ukpga/2014/23/contents/enacted

33.7 Mental health after-care services must be jointly provided or commissioned by local authorities and CCGs. They should maintain a record of people for whom they provide or commission after-care and what after-care services are provided. Services provided under section 117 can include services provided directly by local authorities or which local authorities commission from other providers. CCGs will commission (rather than provide) these services.

33.8 The NHS Commissioning Board (NHS England) is responsible for a patient's after-care if the after-care services required are of the type that the NHS Commissioning Board would be responsible for commissioning rather than a CCG. In these circumstances local authorities and CCGs should liaise with the NHS Commissioning Board to ensure these services are commissioned promptly.

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

After-care planning

33.10 Although the duty to provide after-care begins when the patient leaves hospital, the planning of after-care needs to start as soon as the patient is admitted to hospital. CCGs and local authorities should take reasonable steps, in consultation with the care programme approach care co-ordinator and other members of the multi-disciplinary team to identify appropriate after-care services for patients in good time for their eventual discharge from hospital or prison.

33.11 When considering relevant patients' cases, the Tribunal and hospital managers will expect to be provided with information from the professionals concerned on what after-care arrangements might be made if they were to be discharged. Some discussion of after-care arrangements involving local authorities, other relevant agencies and families or carers (where appropriate) should take place in advance of the Tribunal hearing.

33.12 Where a Tribunal or hospital managers' hearing has been arranged for a patient who might be entitled to after-care under section 117 of the Act, the hospital managers should ensure that the relevant CCG and local authority have been informed. The CCG and local authority should consider putting practical preparations in hand for after-care in every case, but should in particular consider doing so where there is a strong possibility that the patient will be discharged if appropriate after-care can be arranged. Where the Tribunal has provisionally decided to give a restricted patient a conditional discharge, the CCG and local authority should do their best to put after-care in place which would allow that discharge to take place.

33.13 Before deciding to discharge or grant more than very short-term leave of absence to a patient or to place a patient onto a CTO, the responsible clinician should ensure that the patient's needs for after-care have been fully assessed, discussed with the patient (and their carers, where appropriate) and addressed in their care plan. If the patient is being given 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.

33.14 After-care for all patients admitted to hospital for treatment for mental disorder should be planned within the framework of the care programme approach (see chapter 34). This applies whether or not they are detained or will be entitled to receive after-care under section 117 of the Act. But because of the specific statutory obligation it is important that all patients who are entitled to after-care under section 117 are identified and that records are kept of what is provided to them under that section.

33.15 In order to ensure that the after-care plan reflects the full range of needs of each patient, it is important to consider who needs to be involved, in addition to patients themselves. This may involve carers and a wide range of professionals (see the list in paragraph 34.12).

33.16 The issues likely to be covered by a thorough assessment are set out in paragraph 34.19.

After-care payments

33.17 A local authority may make direct payments to pay for after-care services under section 117 of the Act.[2] An adult who is eligible for after-care can request the local authority to make direct payments to them, if they have capacity to do this. If the adult lacks capacity to do so, the local authority can make direct payments to an authorised person or suitable person if certain conditions are met. A key condition is that the local authority must consider that making the direct payments to the 'authorised person' is an appropriate way to discharge their section 117 duty, and that they must be satisfied the 'authorised person' will act in the adult's best interests in arranging for the after-care.

33.18 If a local authority is providing or arranging accommodation as part of a patient's after-care, the patient and/or friends or relatives identified in regulations may make top-up payments to enable the patient to live in their preferred accommodation if certain conditions are met.[3]

[2] Care and Support Statutory Guidance Issued under the Care Act 2014. Department of Health. 2014. http://www.gov.uk/government/uploads/system/uploads/attachment_data/file/315993/Care-Act-Guidance.pdf

[3] Care and Support Statutory Guidance Issued under the Care Act 2014. Department of Health. 2014. http://www.gov.uk/government/uploads/system/uploads/attachment_data/file/315993/Care-Act-Guidance.pdf

33.19 A CCG or the NHS Commissioning Board may also make direct payments in respect of after-care to the patient or, where the patient is a child or a person who lacks capacity, to a representative who consents to the making of direct payments in respect of the patient. A payment can only be made if valid consent has been given. In determining whether a direct payment should be made, a CCG or the NHS Commissioning Board is required to have regard to whether it is appropriate for a person with that person's condition, the impact of that condition on the person's life and whether a direct payment represents value for money. A payment can also, in certain circumstances, be made to a nominee.[4]

Ending section 117 after-care services

33.20 The duty to provide after-care services exists until both the CCG and the local authority are satisfied that the patient no longer requires them. The circumstances in which it is appropriate to end section 117 after-care will vary from person to person and according to the nature of the services being provided. The most clear-cut circumstance in which after-care would end is where the person's mental health improved to a point where they no longer needed services to meet needs arising from or related to their mental disorder. If these services included, for example, care in a specialist residential setting, the arrangements for their move to more appropriate accommodation would need to be in place before support under section 117 is finally withdrawn. Fully involving the patient and (if indicated) their carer and/or advocate in the decision-making process will play an important part in the successful ending of after-care.

33.21 After-care services under section 117 should not be withdrawn solely on the grounds that:

- the patient has been discharged from the care of specialist mental health services
- an arbitrary period has passed since the care was first provided
- the patient is deprived of their liberty under the MCA
- the patient has returned to hospital informally or under section 2, or
- the patient is no longer on a CTO or section 17 leave.

33.22 After-care services may be reinstated if it becomes obvious that they have been withdrawn prematurely, eg where a patient's mental condition begins to deteriorate immediately after services are withdrawn.

33.23 Even when the provision of after-care has been successful in that the patient is now well-settled in the community, the patient may still continue to need after-care services, eg to prevent a relapse or further deterioration in their condition.

[4] The National Health Service (Direct Payments) Regulations. 2013. SI 2013/1617, as amended by the National Health Service (Direct Payments) (Amendment) Regulations. 2013. SI 2013/2354 prescribe the conditions for making a direct payment. http://www.legislation.gov.uk/uksi/2013/2354/pdfs/uksi_20132354_en.pdf

33.24 Patients are under no obligation to accept the after-care services they are offered, but any decisions they may make to decline them should be fully informed. An unwillingness to accept services does not mean that patients have no need to receive services, nor should it preclude them from receiving them under section 117 should they change their minds.

Related material

- Refocusing the Care Programme Approach: policy and positive practice guidance. Department of Health. 2008. http://webarchive.nationalarchives.gov.uk/20130107105354/http:/www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_083647
- Guidance on Direct Payments for Healthcare: understanding the regulations. NHS England. 2014. http://www.personalhealthbudgets.england.nhs.uk/About/faqs/DPforhealthcare/
- Care Act 2014. http://www.legislation.gov.uk/ukpga/2014/23/contents/enacted (This includes any regulations made concerning direct payments and top-up payments for after-care.)

This material does not from part of the Code. It is provided for assistance only.

34 Care programme approach

Why read this chapter?

34.1 The care programme approach (CPA) is an overarching system for co-ordinating the care of people with mental disorders. The CPA requires identification of a named care co-ordinator. This chapter provides guidance on the key features of the CPA, when to use it, who should be involved, and on care planning. Guidance is also given on patients from Wales who are placed in England.

What is the care programme approach?

34.2 The CPA is an overarching system for co-ordinating the care of people with mental disorders. It requires close engagement with service users and their carers and includes arrangements for assessing, planning and reviewing care.

34.3 Central to CPA is the CPA care plan which aims to ensure a transparent, accountable and coordinated approach to meeting wide ranging physical, psychological, emotional and social needs which are associated with a person's mental disorder. Included with the CPA care plan are:

- a treatment plan which details medical, nursing, psychological and other therapeutic support for the purpose of meeting individual needs promoting recovery and/or preventing deterioration.
- details regarding any prescribed medications
- details of any actions to address physical health problems or reduce the likelihood of health inequalities
- details of how the person will be supported to achieve their personal goals
- support provided in relation to social needs such as housing, occupation, finances etc
- support provided to carers
- actions to be taken in the event of a deterioration of a person's presentation, and
- guidance on actions to be taken in the event of a crisis.

34.4 CPA care plans should include details of any areas of need which are critical to preventing behavioural disturbance. These should be met through primary and secondary preventative strategies. Care plans should also provide guidance on how staff and carers should respond if behavioural disturbance does arise (tertiary strategies). See paragraphs 26.15 – 26.17.

34.5 The CPA also requires the clear identification of a named individual who has responsibility for co-ordinating the preparation, implementation and evaluation of the CPA care plan.

When to use the care programme approach

34.6 The CPA should be used in secondary and tertiary mental healthcare to assess, plan, review and coordinate the range of treatment, care and support needs of those people in contact with secondary mental health services who have complex needs. Active involvement of and engagement with the patient are at the heart of the CPA, which focuses on reducing distress and promoting social inclusion and recovery.

34.7 The CPA should be used for individuals who are at high risk of suffering a deterioration in their mental condition and who need:

- multi-agency support
- active engagement
- intense intervention, and/or
- support with dual diagnoses.

34.8 This would include most people who are entitled to after-care under section 117 of the Act (see chapter 33) as well as all guardianship patients (see paragraphs 30.20 – 30.26) and everyone subject to a community treatment order (CTO) (see chapter 29). Because of the specific statutory obligation, however, it is important that all patients who are entitled to after-care are identified and that records are kept of what is provided to them under that section.

34.9 A care plan under the CPA is likely to be appropriate for people who have been treated for mental disorder as informal hospital in-patients whenever they meet the criteria. It will also be appropriate for people who have been detained under section 2, whose needs may be equally complex but who do not qualify for support under section 117.

Who should be involved

34.10 Most importantly, the care plan should be prepared in close partnership with the patient from the outset, particularly where it is necessary to manage the process of discharge from hospital and reintegration into the community. It is also essential that a suitable care co-ordinator is identified. For patients who have been or continue to be subject to provisions in the Act, this is likely to be a different person from the responsible clinician, but need not be.

34.11 If a different responsible clinician is to take over responsibility for a formerly detained patient, it will be essential to seek the agreement of that clinician, and the community team, at an early stage. It is good practice for the clinician who will be the community responsible clinician and the community care co-ordinator to be present at CPA assessments before and after discharge.

34.12 In order to ensure that the after-care plan reflects the needs of each patient, it is important to consider who needs to be involved, in addition to patients themselves. Subject to the patient's views, this may include:

- the patient's responsible clinician
- nurses and other professionals involved in caring for the patient in hospital
- a practitioner psychologist registered with the Health and Care Professions Council, community mental health nurse and other members of the community team
- the patient's general practitioner (GP) and primary care team (if there is one). (It is particularly important that the patient's GP should be aware if the patient is to go onto a community treatment order (CTO), (see chapter 29). A patient who does not have a GP should be encouraged and helped to register with a practice
- any carer who will be involved in looking after them outside hospital (including, in the case of children and young people, those with parental responsibility)
- the patient's nearest relative (if there is one) or other carers
- a representative of any relevant voluntary organisations
- in the case of a restricted patient, multi-agency public protection arrangements (MAPPA)[1] co-ordinator
- in the case of a transferred prisoner, the probation service
- a representative of housing authorities, if accommodation is an issue
- an employment expert, if employment is an issue
- the clinical commissioning group's appointed clinical representative (if appropriate)
- an independent mental health advocate, if the patient has one
- an independent mental capacity advocate, if the patient has one
- the patient's attorney or deputy, if the patient has one
- a person to whom the local authority is considering making direct payments for the patient
- any another representative nominated by the patient, and
- anyone with authority under the Mental Capacity Act 2005 (MCA) to act on the patient's behalf.

The care plan

34.13 The care plan should set out the practicalities of how the patient will receive treatment, care and support from day-to-day, and should not place undue reliance on the patient's carers. Where needed, arrangements should be made for a second

[1] Guidance with Multi-agency Public Protection Arrangements (MAPPA). Ministry of Justice. 2014. https://www.gov.uk/government/publications/multi-agency-public-protection-arrangements-mappa--2 and paragraphs 22.87 – 22.92.

opinion appointed doctor (SOAD) to provide the part 4A certificate to enable treatment to be given (see paragraphs 25.26 – 25.32). If the patient so wishes, help should be given to access independent advocacy or other support where this is available (see chapter 6).

34.14 The care plan should be recorded in writing and a copy given to the patient. Once plans are agreed, it is essential that any changes are discussed with the patient as well as others involved with the patient before they are implemented.

34.15 The care plan should be regularly reviewed. It will be the responsibility of the care co-ordinator (or other officer responsible for its review) to arrange reviews of the plan until it is agreed between all parties, including the patient, that it is no longer necessary.

34.16 In particular, the care plan will need to be reviewed if the patient moves to another area. The care co-ordinator in the original area will be responsible for making transfer arrangements if commissioning responsibility consequently passes to authorities in the new area.

Care planning

34.17 The planning of after-care needs to start as soon as the patient is admitted to hospital. Clinical commissioning groups (CCGs) and local authorities should take reasonable steps to identify appropriate after-care services for patients in good time for their eventual discharge from hospital.

34.18 The professionals concerned should, in discussion with the patient, establish an agreed outline of the patient's needs and agree a timescale for the implementation of the various aspects of the plan. All key people with specific responsibilities with regard to the patient should be properly identified.

34.19 Care planning requires a thorough assessment of the patient's needs and wishes. It is likely to involve consideration of:

- continuing mental healthcare, whether in the community or on an outpatient basis
- the psychological needs of the patient and, where appropriate, of their carers
- physical healthcare
- daytime activities or employment
- appropriate accommodation
- identified risks and safety issues
- any specific needs arising from, eg co-existing physical disability, sensory impairment, learning disability or autistic spectrum disorder
- any specific needs arising from drug, alcohol or substance misuse (if relevant)
- any parenting or caring needs

- social, cultural or spiritual needs
- counselling and personal support
- assistance in welfare rights and managing finances
- involvement of authorities and agencies in a different area, if the patient is not going to live locally
- the involvement of other agencies, eg the probation service or voluntary organisations (if relevant)
- for a restricted patient, the conditions which the Secretary of State for Justice or the first-tier Tribunal has – or is likely to – impose on their conditional discharge, and
- contingency plans (should the patient's mental health deteriorate) and crisis contact details.

34.20 Care planning should take particular account of the patient's age.

- Where the patient is under the age of 18 the responsible clinician and the care co-ordinator should bear in mind that the most age-appropriate treatment should be that provided by a child and adolescent mental health service (CAMHS). It may also be necessary to involve the patient's parent, or whoever will be responsible for looking after the patient, to ensure that they will be ready and able to provide the assistance and support which the patient may need (see also paragraphs 19.6 – 19.10 and 19.90 – 19.104).
- Similarly, specialist services for older people may have a role in the delivery of services for older patients. Particular care should be taken to ensure that the concepts of participation and proportionality are applied to older patients.

34.21 Professionals with specialist expertise should also be involved in care planning for people with autistic spectrum disorders or learning disabilities.

34.22 It is important that those who are involved are able to take decisions regarding their own involvement and, as far as possible, that of their organisation. If approval for plans needs to be obtained from more senior levels, it is important that this causes no delay to the implementation of the care plan.

34.23 If accommodation is to be offered as part of the after-care plan to patients who are offenders, the circumstances of any victim of the patient's offence and their families should be taken into account when deciding where the accommodation should be offered. Where the patient is to live may be one of the conditions imposed by the Secretary of State for Justice or the Tribunal when conditionally discharging a restricted patient.

Patients from Wales placed in England

34.24 Local health boards and local authorities in Wales are under duties in the Mental Health (Wales) Measure 2010 to provide a care co-ordinator and a care and treatment plan for individuals for whom they are responsible for providing secondary mental health services (or who would be provided such services if the individuals co-operated) and patients under the guardianship of a local authority in Wales.

34.25 These statutory duties apply to patients who are placed in hospitals in England and who remain the responsibility of Welsh authorities. With agreement, this responsibility can be delegated to an eligible individual within the host organisation who can then become the care co-ordinator on behalf of the home authority.

34.26 The cross-border protocol[2] applies to the commissioning of secondary mental health services in England by Welsh authorities.

34.27 Under part 3 of the Mental Health (Wales) Measure, patients discharged from secondary mental health services in England who become resident in Wales can directly request a re-assessment of their mental state for up to three years from their date of discharge. A Code of Practice to parts 2 and 3[3] of the Measure has been published.

Related material

- Refocusing the Care Programme Approach: policy and positive practice Guidance. Department of Health. 2008. http://webarchive.nationalarchives.gov.uk/20130107105354/http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_083647
- Mental Health Act 1983. Code of Practice for Wales. Welsh Assembly Government. 2008. http://www.wales.nhs.uk/sites3/Documents/816/Mental%20Health%20Act%201983%20Code%20of%20Practice%20for%20Wales.pdf
  (The Welsh Government is currently reviewing this Code of Practice.)
- Information on Cross-Border Healthcare for the NHS in England and Wales. NHS England. http://www.england.nhs.uk/ourwork/part-rel/x-border-health/
- Code of Practice to Parts 2 and 3 of the Mental Health (Wales) Measure 2010. Welsh Government. 2012. http://www.assemblywales.org/bus-home/bus-business-fourth-assembly-laid-docs.htm?act=dis&id=232786&ds=4/2012
- Guidance with Multi-agency Public Protection Arrangements (MAPPA). Ministry of Justice. 2014. https://www.gov.uk/government/publications/multi-agency-public-protection-arrangements-mappa--2

This material does not from part of the Code. It is provided for assistance only.

[2] Information on Cross-Border Healthcare for the NHS in England and Wales. NHS England. http://www.england.nhs.uk/ourwork/part-rel/x-border-health/

[3] Code of Practice to Parts 2 and 3 of the Mental Health (Wales) Measure 2010. Welsh Government. 2012. http://www.assemblywales.org/bus-home/bus-business-fourth-assembly-laid-docs.htm?act=dis&id=232786&ds=4/2012

34

Professional responsibilities

Hospital managers, responsible clinicians and other professionals have specific responsibilities under the Act. This group of chapters provides guidance on responsibilities in relation to receiving and scrutinising documents, identifying a responsible clinician and the particular functions of hospital managers and their powers of discharge. Guidance is also provided on the circumstances that may constitute a conflict of interests that may prevent an approved mental health professional from making an application for a patient's detention or guardianship, and a doctor from making a recommendation supporting the application.

Victims of serious violence and sexual offences have specific rights in relation to specific information about a part 3 patient and may also engage with the Victims Contact Scheme. Guidance is given on the Victims' Code and on the rights of victims and the obligations placed on professionals and on the Secretary of State for Justice.

Chapter 35 Receipt and scrutiny of documents

Chapter 36 Allocating or changing a responsible clinician

Chapter 37 Functions of hospital managers

Chapter 38 Hospital managers' discharge power

Chapter 39 Conflicts of interest

Chapter 40 Information for victims

35 Receipt and scrutiny of documents

Why read this chapter?

35.1 This chapter provides guidance on the receipt and scrutiny of documents under the Act. This chapter distinguishes between receiving documents and scrutinising them, and provides guidance on delegation by hospital mangers.

Statutory forms

35.2 Regulations require specific statutory forms to be used for certain applications, recommendations, decisions, reports and records under the Act. The forms are set out in the regulations themselves.

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

Applications for detention in hospital and supporting medical recommendations

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

35.5 People who sign applications and make the supporting medical recommendations must take care to comply with the requirements of the Act. People who act on the authority of these documents should also make sure that they are in the proper form, as an incorrectly completed or indecipherable form may not constitute authority for a patient's detention.

35.6 This chapter distinguishes between receiving admission documents and scrutinising them. For these purposes, receipt involves physically receiving documents and checking that they appear to amount to an application that has been duly made (since that is sufficient to give the managers the power to detain the patient). Scrutiny involves more detailed checking for omissions, errors and other defects and, where permitted, taking action to have the documents rectified after they have already been acted on.

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

35.8 Hospitals should have a checklist for the guidance of people delegated to receive documents ('receiving officers'), to help them detect those errors which fundamentally invalidate an application and which cannot be corrected at a later stage in the procedure.

35.9 When a patient is being admitted on the application of an approved mental health professional (AMHP), the receiving officer should go through the documents and check their accuracy with the AMHP.

35.10 Receiving officers should have access to a manager for advice outside office hours, especially at night.

35.11 Where the receiving officer is not also authorised by the hospital managers to agree to the rectification of a defective admission document, the documents should be scrutinised by a person who is authorised to do so. This scrutiny should happen at the same time as the documents are received or as soon as possible afterwards (and certainly no later than the next working day).

35.12 Documents should be scrutinised for accuracy and completeness and to check that they do not reveal any failure to comply with the procedural requirements of the Act in respect of applications for detention. Medical recommendations should also be scrutinised by someone with appropriate clinical expertise to check that the reasons given appear sufficient to support the conclusions stated in them.

35.13 If admission documents reveal a defect which fundamentally invalidates the application and which cannot, therefore, be rectified under section 15 of the Act, the patient can no longer be detained on the basis of the application. Authority for the patient's detention can be obtained only through a new application (or, in the interim, by the use of the holding powers under section 5 if the patient has already been admitted to the hospital). Unless that authority is to be sought, the hospital managers should use their power under section 23 to discharge the patient. The patient should be informed both orally and in writing, and in an accessible format for the patient.

Guardianship applications and supporting medical recommendations

35.14 Where a guardianship application is made, the person receiving the documents on behalf of the local authority should check them for inaccuracies and defects with the AMHP or nearest relative making the application.

35.15 Local authorities should prepare a checklist for the guidance of those delegated to receive guardianship applications on their behalf. That checklist should identify those errors which can be rectified and those which cannot.

Community treatment orders – documentation

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

35.17 To avoid errors being made, hospital managers should ensure that responsible clinicians have access to advice about how the relevant forms should be completed and the opportunity (where practicable) to have them checked in advance by someone else familiar with what the Act requires.

Audit

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

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

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

36 Allocating or changing a responsible clinician

Why read this chapter?

36.1 This chapter deals with the identification of responsible clinicians for patients being assessed and treated under the Act, including on change of responsible clinician.

Allocating a responsible clinician

36.2 The responsible clinician is the approved clinician who will have overall responsibility for the patient's case.

36.3 Hospital managers should have local protocols in place for allocating responsible clinicians to patients. This is particularly important when patients move between hospitals or from the hospital to the community and vice versa. The protocols should:

- ensure that the patient's responsible clinician is the available approved clinician with the most appropriate expertise to meet the patient's main assessment and treatment needs
- ensure that it can be easily determined who a particular patient's responsible clinician is
- ensure that cover arrangements are in place when the responsible clinician is not available (eg during non-working hours, annual leave etc), and
- include a system for keeping the appropriateness of the responsible clinician under review.

36.4 To ensure that the most appropriate available approved clinician is allocated as the patient's responsible clinician, hospital managers should keep a register of approved clinicians to treat patients for whom they are responsible.

36.5 The selection of the appropriate responsible clinician should be based on the individual needs of the patient concerned. For example, where psychological therapies are central to the patient's treatment, it may be appropriate for a professional with particular expertise in this area to act as the responsible clinician.

36.6 Wherever possible, the clinician responsible for the care and treatment of children and young people should be a child and adolescent mental health services (CAMHS) specialist. (For further information please refer to chapter 19.)

36.7 Even if the patient's main treatment needs are not immediately clear, it will be necessary to allocate a responsible clinician promptly upon the patient's detention in hospital.

Change of responsible clinician

36.8 As the needs of the patient may change over time, it is important that the appropriateness of the responsible clinician is kept under review throughout the care planning process. It may be appropriate for the patient's responsible clinician to change during a period of care and treatment, if such a change enables the needs of the patient to be met more effectively. If the patient requests a change their reasons should be established to inform an appropriate response. In considering such a change it is also important to take account of the need for continuity and continuing engagement with, and knowledge of, the patient.

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

36.10 There may be circumstances where the responsible clinician is qualified with respect to the patient's main assessment and treatment needs but is not appropriately qualified to be in charge of a subsidiary treatment needed by the patient (eg medication which the responsible clinician is not qualified to prescribe). In such situations, the responsible clinician will maintain their overarching responsibility for the patient's case, but another appropriately qualified professional will take responsibility for a specific treatment or intervention.

36.11 Where the person in charge of a particular treatment is not the patient's responsible clinician, the person in charge of the treatment should ensure that the responsible clinician is kept informed about the treatment and that treatment decisions are discussed with the responsible clinician in the context of the patient's overall case. Guidance should be available locally on the procedures to follow, including when to seek a second opinion, if there are unresolved differences of opinion.

37 Functions of hospital managers

Why read this chapter?

37.1 This chapter gives guidance on the responsibilities of hospital managers under the Act, and on specific powers and duties not addressed in other chapters. It provides guidance on the identification of hospital managers, the exercise of hospital managers' functions and on specific powers and duties of hospital managers, including admission, transfer between hospitals, transfers to guardianship, transfer and assignment of responsibility for community treatment order (CTO) patients, information for patients and relatives, duties in respect of victims of crime, patients' correspondence and the duty to refer cases to Tribunals. It also provides guidance on the Secretary of State for Health's power to refer cases to a tribunal and hospital accommodation for children and young people.

Identification of hospital managers

37.2 In England, NHS hospitals are managed by NHS trusts and NHS foundation trusts. For these hospitals (including acute/non-mental health hospitals), the trusts themselves are defined as the 'hospital managers' for the purposes of the Act. In an independent hospital the person or persons in whose name the hospital is registered are the hospital managers.

37.3 Hospital managers have the authority to detain patients under the Act. They have the primary responsibility for seeing that the requirements of the Act are followed. In particular, they must ensure that patients are detained only as the Act allows, that their treatment and care accord fully with its provisions, and that they are fully informed of, and are supported in exercising, their statutory rights.

37.4 As managers of what the Act terms 'responsible hospitals', hospital managers have equivalent responsibilities towards CTO patients, even if those patients are not actually being treated at one of their hospitals.

37.5 In practice, most of the decisions of the hospital managers are actually taken by individuals (or groups of individuals) on their behalf. In particular, decisions about discharge from detention and CTOs are taken by panels of people (managers' panels) specifically selected for the role.

37.6 In this chapter, unless otherwise stated, 'hospital managers' includes anyone authorised to take decisions on their behalf, except managers' panels.

Exercise of hospital managers' functions

37.7 Special rules apply to the exercise of hospital managers' power to discharge patients from detention or CTOs. In broad terms, this power can be delegated only to managers' panels made up of people (sometimes called associate hospital managers) appointed specifically for the purpose who are not officers or employees of the organisation concerned. For guidance on these powers see chapter 38.

37.8 Otherwise, hospital managers (meaning the organisation, or individual, in charge of the hospital) may arrange for their functions to be carried out, day-to-day, by particular people on their behalf. In some cases, regulations say they must do so.

37.9 The arrangements for who is authorised to take which decisions should be set out in a scheme of delegation. If the hospital managers are an organisation, that scheme of delegation should be approved by a resolution of the body itself. Unless the Act or the regulations say otherwise, organisations may delegate their functions under the Act to any one and in any way that their constitution or, in the case of NHS providers or NHS commissioners, NHS legislation allows them to delegate their other functions.

37.10 Organisations (or individuals) in charge of hospitals retain responsibility for the performance of all hospital managers' functions exercised on their behalf and must ensure that the people acting on their behalf are competent to do so.

37.11 The organisation (or individual) concerned should put in place appropriate governance arrangements to monitor and review the way that functions under the Act are exercised on its behalf. Many organisations establish a Mental Health Act steering or scrutiny group especially for that task, and whilst recognising that the Act is a legal framework for the delivery of care, also monitor and review via clinically-focussed forums. Ideally, such forums should have representation from the Board or registered manager.

37 Specific powers and duties of hospital managers

Admission

37.12 It is the hospital managers' responsibility to ensure that the authority for detaining patients is valid and that any relevant admission documents are in order. A copy of the report made by the approved mental health professional (AMHP) should also be obtained. Hospital managers should have a clear system in place for notifying local authorities when the patient is a child or young person. For guidance on the receipt, scrutiny and rectification of documents see chapter 35.

37.13 Where a patient is admitted under the Act on the basis of an application by their nearest relative, the hospital managers must request the relevant local authority to provide them with the social circumstances report required by section 14.

Information about independent mental health advocates (IMHAs)

37.14 Hospital managers are required to take such steps as are practicable to ensure that community patients and certain patients who are liable to be detained understand that help is available from an IMHA and how to obtain that help. The hospital manager must give the patient this information (both orally and in writing) as soon as practicable after the patient becomes liable to be detained or becomes a community patient (as the case may be). IMHAs have a particularly important role in ensuring that children and young people understand, and are able to exercise, their rights under the Act (see chapter 6).

37.15 If a patient lacks capacity to decide whether or not to obtain help from an IMHA, the hospital manager should ask an IMHA to attend the patient so that the IMHA can explain what they can offer to the patient directly. Hospital managers should ensure that procedures are in place to allow the patient's nearest relative, responsible clinician or AMHP to ask an IMHA to attend.

Transfer between hospitals

37.16 The Act allows hospital managers to authorise the transfer of most detained patients from one hospital to another in accordance with the regulations. For restricted patients, the consent of the Secretary of State for Justice is also required (see paragraphs 22.25 – 22.29). Decisions on transfers may be delegated to an officer via a scheme of delegation described in 37.9 above, who could (but need not be) the patient's responsible clinician.

37.17 A hospital manager does not have the power to insist that another hospital accepts a patient, nor to insist that a proposed new placement is funded by a clinical commissioning group (CCG) or anyone else. Decisions about funding should be taken in the same way as for any other patient.

37.18 People authorising transfers on the hospital managers' behalf should ensure that there are good reasons for the transfer and that the needs and interests of the patient have been considered. Transfers are potentially an interference with a patient's right to respect for privacy and family life under article 8 of the European Convention on Human Rights (ECHR), and care should be taken to act compatibly with the ECHR when deciding whether to authorise a transfer.

37.19 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, or to move the patient closer to home. In some cases, a transfer may be unavoidable, because the hospital is no longer able to offer the care that the patient needs.

37.20 Wherever practicable, patients should be involved in the process leading to any decision to transfer them to another hospital. It is important to explain the reasons for a proposed transfer to the patient and, where appropriate, their nearest relative and carers. The reasons should be recorded. Only in exceptional circumstances should patients be transferred to another hospital without warning.

37.21 Among the factors that need to be considered when deciding whether to transfer a patient are:

- whether the transfer would give the patient greater access to carers, or have the opposite effect
- what effect a transfer is likely to have on the course of the patient's disorder or their recovery
- the availability of appropriate beds at the potential receiving hospital, and
- whether a transfer would be appropriate to enable the patient to be in a more culturally suitable or compatible environment, or whether it would have the opposite effect.

37.22 In the case of transfers to high security psychiatric hospitals, unless the circumstances are urgent or there would be clinical risks to the patient or others or there is some other significant reason to make it inadvisable, the relevant hospital managers should:

- give the patient and/or their representative sufficient information and opportunity to make written representations to the admissions panel of the receiving hospital. At a minimum this will be a summary (if the documents are not provided) of:
- the letter of reference from the hospital that wishes to transfer the patient to the high security hospital
- the assessment by the clinician from the high security hospital; and any other accompanying reports and/or documents the hospital managers think should be shared in the interests of fairness, and
- if the assessing doctor is invited to attend the deliberations of the admissions panel, the hospital should consider whether the patient and/or their representative should be invited to attend or be represented at those deliberations.

37.23 Detained patients may themselves want a transfer to another hospital for example, to be nearer their family or friends. Or they may have a reasonable wish to be treated by a different clinical team, which could only be met by a transfer.

37.24 The professionals involved in their care should always be prepared to discuss the possibility of a transfer, and should raise the issue themselves with the patient if they think the patient might be interested in, or benefit from, a transfer.

37.25 Requests made by, or on behalf of, patients should be recorded and given careful consideration. Every effort should be made to meet the patient's wishes. If that cannot be done, the patient (or the person who made the request on the patient's behalf) should be given a written statement of the decision and the reasons for it.

37.26 It is not a statutory requirement to have a nearest relative's consent to transfer. However unless the patient objects, the patient's nearest relative should normally be consulted before a patient is transferred to another hospital, and, in accordance with the regulations, they must normally be notified of the transfer as soon as practicable after the decision is made.

37.27 When a patient is transferred, the documents authorising detention, including the authority for transfer, any original AMHP reports, risk reports, Tribunal information, care plans and other relevant information should be sent to the hospital to which the patient is transferred. The transferring hospital should retain copies of these documents.

Transfers to guardianship

37.28 Regulations allow hospital managers to authorise the transfer of most detained patients into guardianship instead, with the agreement of the relevant local authority. This is an administrative procedure which avoids the more formal alternative of discharging the patient under detention under the Act and making a fresh application to place them under guardianship. This decision may be delegated to officers, including the patient's responsible clinician.

37.29 As with transfers between hospitals, people taking decisions on behalf of hospital managers and local authorities should ensure that there are good reasons for any transfer and that that the needs and interests of the patient have been considered.

Transfer and assignment of responsibility for CTO patients

37.30 The managers of a hospital to which a CTO patient has been recalled may authorise the patient's transfer to another hospital during the 72-hour maximum period of recall. These decisions may be delegated in the same way as other transfer decisions described above. The people exercising this power on the managers' behalf must ensure that the needs and interests of the patient are considered before a transfer is authorised, in the same way as when considering the transfer of a detained patient.

37.31 The hospital managers may also reassign responsibility for CTO patients so that a different hospital will become the patient's responsible hospital. The same considerations apply.

Information for patients and carers

37.32 Sections 132, 132A and 133 of the Act and regulations require hospital managers to arrange for detained patients, CTO patients and (where relevant) their nearest relatives, to be given important information about the way the Act works and about their rights. For further guidance on the exercise of these duties see chapter 4 regarding children and young people, and chapter 19. If the nearest relative is not the carer, the carer should also receive this information.

37.33 Section 130D of the Act also imposes a duty on hospital managers to take such steps as are practicable to ensure that every patient understands that help is available from an IMHA.

Duties in respect of victims of crime

37.34 The Domestic Violence, Crime and Victims Act 2004 (DVCVA) as amended by the Mental Health Act 2007 places a number of duties on hospital managers in relation to certain unrestricted part 3 patients who have committed sexual or violent crimes.[1] This includes ensuring the following information is communicated to victims:

- whether a CTO is to be made, including allowing the victim to make representations on the need for a CTO (and forwarding these to people responsible for making decisions on discharge), including allowing representations about the conditions attached to the CTO
- any conditions on the CTO relating to the victim or their family, and any variation of the conditions
- when the CTO ceases
- when authority to detain the patient expires
- when the part 3 patient is discharged, including allowing the victim to make representations about discharge conditions, and
- what conditions of discharge relate to the victim, and when these cease.

37.35 These duties complement similar arrangements for restricted part 3 patients, which are managed by the probation service rather than hospital managers.

37.36 Details on support for victims is also included in chapter 40.

[1] Domestic Violence, Crime and Victims Act 2004. http://www.legislation.gov.uk/ukpga/2004/28/contents
See also Mental Health Act 2007: Guidance on the extension of victims' rights under the Domestic Violence, Crime and Victims Act 2004. Department of Health and Ministry of Justice. 2008. http://webarchive.nationalarchives.gov.uk/20130107105354/http:/www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_089407.pdf

Patients' correspondence

37.37 Section 134 allows hospital managers to withhold outgoing post from detained patients if the person to whom it is addressed has made a written request to the hospital managers, the approved clinician with overall responsibility for the patient's case or the Secretary of State that post from the patient in question should be withheld. The fact that post has been withheld must be recorded in writing by an officer authorised by the hospital managers as indicated in the scheme of delegation (see paragraph 37.9 above), and the patient must be informed in accordance with the regulations. Except in high-security psychiatric hospitals, post should not be opened or inspected unless section 134 applies.

37.38 The managers of high-security psychiatric hospitals have wider powers under section 134 to withhold both incoming and outgoing post from patients in certain circumstances.[2] Their decisions are subject to review by the Care Quality Commission (CQC). The hospital managers of high-security psychiatric hospitals should have a written policy for the exercise of these powers, which also implement requirements in regulations for patients to be given notice within seven days when post is withheld and notified of their right to ask the CQC to review the decisions taken.[3]

Duty to refer cases to Tribunals

37.39 Hospital managers are under a duty to refer a patient's case to the Tribunal in the circumstances set out in section 68 of the Act, summarised in figure 20. Children and young people who are detained under the Act have the same rights as other patients to apply to the Tribunal and further guidance can be found in chapter 19.

[2] The Secretary of State for Health issued directions requiring the managers of these hospitals to take similar action in respect of correspondence between patients within the hospital, phone calls and items brought in for patients from outside.
See https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/268545/HSH_Directions_Signed__2_.pdf

[3] See sections 134 and 134A of the Act, and regulation 29 of the Mental Health (Hospital, Guardianship and Treatment) (England) Regulations 2008. S.I. 2008/1184.

Figure 20: Hospital managers' duties to refer cases to the Tribunal

Hospital managers must refer the following patients	When
Patients who are detained under part 2 of the Act, and patients who were detained under part 2 but are now CTO patients	Six months have passed since they were first detained, unless: • the patient applied to the Tribunal themselves after they became a section 3 patient • the patient's nearest relative applied to the Tribunal after the responsible clinician barred the nearest relative's order to discharge a section 3 patient • the patient's displaced nearest relative has applied to the Tribunal after the displacement order is made • the patient's case was referred to the Tribunal by the Secretary of State for Health after the patient became a section 3 patient, or • the managers have already referred the patient's case to the Tribunal because their community treatment order was revoked (see below). (If the patient is still a section 2 patient, pending the outcome of an application to the county court for a change in their nearest relative, there are no exceptions)
Patients who are detained under part 2 of the Act, or were detained under part 2 but are now CTO patients	Three years have passed since their case was last considered by the Tribunal (one year if they are under 18)
People who were CTO patients but whose CTOs have been revoked	As soon as practicable after the responsible clinician revokes the CTO
Patient was transferred from guardianship to a hospital Patients detained under hospital orders, hospital directions or transfer directions under part 3 of the Act without being subject to special restrictions (collectively, unrestricted part 3 patients), or who were detained under part 3 of the Act but are now CTO patients	Six months have passed, unless the patient has already applied to the Tribunal after being transferred from guardianship to a hospital Three years have passed without their case being considered by the Tribunal (one year if they are under 18)

Note: for these purposes:

- detention under part 2 of the Act does not include any time spent detained under the 'holding powers' in section 5 (see chapter 18), and
- applications to the Tribunal do not count if they are withdrawn before they are determined.

37.40 Hospitals will be able to comply properly with these duties only if they maintain full and accurate records about:

- the detention and discharge of the patients for whom they are responsible
- applications made by those patients to the Tribunal, and
- applications and references to the Tribunal made by other people in respect of those patients.

37.41 Hospital managers should ensure that they have systems in place to alert them (or the officers to whom the function is delegated) in good time to the need to make a reference. Officers exercising this function for the managers should be familiar with the relevant requirements of the Tribunal itself and the procedural rules by which it operates.

37.42 When hospital managers are required to refer the case of a patient whose CTO is revoked to the Tribunal, this must be done as soon as possible after the CTO is revoked.

37.43 Hospital managers should from time to time audit the timeliness with which they comply with their duties to refer patients to the Tribunal.

References by the Secretary of State for Health

37.44 The Secretary of State for Health may at any time refer the case of most detained patients, and all CTO patients, to the Tribunal. Anyone may request such a reference, and the Secretary of State will consider all such requests on their merits. See chapter 19 for further information regarding children and young people.

37.45 Hospital managers should consider asking the Secretary of State to make a reference in respect of any patients whose rights under article 5(4) of the ECHR might otherwise be at risk of being violated because they are unable (for whatever reason) to have their cases considered by the Tribunal speedily following their initial detention or at reasonable intervals afterwards.

37.46 In particular, they should normally seek such a reference in any case where:

- a patient's detention under section 2 has been extended under section 29 of the Act pending the outcome of an application to the county court for the displacement of their nearest relative
- the patient lacks the capacity to request a reference, or
- either the patient's case has never been considered by the Tribunal, or a significant period has passed since it was last considered.

Hospital accommodation for children and young people

37.47 Section 131A of the Act puts a duty on hospital managers to ensure that any children or young people aged under 18 receiving in-patient care for mental disorder in their hospitals are accommodated in an environment which is suitable for their age (subject to their needs) (see paragraphs 19.90 – 19.103). The duty applies to children and young people admitted informally to hospitals, as well as those detained under the Act.

Related material

- The Code of Practice for Victims of Crime. Ministry of Justice. 2013. A range of supporting materials can be found at: https://www.gov.uk/government/publications/the-code-of-practice-for-victims-of-crime
- Guidance for Clinicians: duties to victims under the domestic violence, crime and victims Act 2004. Home Office Mental Health Unit. 2005.
- The High Security Psychiatric Services (Arrangements for Safety and Security) Directions. 2013. https://www.gov.uk/government/publications/high-security-psychiatric-services-directions
- Guidance on the High Security Psychiatric Services (Arrangements for Safety and Security) Directions. 2013. https://www.gov.uk/government/publications/high-security-psychiatric-services-directions
- Mental Health Act 2007: Guidance on the extension of victims' rights under the Domestic Violence, Crime and Victims Act 2004. Department of Health and Ministry of Justice. 2008. http://webarchive.nationalarchives.gov.uk/20130107105354/http:/www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_089407.pdf

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38 Hospital managers' discharge power

Why read this chapter?

38.1 Hospital managers have the power to discharge most detained patients and all patients subject to a community treatment order (CTO). This chapter provides guidance on the exercise of these powers. It includes matters relating to when to review detention or a CTO, the criteria to be applied, the procedure for reviewing detention or a CTO, how to conduct reviews where the detention or CTO is contested, uncontested renewals, and recording the reasons for a decision.

The power to discharge

38.2 Section 23 of the Act gives hospital managers the power to discharge most detained patients and all CTO patients. They may not discharge patients who are held under the section 5 holding powers or in a place of safety under sections 135 or 136 or those remanded to hospital under sections 35 or 36 of the Act or subject to interim hospital orders under section 38, and they may not discharge restricted patients without the consent of the Secretary of State for Justice.

Exercise of power of discharge

38.3 The hospital managers – meaning the organisation or individual in charge of the hospital – must either consider discharge themselves or arrange for their power to be exercised on their behalf by a 'managers' panel'.

38.4 A managers' panel may consist of three or more people who are:

- members of the organisation in charge of the provider (eg the chair or non-executive directors), or
- members of a committee or sub-committee which is authorised for the purpose.

38.5 In the case of an NHS foundation trust, a panel can consist of any three or more people appointed for the purpose by the trust whether or not they are members of the trust itself or any of its committees or sub-committees.

38.6 In NHS trusts and NHS foundation trusts none of the people on managers' panels may be employees of the body concerned (or executive directors of the boards of NHS foundation trusts). People do not become employees or officers simply because they are paid a fee for serving on managers' panels.

38.7 In independent hospitals, managers' panels should not include people who are on the staff of the hospital or who have a financial interest in it.

38.8 In all cases, the board (or the equivalent) of the organisation concerned should ensure that the people appointed properly understand their role and the working of the Act. The organisation should ensure that people appointed to a managers' panel receive suitable training to understand the law, work with patients and professionals, to be able to reach sound judgements and properly record their decisions. This should include training or development in understanding risk assessment and risk management reports, and the need to consider the views of patients, and if the patient agrees, their nearest relative, and if different, carer.

38.9 Appointments to managers' panels should be made for a fixed period. Reappointment (if permitted) should not be automatic and should be preceded by a review of the person's continuing suitability.

38.10 Hospital managers should ensure that they and the hospital managers' panel understand equality issues and that there are sufficient numbers of panel members with a specialised understanding of the specific needs of particular groups including those listed below, and that panel members can communicate effectively with them:

- patients from minority cultural or ethnic backgrounds
- patients with physical impairments and/or sensory impairments, and/or
- patients with learning disabilities and/or autistic spectrum disorders.

Reviewing detention or a CTO

38.11 Hospital managers should ensure that all relevant patients, and their nearest relative and, if different carer, are aware that the patient may ask to be discharged by the hospital managers and of the distinction between this and their right to apply for a Tribunal hearing (see chapter 12). Hospital managers should ensure that the appropriate level of support is provided to help the patient understand this right and distinction. This is particularly important if the patient is a child or young person or an individual who has communication difficulties or limited capacity.

38.12 Hospital managers:

- may undertake a review of whether or not a patient should be discharged at any time at their discretion
- must undertake a review if the patient's responsible clinician submits a report to them under section 20 of the Act renewing detention or under section 20A extending the CTO
- should consider holding a review when they receive a request from a patient (who may be supported by their independent mental health advocate (IMHA) (see chapter 6), independent mental capacity advocate (IMCA), attorney or deputy (see chapter 7) or a carer, and

- should consider holding a review when the responsible clinician makes a report to them under section 25 barring an order by the nearest relative to discharge a patient.

38.13 In the last two cases, when deciding whether to consider the case, hospital managers are entitled to take into account whether the Tribunal has recently considered the patient's case or is due to do so in the near future. The decision should be recorded in writing and if the decision is taken not to consider the case the reasons documented.

38.14 Before the current period of detention or the CTO ends, it is desirable that a managers' panel considers a report made under section 20 or section 20A and decides whether to exercise its discharge power. However, the responsible clinician's report itself provides authority for the patient's continued detention or period on a CTO, even if a managers' panel has not yet considered the case or reached a decision.

Criteria to be applied

38.15 The Act does not define specific criteria to be used by hospital managers when considering discharge. The essential consideration is whether the grounds for continued detention or continued CTO under the Act are satisfied. To ensure that this is done in a systematic and consistent way, managers' panels should consider the questions set out below, in the order stated.

38.16 For patients detained for assessment under sections 2 or 4 of the Act:

- Is the patient still suffering from mental disorder?
- If so, is the disorder of a nature or degree that warrants the continued detention of the patient in hospital?
- Ought the detention to continue in the interests of the patient's health or safety or for the protection of other people?

38.17 For other detained patients:

- Is the patient still suffering from mental disorder?
- If so, is the disorder of a nature or degree that makes treatment in a hospital appropriate?
- Is continued detention for medical treatment necessary for the patient's health or safety or for the protection of other people?
- Is appropriate medical treatment available for the patient?
- Consideration should also be given to whether the Mental Capacity Act 2005 can be used to treat the patient safely and effectively.

38.18 For patients on a CTO:

- Is the patient still suffering from mental disorder?
- If so, is the disorder of a nature or degree that makes it appropriate for the patient to receive medical treatment?
- If so, is it necessary in the interests of the patient's health or safety or the protection of other persons that the patient should receive such treatment?
- Is it still necessary for the responsible clinician to be able to exercise the power to recall the patient to hospital, if that is needed? (For example, if a patient has been on a CTO for an extended period without the need to exercise the power to recall, it may not be appropriate to continue on a CTO)
- Is appropriate medical treatment available for the patient?

38.19 If three or more members of the panel (who between them make up a majority) are satisfied from the evidence presented to them that the answer to any of the questions set out above is 'no', the patient should be discharged. If so, where a patient lacks capacity to decide where to live, the hospital managers may request that consideration be given to making a deprivation of liberty authorisation or a deprivation of liberty order.

38.20 Where the answer to all the relevant questions above is 'yes', but the responsible clinician has made a report under section 25 barring a nearest relative's attempt to discharge the patient, the panel should also consider the following question:

- Would the patient, if discharged, be likely to act in a manner that is dangerous to other persons or to themselves?

38.21 This last question provides a more stringent test for continuing the detention or the CTO (see chapter 29).

38.22 If three or more members of the panel (being a majority) disagree with the responsible clinician and decide that the answer to this question is 'no', the panel should usually discharge the patient. The hospital managers retain a residual discretion not to discharge in these cases, so panels should always consider whether there are exceptional reasons why the patient should not be discharged.

38.23 In all cases, hospital managers have discretion to discharge patients even if the criteria for continued detention or a CTO are met. Managers' panels should always consider whether there are other reasons why the patient should be discharged despite the answers to the questions set out above; regard should be had to the principle of least restrictive option and maximising independence (see paragraphs 1.2 – 1.6).

Procedure for reviewing detention or a CTO

38.24 The Act does not define the procedure for reviewing a patient's detention or a CTO. However, the exercise of this power is subject to the general law and to public law duties that arise from it. Hospital managers' conduct of reviews must satisfy the fundamental legal requirements of fairness, reasonableness and lawfulness. Hospital managers' panels should:

- adopt and apply a procedure which is fair and reasonable
- not make irrational decisions – that is, decisions which no managers' panel, properly directing itself as to the law and on the available information, could have made, and
- not act unlawfully – that is, contrary to the provisions of the Act and any other legislation (including the Human Rights Act 1998 (HRA) and the Equality Act 2010 – for further details see chapter 3).

38.25 Hospital managers should have a process in place that seeks to involve the patient, their nearest relative and, if different, carer, including at the hearing, and in doing so, should have regard to the empowerment and involvement principle. This should include offering the patient information and advice on the review process, supporting them to fully participate and ensuring that, wherever practicable, hearings are scheduled in consultation with the patient so that any representative of the patient and others supporting them may attend. Patients and their representatives should be given reasonable notice of when a hearing will take place and arrangements put in place to enable them to be fully involved.

Conduct of reviews where detention or CTO is contested

38.26 Reviews should be conducted in such a way as to ensure that the case for continuing the patient's detention or CTO is properly considered against the questions set out above and in the light of all the relevant evidence. This means that managers' panels need to have before them sufficient information about the patient's past history of care and treatment, and details of any future plans. The main source of this is likely to be the patient's documentation and care plan under the care programme approach (CPA) (or its equivalent) (see paragraphs 34.13 – 34.16). It is essential that panels are fully informed about any history of violence or self-harm and that a recent risk assessment and/or risk management plan is provided to the panel.

38.27 Hospital managers should ensure that mechanisms are in place so that, in advance of the hearing, managers' panels are provided with written reports from the patient's responsible clinician and from other key individuals directly involved in the patient's care as appropriate, such as the patient's care co-ordinator, named nurse, social worker, occupational therapist or clinical psychologist.

38.28 The patient should be provided with copies of the reports as soon as they are available, unless (in the light of any recommendation made by their authors) panels are of the opinion that disclosing the information would be likely to cause serious harm to the physical or mental health of the patient or any other individual. The patient's legal or other representative (such as their donee or deputy), including their IMHA, and, if the patient agrees, their nearest relative and, if different, carer should receive copies of these reports.

38.29 Reports should be provided in good time so that patients and their representatives can consider them and, where relevant, draw the panel's attention to any apparent inaccuracies. Any decision to withhold a report (in whole or part) should be recorded, with reasons.

38.30 The nearest relative should normally be informed when managers' panels are to consider a patient's case, unless the patient objects, subject to the normal considerations about involving nearest relatives (see paragraphs 4.31 – 4.36).

38.31 Panels should be prepared to consider the views of the patient's relatives and carers, and other people who know the patient well, either at the patient's request or where such people offer their views on their own initiative. Carers and any other relevant people may be invited to put their views to the managers' panel in person or in writing. If the patient objects to this, a suitable member of the professional care team should be asked to include the person's views in their report.

38.32 The report submitted by the responsible clinician should be in a similar format to those provided for Tribunals and cover the history of the patient's care and treatment and details of their care plan, including all risk assessments. Where the review is being held because the responsible clinician has made a report under section 20, 20A or 21B renewing detention or extending the CTO, panels should also have a copy of the report itself before them. This should be supplemented by a record of the consultation undertaken by the responsible clinician in accordance with those sections before making the report. The written reports should be considered by the panel alongside documentation compiled under the CPA (or its equivalent).

38.33 Where relevant, panels should also have in front of them any order made by the responsible clinician under section 25 barring a patient's discharge by their nearest relative.

38.34 The procedure for the conduct of any hearing is for managers' panels themselves to decide, but generally it needs to balance informality against the rigour demanded by the importance of the task, as this promotes the empowerment and involvement principle (see paragraphs 1.7 – 1.12). Key points are:

- the patient should be given a full opportunity, and any necessary help, eg from an IMHA, to explain why they should no longer be detained or on a CTO

- the patient should be allowed to be accompanied by a representative of their own choosing to help in putting their point of view to the panel. If the patient lacks capacity to put their point of view, their deputy, attorney or other representative of their choosing should be allowed to represent them
- the patient should also be allowed to have a relative, friend, carer, deputy, attorney or advocate attend to support them, and
- the responsible clinician and other professionals should be asked to give their views on whether the patient's continued detention or a CTO is justified and to explain the grounds on which those views are based.

38.35 It is for hospital managers themselves to decide where hearings should take place, but that decisions should take into account what is in the best interests of the patient. For CTO patients, and patients currently on leave of absence from hospital, the hospital itself may not be the most convenient or acceptable place for the patient. Hospital managers should be prepared to consider whether there are more appropriate locations it would be feasible to use.

38.36 The patient and the other people giving views to the panel should, if the patient wishes, be able to hear each other's statements to the panel and to put questions to each other, unless the panel believes that would be likely to cause serious harm to the physical or mental health of the patient or any other individual. Unless, exceptionally, it is considered too unsafe, patients should always be offered the opportunity of speaking to the panel alone (with or without their representative and anyone else they have asked to attend to support them at the hearing).

38.37 Member of managers' panels will not normally be qualified to form clinical assessments of their own. They should give full weight to all the evidence in relation to the patient's care. If there is a divergence of views among the professionals about whether the patient meets the clinical grounds for continued detention or CTO, managers' panels should reach an independent judgement based on the evidence that they hear. Regard should be had to the least restrictive option and maximising independence principle (see paragraphs 1.2 – 1.6). In some cases, it might be necessary to consider adjourning to seek further medical or other professional advice.

38.38 In considering the questions set out earlier in this chapter and in the light of them deciding whether or not to discharge the patient from detention, managers' panels need to consider very carefully the implications for the patient's subsequent care. Before a managers' panel considers a case, the responsible clinician, in consultation with the multi-disciplinary team, should have considered what services and other arrangements might be put in place for the patient if discharged and whether those arrangements would be sufficient to make it no longer necessary to continue detention or the CTO (as the case may be).

38.39 The presence or absence of adequate community care arrangements, including a deprivation of liberty authorisation or Court of Protection order may be critical in deciding whether continued detention (in particular) is necessary. If managers' panels believe they have not been provided with sufficient information about arrangements that could be made were the patient discharged, they should consider adjourning and request further information.

38.40 If panels conclude that the patient ought to be discharged, but practical steps to put after-care in place (chapter 33), or obtain a deprivation of liberty authorisation or a Court of Protection order, need to be taken first, they may adjourn the panel for a brief period to enable that to happen before formally discharging the patient. Professionals should work together to minimise the time it takes to do this.

Uncontested renewals

38.41 If a patient's detention is renewed or their CTO is extended by their responsible clinician, the hospital managers must always decide whether the patient should be discharged anyway, even if the patient has indicated that they do not wish to challenge the renewal or extension. This applies in all cases, but particularly where the patient lacks capacity.

38.42 Hospital mangers and managers' panels should apply as much rigour to considering uncontested cases as to contested ones to ensure that the least restrictive option and maximising independence principle is being applied and those decisions are only being made on the basis of the statutory criteria.

38.43 It is good practice to follow the same procedures to conduct reviews in uncontested cases as in contested cases. If hospital managers decide to adopt a different procedure (eg a paper based review) in a particular uncontested case this should be documented with the reasons for this recorded.

38.44 Where a different procedure is used patients should be offered the opportunity to be interviewed by at least one member of the managers' panel considering their case.

38.45 Hospital managers may consider the case based on the papers, if they wish (sometimes referred to as a 'paper review'). They should hold a full hearing if they have reason to suspect that the patient may, in fact, want to contest, or there are prima facie grounds to think that the statutory grounds to renew detention or extend the CTO are not met. This is particularly important if the patient lacks capacity. The fact that patients have not said they object to the renewal or extension should not be taken as evidence that they agree with it, or that it is the correct decision.

38.46 In deciding whether or not to review the case on the papers, hospital managers should consider if previous reviews during the current period of compulsory powers have been 'paper reviews'.

Decisions

38.47 Hospital managers have a common law duty to give reasons for their decisions. The decisions of managers' panels, and the reasons for them, should be fully recorded at the end of each review. The decision should be communicated as soon as practicable, both orally and in writing, to the patient and their representative, to the nearest relative and, if different, carer (where relevant), and to the professionals concerned.

38.48 If the patient is not to be discharged, where practicable at least one member of the panel should offer to see the patient (or their representative) to explain in person the reasons for the decision. The formal record of the decision and reasons should be shared with the patient, and copies of the papers relating to the review should be kept in the patient's notes.

38.49 Following the hearing, hospital managers should ensure that patients are offered an opportunity to discuss the hearing and informed of their rights to be considered for discharge by the Tribunal (paragraphs 4.21 – 4.24).

Not holding a review before detention expires

38.50 If a responsible clinician or the hospital manager, as appropriate, does not hold a review before the period of detention or CTO expires, this should be considered a very serious matter that should be urgently reviewed (see paragraphs 32.10). The hospital managers should have processes in place to ensure that this does not happen. The reasons for the review not having been taken place and the actions put in place to stop this happening again should be fully documented.

39 Conflicts of interest

Why read this chapter?

39.1 Conflicts of interest may arise which prevent an approved mental health professional from making an application for a patient's detention or guardianship, and a doctor from making a recommendation supporting the application. This chapter provides guidance on the circumstances that constitute a conflict of interest. These may be financial, business, professional or personal.

Conflict of interest regulations

39.2 The Mental Health (Conflict of Interest) (England) Regulations 2008 set out the circumstances in which a potential conflict of interest prevents an approved mental health professional (AMHP) from making an application for a patient's detention or guardianship and a doctor from making a recommendation supporting the application. AMHPs and these doctors are jointly referred to as 'assessors' in this chapter.

39.3 These potential conflicts of interest may concern the relationship of AMHPs and doctors to each other, to the patient, to the nearest relative or to the hospital where the patient is to be admitted. They concern potential conflicts of interest for financial, business, professional and personal reasons.

Financial conflict

39.4 The current regulations[1] require that where the patient is to be admitted to an independent hospital and the doctor providing one of the medical recommendations is on the staff of that independent hospital, the other medical recommendation must be given by a doctor who is not on the staff of that independent hospital. That is, there will be a potential conflict if both doctors giving recommendations are on the staff of the independent hospital. It is also good practice for doctors on the staff of an NHS trust or NHS foundation trust to ensure that one of the recommendations is given by a doctor not on the staff of that trust.

39.5 It may be beneficial for providers (NHS trusts, foundation trusts and the independent sector) in close proximity to organise a list of doctors who are available to provide a second recommendation.

[1] The Mental Health (Conflicts of Interest) (England) Regulations. 2008. SI 2008/1205. http://www.legislation.gov.uk/uksi/2008/1205/contents/made

39.6 An assessor will have a conflict of interest for financial reasons if the assessor stands to make a financial benefit (or loss) for their decision. There will not be a potential conflict of interest for financial reasons where an assessor is paid a fee for making an application or giving a medical recommendation if it is paid regardless of the outcome of the assessment.

39.7 An assessor will have a potential conflict of interest if both that assessor and one of the other assessors, the patient or the nearest relative (if the nearest relative is the applicant) are closely involved in the same business venture. Being 'closely involved' is not defined in the regulations. Examples could include being a partner in a partnership, being a director or other office-holder of a company, or being a major shareholder in it. This will apply even if the business venture is not associated with the provision of services for the care and treatment of persons with a mental disorder.

39.8 Business ventures include any form of commercial enterprise from which the person concerned stands to profit. Such people include: directors and major investors in a company (of any size) which provides goods or services for profit; partners in a general practitioner (GP) practice; partners in a business established as a limited liability partnership. Involvement in a business venture does not include involvement in societies and similar organisations which are essentially non-commercial, and from which the people concerned do not stand to profit.

Professional conflict

39.9 Regulations set out that a conflict of interest for professional reasons will occur where:

- the assessor is in a line management or employment relationship with one of the other assessors or the patient or the nearest relative (where the nearest relative is the applicant)
- the assessor is a member of the same team as the patient, or
- where there are three assessors, all of them are members of the same team.

39.10 A line management relationship will exist whether an assessor manages, or is managed by, one of the other assessors, the patient or the nearest relative (where the nearest relative is the applicant). Similarly an employment relationship will exist whether the assessor employs, or is employed by, one of the other assessors, the patient or the nearest relative (where the nearest relative is the applicant).

39.11 For the purposes of the regulations a team is defined as a group of professionals who work together for clinical purposes on a routine basis. That might include a community mental health team, a crisis resolution or home treatment team, or staff on an in-patient unit (but not necessarily the staff of an entire hospital).

Urgent necessity

39.12 If there is a case of urgent necessity all three assessors may be from the same team. However, this should happen only in a genuine emergency, where the patient's need for urgent assessment outweighs the desirability of waiting for another assessor who has no potential conflict of interest. Any decisions made to proceed despite a potential conflict of interest should be recorded, with reasons, in case notes.

39.13 In a case of urgent necessity it is preferable to proceed with three assessors, despite a potential conflict of interest, rather than make the application under section 4 of the Act with only two assessors (one doctor and one AMHP) (see paragraphs 15.6 – 15.8).

39.14 There are no other circumstances in which potential conflict of interest can be set aside because of urgent necessity.

Other potential conflicts

39.15 There may be circumstances not covered by these regulations where the assessor feels, nonetheless, that there is (or could be seen to be) a potential conflict of interest. Assessors should work on the principle that in any situation where they believe that the objectivity or independence of their decision is (or could be seen to be) undermined then they should not become involved or should withdraw.

39.16 These regulations do not cover potential conflicts of interest relating to a community treatment order (CTO). The responsible clinician responsible for making the decision as to whether to place a patient on a CTO, or any decision to revoke a CTO, should not have any financial interest in the outcome of the decision. Responsible clinicians should not be considered to have a financial interest in a hospital on the sole basis that they work there. Similarly, the responsible clinician should not be a relative of the patient.

39.17 These regulations do not cover potential conflicts of interest relating to renewal of detention or guardianship. The persons involved in making the decision as to whether to renew the detention (the responsible clinician and other professionals consulted by the responsible clinician) or the guardianship (the appropriate practitioner) should not have any financial interest in the outcome of the decision.

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

40 Information for victims

Why read this chapter?

40.1 This chapter provides information about the rights of victims of serious violent and sexual offences with regard to a part 3 patient's (mentally disordered offender) treatment and discharge. Under the Domestic Violence, Crime and Victims Act 2004, and the Mental Health Act (the Act) victims of serious violent and sexual offences have the right to receive certain information about key stages in a part 3 patient's progress and treatment. Victims may also engage with the Victim Contact Scheme (VCS). This chapter provides further guidance about the statutory rights of victims to information and the obligations placed on Secretaries of State for Justice and Health and professionals with regard to victims. It also provides guidance on the Victims' Code.

The Victim Contact Scheme (VCS) and the Victims' Code

40.2 The concerns of victims must be given appropriate weight and fully considered by staff responsible for the treatment of part 3 patients. The offence may have been committed by someone with a mental disorder, but the impact on the victim will be the same as if the part 3 patient had been well. Victims' concerns and fears, including those of bereaved victims, must be given appropriate weight and consideration at all key points of the part 3 patient's treatment, including community leave and discharge.

40.3 Under the Domestic Violence, Crime and Victims Act 2004 (DVCVA), where the part 3 patient was sentenced on or after 1 July 2005, victims of serious violent and sexual offences have the right to information from the National Probation Service (NPS) under the VCS. Under the VCS, these victims ('statutory victims') have a right to be informed of key developments in the part 3 patient's progress and to make representations about conditions that should be in place on discharge.

40.4 The Code of Practice for Victims of Crime[1] ('the Victims' Code') sets out the information, support and services, that victims of relevant crimes can expect to receive from criminal justice agencies in England and Wales. The Victims' Code also summarises the information victims are entitled to under the VCS, as set out in the DVCVA 2004.

[1] The Code of Practice for Victims of Crime. Ministry of Justice. 2013. https://www.gov.uk/government/publications/the-code-of-practice-for-victims-of-crime

40.5 The Victims' Code and the VCS apply to victims in respect of restricted and unrestricted part 3 patients. Where victims of part 3 restricted patients do not fall within the scope of the DVCVA 2004 for statutory contact under the VCS (ie non-statutory victims), it is good practice for the National Probation Service (NPS) to consider providing VCS services to any victim of a restricted patient who requests information. Examples include:

- where the conviction occurred prior to the DVCVA 2004, but the victim has now made contact
- the victim of a non-qualifying offence or sentence length (for prisoners transferred under sections 47 who are subject to restriction directions made under section 49) where the victim has expressed concerns about their safety, or
- to the victims of co-defendants convicted in connection with the same incident.

40.6 Once the discretion has been exercised to offer such a non-statutory victim contact under the VCS, they should be offered the same service as statutory victims. This means that, once the NPS has decided to offer the VCS to these non-statutory victims, they should be assigned a victim liaison officer (VLO), provided with the opportunity to make representations about discharge conditions, and provided with information which the NPS considers to be appropriate in all the circumstances of the case, in the same way as statutory victims.

40.7 Each provider organisation should have a nominated individual who is responsible for understanding the Victims Code, VCS, promoting the rights of victims and developing, overseeing and reporting on policy and initiatives in the organisation to support all victims (including those of restricted and unrestricted patients). Details of who this individual is should be available so that victims, professionals and patients can identify them and obtain the required information and, if required, raise any concerns or complaints.

The NPS Victim Contact Scheme

Specified offences

40.8 For relevant offences committed on or after 1 July 2005, the police or joint police and Crown Prosecution Service Witness Care Unit should send details of statutory victims to the appropriate NPS Victim Liaison Unit (VLU). The VLU should offer victims the opportunity to engage with the VCS if the part 3 patient is:

- convicted of a specified sexual or violent offence and made the subject of a hospital order with a restriction order (section 37 and section 41 of the Act)
- found unfit to plead in respect of a specified sexual or violent offence, but has committed and been charged with the offence
- found not guilty by reason of insanity under the Criminal Procedure (Insanity) Act 1964 in respect of a specified sexual or violent offence, and made subject to a hospital order with special restrictions (section 37 and section 41 of the Act)

- convicted of a specified sexual or violent offence and then made the subject of a hospital direction and limitation direction (section 45A and section 45B of the Act), or
- sentenced to 12 months imprisonment or more for a specified sexual or violent offence, and transferred to hospital under a transfer direction and restriction direction (section 47 and section 49 of the Act).

40.9 For the purpose of this chapter, 'relevant offences', or 'specified offences', are those set out in section 45(2) of the DVCVA 2004:

- murder or an offence specified in Schedule 15 to the Criminal Justice Act 2003[2]
- an offence in respect of which the patient is subject to the notification requirements of part 2 of the Sexual Offences Act 2003,[3] or
- an offence against a child within the meaning of part 2 of the Criminal Justice and Court Services Act 2000.[4]

The NPS Victim Contact Scheme (restricted patients)

40.10 Under the VCS, victims must, as a minimum, be:

- offered the opportunity to engage with the VCS by the VLU
- assigned a VLO (for restricted patients and prisoners transferred under section 47 who are subject to restriction directions made under section 49 who have not passed their licence expiry date)
- offered the right to make representations to whoever is responsible for making the decision on the patient's discharge, either the Secretary of State for Justice or the Tribunal, about the patient's discharge conditions – victims typically request geographic exclusion zones or 'no contact' conditions
- informed of discharge conditions which relate to them, and
- informed about any other key information about the patient's progress, which it is appropriate to share in all the circumstances of the case.

40.11 Victims can choose to opt in or out of the VCS at any time. If a victim was not identified at the time of sentencing or did not take up contact when it was offered, they may contact or be referred to the VLU at any time during the patient's treatment and rehabilitation. From 22 April 2014 victims of restricted part 3 patients, who have opted in to the VCS, will be told if permission for community leave, whether escorted or unescorted, is granted by the Mental Health Casework Section (MHCS) of the Ministry of Justice, unless there are exceptional reasons why

[2] The full list of offences can be found at: http://www.legislation.gov.uk/ukpga/2003/44/schedule/15. This list can change as new offences can be added. Practitioners can contact the Victims Team in the Ministry of Justice at VCSpolicy@noms.gsi.gov.uk if they wish to check if a new offence has been included in the Schedule.

[3] Sexual Offences Act 2003. http://www.legislation.gov.uk/ukpga/2003/42/contents

[4] A full list of offences can be found at Schedule 4 of the Criminal Justice and Court Services Act 2000: http://webarchive.nationalarchives.gov.uk/20100416132449/http://opsi.gov.uk/acts/acts2000/ukpga_20000043_en_10

they should not be told. This followed a Ministerial commitment and means that the scope of information provided to victims of part 3 patients granted leave from the detaining authority is the same as the information given to victims of prisoners who are granted temporary licence from prison (eg Release on Temporary Licence (ROTL) and Home Detention Curfew (HDC)).

40.12 Information about restricted patients will be provided by the VLO to the victim whereas information about unrestricted patients will come directly to the victim from hospital managers or clinicians once any relevant licence period has expired.

Mental health casework section requirements

Victims of part 3 restricted patients

40.13 The MHCS will, through the VLO, contact victims who are in the VCS. Information will be shared on certain key stages of the patient's progress, including:

- when the patient is transferred to hospital thus becoming a restricted patient
- if the prisoner is transferred to hospital under section 47 of the Act
- when the Secretary of State for Justice is considering a proposal for discharge, to request representations from the victim
- if the Secretary of State for Justice decides to discharge the patient
- the conditions of discharge relating to the victim or their family
- any variation of conditions of discharge relating to the victim or their family
- if the restricted patient is recalled for further treatment under the Act
- if the part 3 patient is absolutely discharged, resulting in the cessation of conditions and the removal of the part 3 patient's liability to be recalled to hospital
- when the patient's restrictions are lifted or expire
- if a patient previously found unfit to plead is remitted back to court to continue legal proceedings
- if a patient is to be remitted to prison
- if the MHCS has approved or rescinded escorted or unescorted leave.

40.14 The MHCS may pass on additional information, for example about a hospital transfer, to VLOs or directly to the victim (in the small number of cases where the victim is in direct contact with MHCS). Similarly the probation VLO may provide victims with more information only if appropriate in all the circumstances of the case, and whilst being mindful of patient confidentiality including in respect of confidential medical information.

40.15 When considering requests for community leave or transfer, MHCS will take into account victim concerns. MHCS also expects that, where the responsible clinician knows of VLO involvement, he or she will contact them to ensure that victim concerns are addressed in any application. This can include ensuring patients are not allowed leave or to be placed in a hospital in the vicinity of the victim.

Duties of hospitals in respect of unrestricted patients

Unrestricted part 3 patients

40.16 The VLU should offer victims the opportunity to engage with the VCS if the part 3 patient has been made subject to a hospital order without a restriction order (section 37 of the Act). Victims who want to engage with the VCS will have their details passed to the hospital. The hospital manager or responsible clinician then becomes responsible for providing information to the victim.

40.17 Where a part 3 patient is transferred from prison to hospital with a restriction order (section 47 and section 49 of the Act), or is transferred without a restriction order as the custodial part of their sentence was about to end (ie they are a 'notional section 37 patient'), they will be treated as an unrestricted patient when they reach their sentence end date (see paragraphs 22.75-22.77 on 'Notional section 37 patients'). At this time, if there is a victim identified in the NPS VCS, the VLU will send the victim's details to the hospital. The hospital manager or responsible clinician then becomes responsible for providing information to the victim. The VLO should continue to provide updates to the victim until the end of the licence period, even if the patient remains in hospital, and, in particular if they are released on licence.

40.18 The probation VLO will pass details of victims who wish to receive information to the hospital, and liaison should then take place between the hospital and the victim. The VLO has no further role so clinical teams and hospital managers should be fully aware of their obligations with respect to the victims of unrestricted patients.

40.19 Hospital managers must ensure that the statutory minimum of information is communicated to victims. Statutory information consists of:

- whether the patient is to be discharged
- whether a community treatment order (CTO) is to be made, including allowing the victim to make representations about the conditions attached to the CTO
- what conditions of the CTO relate to the victim
- when the CTO ceases
- when authority to detain the patient expires
- when the part 3 patient is discharged, including allowing the victim to make representations about discharge conditions, and
- what conditions of discharge relate to the victim, and when these cease.

The decision about whether to pass more information to victims than the statutory minimum will be for the relevant hospital manager to decide. The information that can be provided to a victim will be limited if it relates to medical treatment, as this information will be confidential medical information. The usual rules under the Data Protection Act 2004 and guidance in the Code on confidentiality apply (see chapter 10 on confidentiality and information sharing).

Information for victims of part 3 unrestricted patients

40.20 The Mental Health Act 2007[5] included amendments to the DVCVA 2004 to the extent that victims of part 3 unrestricted patients should be provided with the same level of information as restricted patients in terms of consideration for discharge and the victim's right to make representations with regard to discharge conditions and to be informed of these conditions.

Additional support for victims who are family, carers or friends

40.21 Professionals should be particularly mindful that some victims of mental disordered patients may also be the patient's family member, carer, friend, or their nearest relative, and may wish to maintain contact with the patient, including visiting them in hospital. The guidance in relation to enabling contact and visits should be applied equally to these individuals as to other family, friends and carers (see chapter 11). Professionals may need to balance the needs and rights of victims who are also family, friends or carers with their needs and rights as victims and/or to reduce the risk of harm arising from contact with the patient. Such victims may require additional support in order for them to maintain contact, and keep them safe, especially if the victim is a child or young person, lacks capacity or has a learning disability or autism.

40.22 Hospital managers must ensure that they fulfil the terms specified in the European directive on minimum standards on rights, support and protection of victims of crime in any of their interactions with victims of a part 3 patient.[6]

40.23 There may be a family member, friend and carer who is a victim or for other reasons does not wish to maintain contact or visit, despite a part 3 patient's wish for them to do so. The rights of the individual victim should be protected and maintained in this and, if appropriate, this should be explained to the patient (see for example paragraph 4.27 on withholding patient correspondence).

Related material

- The Code of Practice for Victims of Crime. Ministry of Justice. 2013. A range of supporting materials can be found at: https://www.gov.uk/government/publications/the-code-of-practice-for-victims-of-crime
- Mental Health Act 2007: Guidance on the extension of victims' rights under the Domestic Violence, Crime and Victims Act 2004. Department of Health and Ministry of Justice. 2008. http://webarchive.nationalarchives.gov.uk/20130107105354/http:/www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_089407.pdf

This material does not form part of the Code. It is provided for assistance only.

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[5] Mental Health Act 2007. http://www.legislation.gov.uk/ukpga/2007/12/contents

[6] European directive 2012/29/EU establishes minimum standards on the rights, support and protection of victims of crime. Article 6 in particular aims to ensure victims are provided with certain information in regard to an offender's release or escape from detention. http://ec.europa.eu/justice/criminal/files/victims/guidance_victims_rights_directive_en.pdf

Annexes

Annex A: Key words and phrases used in this Code

Annex B: List of policies and procedures

Annex C: Related materials

Annex D: Flowcharts: written descriptions

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Annex A: Key words and phrases used in this Code

Term	Definition
Absent without leave (AWOL	When a patient absconds from legal custody in the following circumstances: when a detained patient leaves hospital without getting permission first or does not return to hospital when required to do so; when guardianship patients leave the place their guardian says they should live; and when CTO patients and conditionally discharged restricted patients don't return to hospital when recalled, or leave the hospital without permission after they have been recalled.
Advance decision to refuse treatment	A decision, under the Mental Capacity Act 2005, to refuse specified treatment made in advance by a person who has capacity to do so. This decision will then apply at a future time when that person lacks capacity to consent to, or refuse the specified treatment. For the meaning, requirements and general effect of advance decisions, see sections 24 to 26 of the Mental Capacity Act 2005.
Advance statement	A statement made by a person, when they have capacity, setting out the person's wishes about medical treatment. The statement must be taken into account at a future time when that person lacks capacity to be involved in discussions about their care and treatment. Advance statements are not legally binding although health professionals should take them into account when making decisions about care and treatment.
The Act	Unless otherwise stated, the Mental Health Act 1983 (as amended, including by the Mental Health Act 2007, the Health and Social Care Act 2012 and the Care Act 2014).[1]
Advocacy	Independent help and support with understanding issues and assistance in putting forward one's own views, feelings and ideas. A broad group of people which includes independent mental health advocates (IMHAs)
After-care	Health, care and support services in the community following discharge from hospital; especially the duty of the responsible health services and local authority to provide after-care under section 117 of the Act, following the discharge of a patient from detention for treatment under the Act. The duty applies to community patients, transferred prisoners returned to prison from hospital and conditionally discharged restricted patients, as well as those who have been fully discharged.
Application for detention	An application made by an approved mental health professional, or a nearest relative, under Part 2 of the Act for a patient to be detained in a hospital either for assessment or for medical treatment. Applications may be made under section 2 (application for admission for assessment), section 3 (application for admission for medical treatment) or section 4 (emergency application for admission for assessment).

[1] The majority of provisions of the Care Act are expected to come into force on 1 April 2015.

Term	Definition
Appropriate medical treatment	Medical treatment for mental disorder which is appropriate taking into account the nature and degree of the person's mental disorder and all the other circumstances of their case.
Appropriate medical treatment test	The requirement in some of the criteria for detention, and in the criteria for a CTO, that appropriate medical treatment must be available for the patient.
Approved clinician	A mental health professional approved by the Secretary of State or a person or body exercising the approval function of the Secretary of State[2], or by the Welsh Ministers to act as an approved clinician for the purposes of the Act. Some decisions under the Act can only be taken by people who are approved clinicians. All responsible clinicians must be approved clinicians.
Approved mental health professional (AMHP)	A social worker or other professional approved by a local authority to carry out a variety of functions under the Act.
Assessment	Examining a patient to establish whether the patient has a mental disorder and, if they do, what treatment and care they need. It is also used to be mean examining or interviewing a patient to decide whether an application for detention or a guardianship application should be made.
Attorney	A person (aged 18 or over) appointed under the Mental Capacity Act who has the legal right to make decisions (eg decisions about treatment) within the scope of their authority on behalf of the person (the donor - who must be aged 18 or over) who made the power of attorney. Also known as a 'donee of lasting power of attorney'.
Bed manager	A person a provider has appointed to have responsibility for finding a suitable bed in that organisation.
Blanket restrictions	A blanket restriction or a blanket restrictive practice is any practice that restricts the freedom (including freedom of movement and communication with others) of all patients on a ward or in a hospital, which is not applied on the basis of an analysis of the risk to the individual or others.
Caldicott Guardian	The senior person in the organisation responsible for protecting the confidentiality of a patient and service-user information and enabling appropriate information-sharing. Each NHS commissioner, NHS provider and local authority with social services responsibilities is required to have a Caldicott Guardian. It is also good practice for independent sector providers of NHS-funded services to have a Caldicott Guardian.

[2] A person with whom the Secretary of State for Health has made an agreement under section 12ZA of the Act, or a body on whom the Secretary of State has imposed a requirement under section 12ZB of the Act.

Term	Definition
Capacity	The ability to take a decision about a particular matter at the time the decision needs to be made. Some people may lack capacity to take a particular decision (eg to consent to treatment) because they cannot understand, retain, use or weigh the information relevant to the decision. A legal definition of lack of capacity for people aged 16 or over is set out in section 2 of the Mental Capacity Act 2005. See also competence to consent.
Care programme approach (CPA)	A system of care and support for individuals with complex needs which includes an assessment, a care plan and a care coordinator. It is used mainly for adults in England who receive specialist mental healthcare and in some CAMHS services. There are similar systems for supporting other groups of individuals including, children and young people (children's assessment framework), older adults (single assessment process) and people with learning disabilities (person centred planning).
Care Quality Commission	The regulator established by the Health and Social Care Act 2008 of all providers of regulated health and social care. This includes care provided under the Mental Health Act 1983.
Carer	A carer is someone who helps another person, usually a relative or friend, in their day-to-day life. This is not the same as someone who provides care professionally, or through a voluntary organisation.
Certificate required	Whether or not part 4A patients consent to treatment, there are certain treatments they can only be given if they have been approved by a SOAD on a 'part 4A certificate' (see paragraph 24.22). The Act refers to this as the 'certificate requirement', which is above and beyond the requirements described above, which the Act calls the 'authority' to give treatment. Broadly speaking, the certificate requirement applies to any treatment for which a certificate would be necessary under section 58 or 58A of the Act were the patient detained instead (see chapter 25).
Child (and children)	A person under the age of 16.
Child and adolescent mental health services (CAMHS)	Specialist mental health services for children and adolescents. CAMHS covers all types of provision and intervention from mental health promotion and primary prevention, specialist community-based services through to very specialist care as provided by in-patient units for children and young people with mental illness. It is mainly composed of a multi-disciplinary workforce with specialist training in child and adolescent mental health.
Children Act 1989	An Act relating to children and young people and those with parental responsibility for them.

Term	Definition
Clinical commissioning group (CCG)	The NHS body responsible for commissioning (arranging) NHS services for a particular part of England from NHS trusts, NHS foundation trusts and independent sector providers. CCGs replaced primary care trusts from 1 April 2013. CCGs' commissioning plans are reviewed by the NHS Commissioning Board (NHS England). CCGs are generally responsible for commissioning mental healthcare, except for specialist care commissioned by the NHS Commissioning Board.
Comorbidities	The co-occurrence of two or more long term conditions in a person.
Community patient	A patient who is supervised on a community treatment order.
Community treatment order (CTO)	The legal authority for the discharge of a patient from detention in hospital, subject to the possibility of recall to hospital for further medical treatment if necessary. Community patients are expected to comply with the conditions specified in the community treatment order.
Competence to consent	Similar to capacity to consent, but specifically about a child's ability to make particular decisions. A child may be unable to make the particular decision in question due to their mental condition or because they do not have the maturity to do so. See also 'Gillick competent'.
Compulsory measures	Things which can be done to people under the Act without their agreement. This includes detention in hospital, a community treatment order and guardianship.
Compulsory treatment	Medical treatment for mental disorder given under the Act, which may be against the wishes of the patient.
Conditional discharge	The discharge from hospital by the Secretary of State for Justice or the Tribunal of a restricted patient subject to conditions. The patient remains subject to recall to hospital by the Secretary of State.
Conditionally discharged restricted patient	A restricted patient who has been given a conditional discharge by the Secretary of State for Justice or the Tribunal.
Consent	Agreeing to allow someone else to do something to or for you. Particularly consent to treatment. Valid consent requires that the person has the capacity to make the decision (or the competence to consent, if a child), and they are given the information they need to make the decision, and that they are not under any duress or inappropriate pressure.
Convey (and conveyance)	Transporting a patient under the Act to hospital (or anywhere else), compulsorily if necessary.
Court of Protection	The specialist court set up under the Mental Capacity Act to deal with issues relating to people who lack capacity to take decisions for themselves.

Term	Definition
Court of Protection order	A welfare order made by the Court of Protection that authorises a deprivation of liberty for an individual who lacks the capacity to decide whether or not to be accommodated in the relevant location, in their best interests.
Criteria for detention	A set of criteria that must be met before a person can be detained, or remain detained, under the Act. The criteria are different in different sections of the Act.
Cultural awareness/ sensitivity	Being aware of, and sensitive to, the cultural values and customs of patients and their carers.
Dementia	The term 'dementia' describes a set of symptoms that include loss of memory, mood changes and problems with communicating and reasoning. These symptoms occur when the brain is damaged by certain diseases, such as Alzheimer's disease or a series of small strokes.
Deprivation of liberty	References to 'deprivation of liberty' in the Mental Capacity Act have the same meaning as Article 5 of the European Convention on Human Rights (ECHR). 'Deprivation of liberty' means the circumstances in which a person's freedom is taken away. Its meaning has been developed through case law.
Deprivation of liberty authorisation (DoL authorisation)	An authorisation under Schedule A1 to the MCA given by a 'supervisory body' (a local authority or, in certain circumstances, the Welsh Ministers) which authorises a deprivation of liberty in a care home or hospital after completion of the statutory assessment process, which includes an assessment that the detention is in the best interests of the person.
Deprivation of liberty safeguards	The framework of safeguards under the Mental Capacity Act 2005 , as amended by the Mental Health Act 2007, for people who need to be deprived of their liberty in their best interests for care or treatment to which they lack the capacity to consent themselves.
Deputy (or Court-appointed deputy)	A person (aged 18 or over) appointed by the Court of Protection under section 16 of the Mental Capacity Act to take specified decisions on behalf of someone who lacks capacity to take those decisions themselves. This is not the same thing as the nominated deputy sometimes appointed by the doctor or approved clinician in charge of a patient's treatment.
Detained patient	Unless otherwise stated, a patient who is detained in hospital under the Act, or who is liable to be detained in hospital but who is (for any reason) currently out of hospital. In chapters 24 and 25, detained patients has a more specific meaning, explained in paragraphs 24.9 - 24.10.

Term	Definition
Detention (and detained)	Unless otherwise stated, being held compulsorily in hospital under the Act for a period of assessment or medical treatment. Sometimes referred to colloquially as 'sectioning'.
Detention for assessment (and detained for assessment)	The detention of a person in order to carry out an assessment. Can normally only last for a maximum of 28 days. Also known as 'section 2 detention'.
Detention for medical treatment (and detained for medical treatment)	The detention of a person in order to give them the medical treatment for mental disorder they need. There are various types of detention for medical treatment in the Act. It most often means detention as a result of an application for detention under section 3 of the Act. But it also includes several types of detention under part 3 of the Act, including hospital directions, hospital orders and interim hospital orders.
Diagnostic overshadowing	A risk for everyone with a mental disorder, but a particular danger for people with learning disabilities, that behavioural problems may be misinterpreted as symptomatic of mental disorder when they are in fact a sign of an underlying physical health problem.
Discharge	Unless otherwise stated, a decision that a patient should no longer be subject to detention, community treatment order , guardianship, or conditional discharge. Discharge from detention is not the same as being discharged from hospital. The patient might already have left hospital on leave of absence, or might agree to remain in hospital as an informal patient.
Disclosure and Barring Service (DBS)	The DBS was established by section 87(1) of the Protection of Freedoms Act 2012. DBS has taken over the functions of the Criminal Records Bureau (now abolished) to provide access to criminal record information and information in relation to the children's barred list and adults' barred list under the Safeguarding Vulnerable Groups Act 2006.
Displacement (of nearest relative)	The provision under section 29 of the Act, under which the County Court can order that the functions of the nearest relative be carried out by another person or by a local authority (as defined by the Care Act 2014).
Doctor	A registered medical practitioner.
Doctor approved under section 12	A doctor who has been approved under the Act by the Secretary of State for Health as having special experience in the diagnosis or treatment of mental disorder, or by a body which the Secretary of State has authorised to exercise the approval function under the Act, or by Welsh Ministers. Some medical recommendations and medical evidence to courts under the Act can only be made by a doctor who is approved under section 12. (Doctors who are approved clinicians are automatically treated as though they have been approved under section 12.)

Term	Definition
Donees (of lasting power of attorney)	An attorney appointed under the Mental Capacity Act to make decisions in relation to the welfare, property or affairs of a person subject to the Act who lacks capacity.
Electro-convulsive therapy (ECT)	A form of medical treatment for mental disorder in which a small, carefully controlled electric current is introduced into the brain. It is administered in conjunction with a general anaesthetic and muscle relaxant medications and is occasionally used to treat very severe depression.
Emergency application	An application for detention for assessment made under section 4 with only one supporting medical recommendation in cases of urgent necessity. The patient can only be detained for a maximum of 72 hours unless second medical recommendation is received. Also known as a section 4 application.
Equality Act 2010	A law making it unlawful (either directly or indirectly) to discriminate against a person on the basis of a protected characteristic (as defined in that Act). Imposes a public sector equality duty on public bodies.
European Convention on Human Rights (ECHR)	The European Convention for the Protection of Human Rights and Fundamental Freedoms. The substantive rights it guarantees are largely incorporated into UK law by the Human Rights Act 1998.
Gillick competent	This term refers to a child under the age of 16 who is considered to have sufficient understanding and intelligence to enable them to understand fully what is involved in a proposed intervention that requires consent, including admission to hospital and medical treatment, and who is therefore competent to consent to that intervention. See also competence to consent.
GP	A patient's general practitioner (or 'family doctor').
Guardian	See guardianship.
Guardianship	The appointment of a guardian to help and supervise patients (aged 16 or over) in the community for their own welfare or to protect other people. The guardian may be either a local authority or someone else approved by a local authority (a private guardian).
Guardianship application	An application to a local authority by an approved mental health professional or a nearest relative for a patient to become subject to guardianship.
Guardianship order	An order by the court, under part 3 of the Act that a mentally disordered offender should become subject to guardianship.
Guiding principles	The five principles set out in chapter 1 which have to be considered when decisions are made under the Act.

Term	Definition
Habilitation	Equipping someone with skills and abilities they have never had. As distinct from rehabilitation, which means helping them recover skills and abilities they have lost.
Health action plan (HAP)	A plan which details the actions needed to maintain and improve the health of an individual with a learning disability and any help needed to achieve them. It links the individual with the range of services and supports they need in order to have better health. It is part of their broader person-centred plan.
Holding powers	The powers in section 5 of the Act which allow hospital in-patients to be detained temporarily so that a decision can be made about whether an application for detention should be made. There are two holding powers. Under section 5(2) doctors and approved clinicians can detain patients for up to 72 hours. Under section 5(4), certain nurses can detain patients for up to 6 hours.
Hospital direction (or hospital and limitation direction)	An order by the court under part 3 of the Act for the detention for medical treatment in hospital of a mentally disordered offender. It is given alongside a prison sentence. Hospital directions are given under section 45A of the Act.
Hospital managers	The organisation (or individual) responsible for the operation of the Act in a particular hospital (eg an NHS trust, an NHS foundation trust or the owners of an independent hospital). Hospital managers have various functions under the Act, which include the power to discharge a patient. In practice, most of the hospital managers' decisions are taken on their behalf by individuals (or groups of individuals) authorised by the hospital managers to do so. This can include clinical staff. Hospital managers' decisions about discharge are normally delegated to a 'managers' panel' of three or more people.
Hospital order	An order by a court under part 3 of the Act for the detention for medical treatment in hospital of a mentally disordered offender, given instead of a prison sentence or other form of punishment. Hospital orders are normally made under section 37 of the Act.
Human Rights Act 1998	A law largely incorporating into UK law the substantive rights set out in the European Convention on Human Rights.
Independent hospital	A hospital which is not managed by the NHS.
Independent mental capacity advocates (IMCA)	An advocate able to offer help to patients who lack capacity under arrangements which are specifically required to be made under the Mental Capacity Act 2005.
Independent mental health advocate (IMHA)	An advocate available to offer help to patients under arrangements which are specifically required to be made under the Act.

Term	Definition
Independent mental health advocate (IMHA) services	The services which make independent mental health advocates available to patients. The Act calls patients who are eligible for these services 'qualifying patients.'
Informal patient	Someone who is being treated for a mental disorder and who is not detained under the Act.
Interim hospital order	An order by a court under part 3 of the Act for the detention for medical treatment in hospital of a mentally disordered offender on an interim basis, to enable the court decides whether to make a hospital order or deal with offender's case in some other way. Interim hospital orders are made under section 38 of the Act.
Lasting power of attorney (attorneys)	Please see attorney.
Learning disability	In the Act, a learning disability means a state of arrested or incomplete development of the mind which includes significant impairment of intelligence and social functioning. Further guidance on the meaning of learning disability is provided in chapter 20.
Learning disability qualification	The rule which says that certain parts of the Act only apply to a learning disability if the learning disability is associated with abnormally aggressive or seriously irresponsible behaviour on the part of the person concerned.
Leave of absence	Permission for a patient who is detained in hospital to be absent from the hospital for short periods eg to go to the shops or spend a weekend at home, or for much longer periods. Patients remain under the powers of the Act when they are on leave and can be recalled to hospital if necessary in the interest of the patient's health or safety or for the protection of other people.
Local authority	The local authority responsible for care and support services in a particular area of England, which is a local authority for the purpose of the Care Act 2013 (except where otherwise indicated).
Long term segregation	Long term segregation refers to a situation where, in order to reduce a sustained risk of harm posed by the patient to others, which is a constant feature of their presentation, a patient is not allowed to mix freely with other patients on the ward/unit on a long term basis. In such cases, it should have been determined that the risk to others is not subject to amelioration by a short period of seclusion combined with any other form of treatment; the clinical judgement is that if the patient were allowed to mix freely in the general ward environment, other patients or staff would almost continuously be open to potentially serious injury or harm.
Managers	See hospital managers.

Term	Definition
Managers' panel	A panel of three or more people appointed to take decisions on behalf of hospital managers about the discharge of patients from detention or community treatment order.
Mechanical restraint	Mechanical restraint is a form of restrictive intervention which involves the use of a device to prevent, restrict or subdue movement of a person's body, or part of the body, for the primary purpose of behavioural control
Medical recommendation	Normally means a recommendation provided by a doctor in support of an application for detention or a guardianship application.
Medical treatment	In the Act, this covers a wide range of services. As well as the kind of care and treatment given by doctors, it also includes nursing, psychological therapies, and specialist mental health habilitation, rehabilitation and care.
Medical treatment for mental disorder	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.
Mental Capacity Act	The Mental Capacity Act 2005. An Act of Parliament that governs decision-making on behalf of people, aged 16 years and over, who lack capacity, both where they lose capacity at some point in their lives, for example as a result of dementia or brain injury, and where the incapacitating condition has been present since birth.
Mental disorder	Any disorder or disability of the mind. As well as mental illnesses, it includes conditions like personality disorders, autistic spectrum disorders and learning disabilities.
Mental Health Casework Section (MHCS)	A section within the National Offender Management Service that takes decisions on behalf of the Secretary of State for Justice in regard to restricted patients.
Mental illness	An illness of the mind. It includes common conditions like depression and anxiety and less common conditions like schizophrenia, bipolar disorder, anorexia nervosa and dementia.
Mentally disordered offender	A person who has a mental disorder and who has committed a criminal offence.
Multi-disciplinary team (MDT)	A professional team including staff from a range of different professions.
Nearest relative	A person defined by section 26 of the Act (and in relation to children and young people, sections 27 and 28) who has certain rights and powers under the Act in respect of a patient for whom they are the nearest relative.
NHS	The National Health Service.

Term	Definition
NHS commissioners	Clinical commissioning groups (CCGs) and the NHS Commissioning Board (NHS England) are responsible for commissioning NHS treatment and care under the Act.
NHS Commissioning Board (NHS England)	The NHS Commissioning Board (also known as NHS England) reviews the commissioning plans of CCGs and assures the Secretary of State that the plans will deliver a comprehensive health service. The NHS Commissioning Board took over most of the functions of Strategic Health Authorities from 1 April 2013.
NHS trust and NHS foundation trust	Types of NHS body responsible for providing NHS services in a local area.
Nominated deputy	A doctor or approved clinician who may make a report detaining a patient under the holding powers in section 5 in the absence of the doctor or approved clinician who is in charge of the patient's treatment.
Offender manager (OM)	A probation official with responsibility for managing the offender in the community.
Parliamentary and Health Service Ombudsman	The Ombudsman investigates complaints that individuals have been treated unfairly or have received poor service from government depart¬ments, other public organisations and the NHS in England. The ombudsman normally investigates complaints about NHS services after these have been unable to be resolved locally.
Parole Board	An independent body that carries out risk assessments on prisoners to determine whether they can be safely released into the community.
Part 2	The part of the Act which deals with detention, guardianship and community treatment orders for civil (ie non-offender) patients. Some aspects of part 2 also applies to some patients who have been detained or made subject to guardianship by the courts or who have been transferred from prison to detention in hospital by the Secretary of State for Justice under part 3 of the Act.
Part 2 patient	A civil patient – ie a patient who became subject compulsory measures under the Act as a result of an application for detention or guardianship application by a nearest relative or an approved mental health professional under part 2 of the Act.
Part 3	The part of the Act which deals with mentally disordered offenders and defendants in criminal proceedings. Among other things, it allows courts to detain people in hospital for treatment instead of punishing them, where particular criteria are met. It also allows the Secretary of State for Justice to transfer people from prison to detention in hospital for treatment.

Term	Definition
Part 3 patient	A patient made subject to compulsory measures under the Act by the courts or by being transferred to detention in hospital from prison under part 3 of the Act. Part 3 patients can be either 'restricted' (ie subject to special restrictions on when they can be discharged, given leave of absence, and various other matters) or 'unrestricted' (ie treated for the most part like a part 2 patient).
Part 4	The part of the Act which deals mainly with the medical treatment for mental disorder of detained patients (including community patients who have been recalled to hospital). In particular, it sets out when they can and cannot be treated for their mental disorder without their consent.
Part 4A	The part of the Act which deals with the medical treatment for mental disorder of community patients when they have not been recalled to hospital.
Part 4A certificate	A SOAD certificate approving particular forms of medical treatment for mental disorder for a community patient.
Part 4A patient	In chapters 24 and 25 means a community patient who has not been recalled to hospital.
Patient	A person who is, or appears to be, suffering from a mental disorder. This use of the term is not a recommendation that the term 'patient' should be used in practice in preference to other terms such as 'service user', 'client' or similar terms. It is just a reflection of the terminology used in the Act itself.
Person-centred plan	An individual plan for each person with a learning disability, tailored to their needs and aspirations, which aims to help them to be a part of their community and to help the community to welcome them.
Physical restraint	Physical restraint is a type of restrictive intervention which refers to any direct physical contact where the intention is to prevent, restrict, or subdue movement of the body (or part of the body) of another person.
Place of safety	A place in which people may be temporarily detained under section 135 or 136 of the Act, as defined in section 135(6).
Positive behaviour support plan (or equivalent)	Positive behaviour support plans (or equivalent) are individualised care plans, which should be available to staff, kept up to date, and should include primary preventative strategies, secondary preventative strategies and tertiary strategies.
Private guardian	An individual person (rather than a local authority) who is a patient's guardian under the Act.
Provider	Either an NHS or an independent sector hospital, except where the Code specifically states a type of provider e.g. NHS trust or NHS foundation trust

Term	Definition
Qualifying patients	Patients who are eligible for support from independent mental health advocate services.
Rapid tranquilisation	Rapid tranquillisation refers to the use of medication to calm and/or lightly sedate an individual to reduce the risk of harm to self and/or others and to reduce agitation and aggression.
Remand to hospital (and remanded to hospital)	An order by a court under part 3 of the Act for the detention in hospital of a defendant in criminal proceedings. Remand under section 35 is for a report on the person's mental condition. Remand under section 36 is for medical treatment for mental disorder.
Recall (and recalled)	A requirement that a patient who is subject to the Act return to hospital. It can apply to patients who are on leave of absence, who are on a community treatment order, or who have been given a conditional discharge from hospital.
Regulations	Secondary legislation made under the Act. In most cases in this Code, it means the Mental Health (Hospital, Guardianship and Treatment) (England) Regulations 2008, but there are other regulations referred to too.
Rehabilitation	See habilitation.
Responsible clinician	The approved clinician with overall responsibility for a patient's case. Certain decisions (such as renewing a patient's detention or placing a patient on a community treatment order) can only be taken by the responsible clinician.
Responsible hospital	The hospital whose managers are responsible for a community patient. To begin with, at least, this is the hospital in which the patient was detained before being discharged onto a community treatment order.
Responsible local authority	For the purposes of guardianship, the local authority responsible for a patient who is subject to guardianship. The responsible local authority is normally the one for the area where the patient lives. But if the patient has a private guardian, it is the one for the area where the guardian lives.
Restricted patient	A part 3 patient who, following criminal proceedings, is made subject to a restriction order under section 41 of the Act, a limitation direction under section 45A or a restriction direction under section 49. The order or direction will be imposed on an offender where it appears that it is necessary to protect the public from serious harm. One of the effects of the restrictions imposed by these sections is that restricted patients cannot be given leave of absence or be transferred to another hospital without the consent of the Secretary of State for Justice, and only the Tribunal can discharge them without the Secretary of State's agreement. See also Unrestricted part 3 patient.

Term	Definition
Revocation (and revoke)	Term used in the Act to describe the rescinding of a community treatment order (CTO) when a community patient needs further treatment in hospital under the Act. If a patient's CTO is revoked, the patient is detained under the powers of the Act in the same way as before the CTO was made.
Scope of parental responsibility	This is a term used in the Code to highlight the need to establish whether or not a particular decision concerning a child or a young person can be authorised by the consent of a person with parental responsibility for that child or young person. Formerly referred to as the 'zone of parental control'.
Seclusion	Seclusion refers to the supervised confinement and isolation of a patient, away from other patients, in an area from which the patient is prevented from leaving, where it is of immediate necessity for the purpose of the containment of severe behavioural disturbance which is likely to cause harm to others.
Second opinion appointed doctor (SOAD)	An independent doctor appointed by the Care Quality Commission who gives a second opinion on whether certain types of medical treatment for mental disorder should be given without the patient's consent.
Secondary legislation	Delegated legislation made by ministers under powers given to them by Acts of Parliament in order to implement and administer the requirements of the Acts. It includes regulations.
Secretary of State	Cabinet ministers in the Government. In the Act, either the Secretary of State for Health or the Secretary of State for Justice, depending on the context.
Secretary of State for Health	The Secretary of State who is responsible, among other things, for the NHS and care and support services for adults. The Secretary of State for Health is supported by the Department of Health.
Secretary of State for Justice	The Secretary of State who is responsible, among other things, for courts, prisons, probation, criminal law and sentencing. The Secretary of State for Justice is supported by the Ministry of Justice.
Section 57 treatment	A form of medical treatment for mental disorder to which the special rules in section 57 of the Act apply, especially neurosurgery for mental disorder (sometimes called 'psychosurgery').[3]
Section 58 treatment	A form of medical treatment for mental disorder to which the special rules in section 58 of the Act apply, which means medication for mental disorder for detained patients after an initial three month period.[4]
Section 58A treatment	A form of medical treatment for mental disorder to which the special rules in section 58 of the Act apply, especially electro-convulsive therapy and medication as part of that therapy.

[3] Other forms of treatment may be added to section 57, section 58 or section 58A by regulations.
[4] Other forms of treatment may be added to section 57, section 58 or section 58A by regulations.

Term	Definition
Section 117	See after-care.
Section 135	A section 135 warrant provided by a magistrate (which may be issued if certain circumstances are met) enables a police officer to enter premises to either: remove a person to a place of safety to make an application under part 2 or other arrangements for their care or treatment; or take or retake into custody a patient who is liable to be detained under the Act or relevant Scottish law.
SOAD certificate	A certificate issued by a second opinion appointed doctor (SOAD) approving particular forms of medical treatment for a patient.
Supervised community treatment or SCT	See community treatment order (CTO).
Statutory consultees	A SOAD (second opinion appointed doctor) is required to consult two people ('statutory consultees') before issuing certificates approving treatment. One of the statutory consultees must be a nurse; the other may not be either a nurse or a doctor. Both must have been professionally concerned with the patient's medical treatment, and neither may be the clinician in charge of the proposed treatment or the responsible clinician (if the patient has one).
Tribunal	The First-tier Tribunal (Mental Health) called in the Code 'the Tribunal' was established under the Tribunals, Courts and Enforcement Act 2007. This is a judicial body which has the power to discharge patients from detention, community treatment orders, guardianship and conditional discharge.
Unrestricted part 3 patient	A patient subject to a hospital order or guardianship order under part 3 of the Act, or who has been transferred from prison to detention in hospital under that part, who is not also subject to a restriction order or direction. For the most part, unrestricted patients are treated in the same way as part 2 patients, although they cannot be discharged by their nearest relative. See also restricted patients.
Victim	A person who has been subject to a serious violent or sexual offence by a mentally disordered offender who, in accordance with the Domestic Violence, Crime and Victims Act 2004, can choose to make representations under the Victim Contact Scheme about the conditions that should be in place on the offender's discharge and be informed about matters set out in chapter 40.
Victim Contact Scheme (VCS)	A statutory scheme offered by probation trusts to victims enabling them to be informed of key developments in the offender's sentence, and to make representations on conditions to which the offender may be subject to on discharge or release.
Victim Liaison Officer (VLO)	Victim Liaison Officers (VLOs) are probation staff who work with victims who are in the Victim Contact Scheme.

Term	Definition
Victim Liaison Unit (VLU)	Local teams within the National Probation Service dealing with victims under the Victim Contact Scheme.
Welsh Measure	The Mental Health (Wales) Measure 2010, which amongst other requirements, places duties on local health boards and local authorities in Wales to provide a care co-ordinator and a statutory care and treatment plan for people for whom they are responsible for providing secondary mental health services and includes those patients under the guardianship of a local authority in Wales.
Welsh Ministers	Ministers in the Welsh Assembly Government.

Annex B: List of policies and procedures

This annex contains a summary of the policies, procedures and guidance which the Code says should be put in place locally by hospital managers, local authorities and others.

Paragraph of Code	Policy, procedure or guidance
3.15	**Human rights and equality policy** Commissioners and providers should have in place an 'Equality and Human Rights Policy' for service provision and practice in relation to the Act, which should be reviewed at Board (or equivalent) level at least annually.
4.48	**Information policy** Hospital managers should have in place policies to ensure that all detained and community patients and their nearest relatives are given information about their legal situation and rights in accordance with the legislation.
4.62-4.63	**Complaints policies** All providers should have clear complaints policies and procedures for patients and those supporting them (including nearest relatives, carers and advocates) in formats that these individuals can understand.
5.17	**Displacement of nearest relatives** All local authorities should provide clear practical guidance to help the AMHP decide whether to make an application and how to proceed.
	Displacement of nearest relatives Local authorities should provide clear practical guidance to help the AMHP decide whom it is appropriate to nominate when making an application to displace a nearest relative.
8.12	**Blanket locked door policy** The impact of a locked door policy on each patient should be considered and documented in the patient's records. The policy should conform to the 'empowerment and involvement' guiding principle.
8.19-8.20	**Mobile phones** Hospital managers should have a policy on the possession and use of mobile phones by patients and their visitors.
8.21-8.22	**Internet and social media access** Hospital managers should have guidance on patients' access to e-mail and the internet using the hospital's own IT infrastructure, and the use of social media.
8.29-8.32	**Searching** Hospital managers should ensure that there is an operational policy on searching detained patients, their belongings and surroundings and their visitors.
8.52	**Accommodation with enhanced levels of security** Hospitals offering accommodation with enhanced levels of security should have written guidelines, setting out the categories of patients for whom it is appropriate to use physically secure conditions and those for whom it is not appropriate.

Paragraph of Code	Policy, procedure or guidance
8.58	**Entry and exit from wards** Wards should have a written policy that sets out precisely what the arrangements are for entry to and exit from the ward.
10.18	**Recording disclosure without consent** Any decision to disclose confidential information about patients – for any reason – should be fully documented. The relevant facts should be recorded, along with the reasons for the decision and the identity of all those involved in the decision-making. Reasons should be given by reference to the grounds on which the disclosure is to be justified.
11.3	**Visits by and to children and young people** Hospital managers should have written policies and procedures regarding the arrangements for children and young people who visit patients in hospital and for visits to patients who are children or young people.
11.11	**Visits to patients in hospitals** Hospital managers should have a policy on the circumstances in which visits to patients may be restricted.
13.61	**Choosing between the Act and a DoLS authorisation** Hospitals should have policies in place to deal with circumstances where disagreement results in an inability to take a decision as to whether the Act or DoLS should be used to give legal authorisation to a deprivation of liberty – to ensure that one is selected.
14.47-14.48	**Police assistance for people undertaking assessments with a view to applications under the Act** Local authorities, providers and police forces should have locally agreed arrangements for the circumstances in which the police should be asked to provide assistance to approved mental health professionals (AMHPs) and doctors undertaking assessments.
14.79	**Commissioning and provision of beds** NHS commissioners should work with providers to ensure that procedures are in place through which beds can be identified whenever required.
14.80	**Joint local policies for admission to hospital** Local authorities, providers, NHS commissioners, police forces and ambulance services should ensure that they have in place a clear joint policy for the safe and appropriate admission of people in their local area agreed at Board or Board-equivalent level by each party and each party should appoint a named senior lead ('senior lead').
14.86	**Delays in placing patients** Local recording and reporting mechanisms should be in place to ensure the details of any delays in placing patients, and the impacts on patients, their carers, provider staff and other professionals are reported to commissioning and local authority senior leads.

Paragraph of Code	Policy, procedure or guidance
14.89	**Bed management** Effective systems of bed management including discharge planning, possible alternatives to admission and demand planning should be in place.
15.11	**Emergency applications under section 4** Hospital managers and local authorities should monitor the use of section 4 to ensure that it is not misused and to allow action to be taken to rectify any problems with the availability of doctors.
16.9	Warrants under section 135 of the Act Local authorities should ensure that guidance to AMHPs on how and when to apply for a warrant is also available to the relevant partner agencies (including the relevant local authority and police force).
16.30	**Local partnership arrangements to deal with people experiencing mental health crises** Local authorities, NHS commissioners, hospitals, police forces and ambulance services should have local partnership arrangements in place to deal with people experiencing mental health crises.
16.31	**Sections 135 and 136 of the Act** Local authorities, hospitals, NHS commissioners, police forces and ambulance services should have an agreed local policy in place governing all aspects of the use of section 135 and 136 (police powers and places of safety).
17.25-17.28	**Transporting of patients under the Act** Relevant authorities, including NHS commissioners responsible for hospitals, ambulance and transport services, NHS-funded providers and the police should agree joint local policies and procedures for transporting patients under the Act, setting out clearly the respective responsibilities of the different agencies and service providers.
18.14/18.17	**Nominating deputies** Hospital managers should ensure that arrangements are in place for nominated deputies who are not approved clinicians (or doctors approved under section 12 of the Act) to seek advice . Hospital managers should also ensure that ward staff know who the nominated deputy for a particular patient is at any given time.
18.39	**Monitoring the use of section 5** Hospital managers should monitor the use of section 5. This should include how quickly patients are assessed for detention and discharged from the holding power, the attendance times of doctors and approved clinicians following the use of nurses' holding power in section 5(4), and the proportions of cases in which applications for detention are, in fact, made following the use of section 5.

Paragraph of Code	Policy, procedure or guidance
19.110	**Referrals to the Tribunal** Hospital managers should ensure that systems are in place to identify cases requiring referral to a Tribunal in accordance with section 68 of the Act.
19.126	**Duties of local authorities relating to children and young people in hospital** Hospital managers should set up systems to ensure that directors of children's services are notified of cases in which their duty to visit and consider the welfare of children and young people in hospital arises.
20.41	**Learning disabilities or autism** Policies and practices should be in place to specifically address issues such as staff awareness and training, communication with patients, , the meeting of physical health needs and regular audits of incidents involving restrictive practices.
24.60	**Food and drink strategy** Every provider should have a food and drink strategy that covers: nutrition and hydration needs of patients; healthier eating for the whole hospital community; and sustainable procurement of food and catering services.
25.6	**Record of approved clinicians** Hospital managers should keep a record of approved clinicians who are available to treat patients for whom they are responsible and should ensure that approved clinicians are in charge of treatment where the Act requires it.
25.42	**Exceptions to certificate requirements (sections 62, 64B, 64C and 64E)** Hospital managers should monitor the use of exceptions to the certificate requirements to ensure that they are not used inappropriately or excessively. They are advised to provide a form (or other method) by which the clinician in charge of the treatment in question can record details of the treatment, the necessity for it and the length of time for which it was given.
25.82	**Continuation of treatment pending a new certificate** As with immediately necessary treatment, hospital managers should monitor the use of such exceptions. They should require clinicians to record details of why it was necessary to continue treatment without a certificate and how long it took to obtain a new certificate.
25.86	**Certificates which no longer authorise treatment** Hospital managers should make sure that arrangements are in place so that certificates which no longer authorise treatment (or particular treatments) are clearly marked as such, as are all copies of those certificates kept with the patient's notes and medication chart.

Paragraph of Code	Policy, procedure or guidance
26.5-7	**Restrictive intervention reduction programmes** All mental health providers should have in place a regularly reviewed and updated restrictive intervention reduction programme, which are overarching, multi-component action plans which aim to reduce the use of restrictive intervention. They should demonstrate organisational commitment to restrictive intervention reduction at a senior level, how the use of data relating to restrictive interventions will inform service developments, continuing professional development for staff, how models of service which are known to be effective in reducing restrictive interventions are embedded into care pathways, how service users are engaged in service planning and evaluation and how lessons are learned following the use of restrictive interventions. They should ensure accountability for continual improvements in service quality through the delivery of positive and proactive care. They should also include improvement goals and identify who is responsible for progressing the different parts of the plan.
26.7	**Provider policies on restrictive interventions** Provider policies on restrictive interventions should include guidance on assessments of risk and support needs; use of positive behaviour support plans; minimisation of risks associated with restrictive interventions; authorisation and application of restrictive interventions; recording and reporting; post-incident reviews and workforce training.
26.33	**Provider policies on use of enhanced observation** Provider policies on the use of enhanced observation should cover selection of appropriate staff taking into account the individual's characteristics and circumstances, minimisation of perception of coercive intent and respect for the individual's dignity and privacy.
	Guidance on use of seclusion Provider policies (see 26.7) should include detailed guidance on the use of seclusion and should be consistent with the guiding principles of the Code.
26.127-26.133	**Medical reviews of seclusion** Local policies should make provision for a 'duty doctor' to deputise if the RC is not immediately available. The policy should also identify which RMPs are competent to carry out a medical review.
26.155-26.156	**Long-term segregation** Providers should have a policy on long-term segregation, which provides for periodic reviews by a senior professional who is not involved with the case, recording of the outcome of all reviews and the reasons for continued segregation, and reporting of outcomes to the responsible commissioner.

Paragraph of Code	Policy, procedure or guidance
26.175	**Training for staff exposed to aggression or violence** Hospital managers should have a policy for training staff who work in areas where they may be exposed to aggression or violence or who may need to become involved in the application of restrictive interventions.
28.11-28.12	**Patients absent without leave from hospital** Hospital managers should ensure that there is a clear written policy about the action to be taken when a detained patient or a patient on a CTO, goes missing. This policy should be agreed with other agencies such as the police and ambulance services.
29.35	**Information for patients on a CTO and others** There is a duty on hospital managers to take steps to ensure that patients understand what a CTO means for them and their rights to apply for discharge. This includes giving patients information both orally and in writing and must be done as soon as practicable after the patient goes onto the CTO. Hospital managers' information policies should set out whether this information is to be provided by the responsible clinician, by another member of the professional team or by someone else. A copy of this information must also be provided to the nearest relative (subject to the normal considerations about involving nearest relatives.)
29.44	**Community treatment orders (CTOs) – concerns of carers and relatives** The managers of responsible hospitals should ensure that local protocols are in place to cover how concerns raised by carers or relatives about CTO patients' health or compliance with the conditions of their CTOs are addressed and taken forward.
29.69	**Recall to hospital of CTO patient** Hospital managers should ensure arrangements are in place to monitor the patient's length of stay following the time of detention after recall, as recorded on the form, so that the maximum period of detention is not exceeded.
30.16	**Guardianship** Each local authority should have a policy setting out the arrangements for the way in which it will discharge its responsibilities in relation to guardianship.
32.5	**Renewal of detention** Hospital managers should determine local policies on the selection of the second professional professionally concerned with the patient's treatment who is required to agree to the renewal of a patient's detention.

Paragraph of Code	Policy, procedure or guidance
35.7-35.8	**Receipt of applications for detention** Hospitals should have a checklist for the guidance of people delegated to receive documents ('receiving officers'), to help them detect those errors which fundamentally invalidate an application and which cannot be corrected at a later stage in the procedure.
35.15	**Receipt of guardianship applications** Local authorities should prepare a checklist for the guidance of those delegated to receive guardianship applications on their behalf. That checklist should identify those errors which can be rectified and those which cannot.
36.3	**Allocation of responsible clinicians** Hospital managers should have local protocols in place for allocating responsible clinicians to patients.
37.9	**Hospital managers' scheme of delegation** Hospital managers should set out the arrangements for who is authorised to take which decisions in a scheme of delegation. If the hospital managers are an organisation, that scheme of delegation should be approved by a resolution of the body itself.
37.12	**Authority for detaining patients** It is the hospital managers' responsibility to ensure that the authority for detaining patients is valid and that any relevant admission documents are in order. A copy of the report made by the approved mental health professional (AMHP) should also be obtained. Hospital managers should have a clear system in place for notifying local authorities when the patient is a child or young person.
37.38	**Patients' correspondence in high security hospitals** The hospital managers of high-security psychiatric hospitals should have a written policy for the exercise of their powers to withhold both incoming and outgoing post from patients in certain circumstances.
38.27	**Reviews of CTO or detention** Hospital managers should ensure that mechanisms are in place so that, in advance of the hearing, managers' panels are provided with written reports from the patient's responsible clinician and from other key individuals directly involved in the patient's care as appropriate.
38.50	**Need to hold a review before detention expires** Hospital managers should have processes in place to ensure that reviews take place before the period of detention or CTO expires. If the review does not take place then the reasons for this, and the actions put in place to stop it happening again, should be fully documented.

Annex C: Related materials

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Annex D: Flowcharts: written description

This annex provides a written description of figure 6 in chapter 13, and figures 7, 8 and 9 in chapter 19 to assist those with visual impairments to access this material.

Figure 6: Deciding whether the Act and/or MCA will be available to be used

The first question in the flowchart is to ask whether the individual in question is suffering from a mental disorder for which they require assessment or treatment in a hospital. If the answer is 'no', then detention under the Act is not an available option.

If the answer is 'yes' then the decision-maker should consider a second question. The second question is: Does the individual in question lack the mental capacity to consent to being accommodated in the hospital for the purpose of being given the proposed care or treatment? If the answer is 'no' then the Mental Capacity Act and the deprivation of liberty safeguards are not an available option.

However, if the answer is 'yes' (in other words the individual in question is suffering from a mental disorder for which they require assessment and treatment in hospital AND they lack the capacity to consent to consent to being accommodated in the hospital for the proposed care or treatment) then the next question to be asked is: Could the care plan result, or be likely to result, in a deprivation of liberty?

If the answer is 'no', then the individual could be admitted to the hospital on an informal basis (ie not detained under the Act) or treated under the provisions of the Mental Capacity Act (without the need to use the deprivation of liberty safeguards).

If the answer is 'yes' (there is, or is likely to be, a deprivation of liberty) then the next question is whether the care and or treatment plan could be amended to reduce any restraints or restrictions in place – thereby preventing a deprivation of liberty from arising. If the answer is 'yes', the care and treatment plan should be amended so that there is no deprivation of liberty.

If the care plan cannot be amended – so that there is (or is likely to be) an unavoidable deprivation of liberty, then the individual in question must either be detained under the Act, a DoLS authorisation or Court of Protection order. The individual cannot be admitted on an informal basis.

In determining whether the MHA or the DoLS is the most appropriate way of authorising the deprivation of liberty the decision-maker should consider the question: does the individual object to being kept in the hospital or to being given mental health treatment or any part of that treatment, or has the individual made a valid and applicable advance decision to refuse any part of the treatment? If the answer to this question is 'yes' then use of the Act is indicated – use of the DoLS would be inappropriate.

However, if the answer is 'no' (in other words, the individual is not objecting) then both detention under the Act and a DOLS authorisation or Court of Protection order are available. Decision-makers must decide under which regime the individual will be detained; the individual cannot be detained under both regimes. Guidance for decision-makers regarding this decision is to be found elsewhere in this chapter but it is important to remember that the choice of which regime to use should be made in the best interests of the individual – not because of the personal preference of the decision-maker.

Figure 7: Informal admission and treatment of under 16s

The first question in the flowchart is to ask whether the child is competent to decide about the proposed admission and/or treatment.

If the answer to this question is 'Yes', then the next question is whether the child does consent to the admission and/or treatment. If the child does consent, the child can be admitted and treated informally on basis of their consent. However, if the child does not consent, admission under the Act will need to be considered. If the criteria for admission under the Act are not met, the child cannot be admitted or treated without court authorisation (although it should be noted that action can be taken in life-threatening emergencies).

If the child is not competent to decide about the proposed admission and/or treatment, the next question is whether the admission or treatment amounts to a deprivation of liberty. Consideration will need to be given to whether a person with parental responsibility can consent to the proposed admission and/or treatment which would, without consent, amount to a deprivation of liberty. If there is a deprivation of liberty, admission under the Act will need to be considered. If the criteria for admission under the Act are not met, the child cannot be admitted or treated without court authorisation (although it should be noted that action can be taken in life-threatening emergencies).

If the child's admission or treatment does not amount to a deprivation of liberty, the next question is whether the decision is within the scope of parental responsibility. If the decision does not fall within the scope of parental responsibility, admission under the Act will need to be considered. If the criteria for admission under the Act are not met, it will be necessary to apply to the court for authorisation (although it should be noted that action can be taken in life-threatening emergencies).

If the decision to admit and/or treat the child does fall within the scope of parental responsibility, the next question is whether the person with parental responsibility consents to the admission and/or treatment. If the parent does consent, the child can be admitted and treated informally on basis of parental consent. If the parent does not consent, admission under the Act will need to be considered. If the criteria for admission under the Act are not met, it will be necessary to apply to the court for authorisation (although it should be noted that action can be taken in life-threatening emergencies).

Figure 8: Informal admission of 16 and 17 year olds

The first question in the flowchart is to ask whether the young person has capacity to consent to the proposed admission. If the answer to this question is 'Yes', then the next question is whether the young person consents to being admitted for assessment and/or treatment. If the young person does consent to the admission the young person can be admitted informally on basis of the young person's consent. If the young person does not consent, admission under the Act will need to be considered. If the criteria for admission under the Act are not met, the young person cannot be admitted without court authorisation (although it should be noted that action can be taken in life-threatening emergencies).

If the young person does not have the capacity to consent to the proposed admission, the next question is whether the proposed admission involves a deprivation of liberty. If it does not involve a deprivation of liberty the young person can be admitted informally, in accordance with the MCA if the admission is in the young person's best interests. If the admission does amount to a deprivation of liberty, admission under the Act will need to be considered. If the criteria for admission under the Act are not met, the young person cannot be admitted without court authorisation (although it should be noted that action can be taken in life- threatening emergencies).

Figure 9: Informal treatment of 16 and 17 year olds

The first question in the flowchart is to ask whether the young person has the ability to make decisions about the proposed treatment. If the answer to this question is 'Yes', the next question is whether the young person consents to the proposed treatment. If the young person does consent, the young person can be treated informally on basis of their consent. If the young person does not consent, admission under the Act will need to be considered. If the criteria for admission under the Act are not met, the young person cannot be treated without court authorisation (although it should be noted that action can be taken in life-threatening emergencies).

If the young person does not have the ability to make decisions about the proposed treatment the next question is whether the proposed treatment involves a deprivation of liberty. Consideration should be given to whether a person with parental responsibility can consent to the arrangements which would, without consent, amount to a deprivation of liberty. If it does amount to a deprivation of liberty, admission under the Act will need to be considered. If the criteria for admission under the Act are not met, the young person cannot be treated without court authorisation (although it should be noted that action can be taken in life-threatening emergencies).

If the proposed treatment does not involve a deprivation of liberty the next question is whether the young person lacks capacity within the meaning of the MCA. If the answer to this question is 'Yes' the young person can be treated informally, in accordance with the MCA if treatment is in young person's best interests.

If the young person does not lack capacity within the meaning of the MCA, (but is unable to decide about the proposed treatment for reasons other than an impairment of, or a disturbance in the functioning of, their mind or brain), the next question is whether the decision to treat is within the scope of parental responsibility. If it is not, admission under the Act will need to be considered. If the criteria for admission under the Act are not met, the young person cannot be treated without court authorisation (although it should be noted that action can be taken in life-threatening emergencies).

If the decision to treat is within the scope of parental responsibility, the next question is whether the person with parental responsibility consents to the proposed treatment. If the person with parental responsibility does not consent, admission under the Act will need to be considered. If the criteria for admission under the Act are not met, the young person cannot be treated without court authorisation (although it should be noted that action can be taken in life-threatening emergencies).

If the person with parental responsibility does consent to the proposed treatment, the young person can be treated informally on the basis of parental consent.

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