Annex A

Review of the Mental Health Act 1983
Code of Practice

Consultation response from CQC

This response combines the responses from across CQC including Mental Health Act Reviewers and Second Opinion Appointed Doctors. Views were sought from a combination of engagement activities between 7 July 2014 and 29 August 2014.

This response should be read in conjunction with our previous submissions to the DH review team, our formal response to the consultation and our MHA Annual Report 2013/14 which will be available to the review team in October 2014.

Key

*Italic* – Text lifted from the Code

*Bold* – Suggested additional text
Contents

1. In your opinion, do the additions to the Code provide sufficient assurances that all commissioners, local authorities, service providers and health and care professionals will understand what is expected of them? If not, what more should be included in the Code? ... 5

2. Should the proposed Code provide more guidance about appropriate governance arrangements for monitoring duties and powers under the Act? If so, what guidance should be included? ......................................................................................................................... 5

3. In your opinion, should any parts of the Code be more specific to determine what ‘good’ service looks like? If so, please indicate which parts should be more specific and how........ 5

4. In your opinion, does the proposed Code provide adequate guidance on local complaints and resolution procedures, specific to the Act? If it does not, please indicate any additional guidance that should be provided.......................................................... 7

5. To what extent do the proposed guiding principles set the correct framework for care, support and treatment under the Act? Are there any additional principles which may be beneficial?.............................................................. 9

6. In your opinion, does the proposed Code ensure that equality and human rights are adequately protected in the use of the Act? Do you have suggestions on where and how the Code could be further strengthened in this regard? Can you provide evidence or examples of the equality impact of the Act? ........................................................................... 10

7. In what ways could the Code say more to ensure that people have a say in their own care and that their wishes and feelings are taken into account? ................................................. 11

8. What additional information in relation to the provision of independent mental health advocates would it be helpful to include? ....................................................................................... 12

9. How should the Code be updated to reflect the use of electronic media in a patient’s correspondence and communications under section 134? .................................................. 14

10. How can the Code be more specific about aspects relating to the right to have visitors and access to family and friends? ................................................................................. 14

11. Is any further guidance required to ensure the avoidance of blanket restrictions? If so what guidance is needed? ........................................................................................................ 15

12. In your opinion what additional guidance is required in relation to the rights and roles of families and carers? ........................................................................................................ 16

13. Is there any other guidance on the interface that you think would be helpful and if so, what? Do you think that this is sufficiently user friendly to help your professional practice? 16

14. What further guidance could the Code give professionals to support their decision making between the choice of adopting section 2 or section 3 for individual patients? ........ 19

15. Considering the options above, what further guidance should be included in relation to where individuals should be geographically located, when detained, within the remit of the current legislative framework? .................................................................................. 19

16. What guidance could the Code give to local governance systems to ensure that AHMPs are not put in this position? ......................................................................................................... 19

17. To what extent do the changes to Chapter 16 on police powers, address concerns around the use of sections 135 and 136? What further changes are required? ...................... 21
18. In relation to the ‘zone of parental control’, do you think that this is a helpful term? If not, do you have any suggestions for an alternative term or is it sufficient to explain that there are limits to decisions that parents can take for their children? .................................................. 21

19. Further guidance has been provided on when a young person who has capacity might not be able to consent, but the term ‘overwhelmed’ has been removed as this was thought to be confusing. Are the relevant sections clearer? ................................................................. 21

20. Does the Code provide sufficient information in relation to individuals where additional safeguards or considerations may be required, e.g. due to age, or disability? Please note any instances where information is not sufficient................................................................. 21

21. What are your views on how the process for transferring restricted patients under Section 19 of the Act 1983, between secure hospitals be improved? ........................................ 32

22. In your opinion does the Code adequately address the issues surrounding restrictive practices to ensure their minimisation and safe application? If not, what further guidance do you recommend? .............................................................................................................. 34

23. In your opinion do the proposed review requirements relating to mechanical restraint, seclusion and long term segregation adequately help safeguard patients? If not, what further guidance do you recommend? .............................................................................................................. 34

24. Should the Mental Health (Conflicts of Interest) (England) Regulations (2008) be amended so that where a patient is to be admitted and the doctor providing one of the medical recommendations is on the staff of that hospital, the other medical recommendation must be given by a doctor who is not on the staff of that hospital, regardless of whether the hospital is an independent hospital or an NHS hospital? ..................................................... 35

25. What are your views on the options proposed as a means of increasing and improving the transparency of decision-making for discharge and reviews? ........................................ 35

26. Does the revised chapter provide as much guidance as possible, within the current legislative framework, to ensure that CTOs are used effectively and appropriately to support patients to maintain stable mental health outside hospital and to promote recovery, in line with the principle of least restrictive option and autonomy? If not, what further guidance do you suggest? .............................................................................................................. 36

27. What further information in relation to the care programme approach (CPA) in chapter 34 would be helpful to include in the Code? ............................................................................. 36

28. How clear is the drafting on how the provisions of the Measure apply to individuals receiving services across the English/Welsh Border? What further guidance would be helpful and why? ................................................................. 37

29. What additional guidance on the role of hospital managers should be included to assist them fulfil their role under the Act? .............................................................................................................. 38

30. What are your views on how to ensure victims do not miss out on their entitlements to receive statutory victim contact, particularly where the responsibility for this lies with hospitals, and that victims’ concerns and views are given appropriate weight and consideration when managing patients subject to a hospital order? ................................................................. 42

31. What specific issues would you like to see addressed within the Code, which are not covered in the proposed draft? What are your views on the new chapters that are proposed in this revision of the Code? .............................................................................................................. 42
32. Do you believe that the proposed changes to the Code address the concerns about access to safeguards, raised at Winterbourne View and other places? Is there any other guidance, within the parameters of the Act, you think the Code should include? If so, please give details. .................................................................................................................................................. 54

33. How far does the proposed structure and order help you navigate the proposed Code? Do you have any suggestions on how the grouping or ordering of chapters could be improved? .................................................................................................................................................. 54

34. Are there any ways in which, the flowcharts or case study examples used in the proposed Code can be further improved? Are there additional places where they would help? ................................................................................................................................................................. 55

35. How far does the consultation stage impact assessment reflect the potential impact of the changes that will be introduced as a result of the proposed changes to the Code? ...... 55

36. Are there any further impacts that you feel should be considered? Please provide evidence to help us assess and quantify this impact. ........................................................................................................................................ 55

Appendix 1 Flowcharts and Matrices.................................................................................................................. 56
Consultation Question

1. In your opinion, do the additions to the Code provide sufficient assurances that all commissioners, local authorities, service providers and health and care professionals will understand what is expected of them? If not, what more should be included in the Code?

2. Should the proposed Code provide more guidance about appropriate governance arrangements for monitoring duties and powers under the Act? If so, what guidance should be included?

3. In your opinion, should any parts of the Code be more specific to determine what ‘good’ service looks like? If so, please indicate which parts should be more specific and how.

Chapter(s) of the Code
Introduction

General Comments

The comments below are in addition to our formal response and proposals for improving the Code’s contribution to determining good.

Our new regulatory approach will help us to better understand what good quality care looks like and we welcome the support of the Code in identifying and exposing the variation within and between services for people who are affected by the MHA.

To support our own regulation, inspection and monitoring we believe that the Code needs to include a clear guide to the definition and guidance used throughout the Code.

We have the following comments to make in regards to specific areas of the text (proposed additions in bold):

‘v The people listed above to whom the Code is addressed must have regard to the Code. Departures from the Code could give rise to challenge and as such, reasons for departure must be recorded clearly, logically and consistently. A court or the Care Quality Commission, in reviewing any departure from the Code, will scrutinise the documented reasons for the departure to ensure that there is sufficiently convincing justification in the circumstances.‘

This should include a requirement to record the reasons in line with the Munjaz judgment of “clearly, logically and consistently” para 69 of the judgment. While courts would address any legal challenge to departure, our own expectation to see documented rationale for departure should be recognised here.

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.

It should be clear from the outset that the Code is statutory guidance. There is reference to it not being statutory guidance for others in paragraph vi but this should be strengthened.

The Code does not refer to the MHA Reference Guide. This should be signposted to ensure people know of its existence and that it may contain the additional technical information that has been omitted from the Code. During our own consultation discussions, there was a lack of awareness of the existence of the Reference Guide across practitioners.

The difference between the two documents could be confusing to readers. Our understanding is the reference guide offers technical information on the legislation while the
Code sets out how the MHA should be operationalised. This is unclear in the Code, as some areas of the Code attempts to explain legal positions such as the interface of the MCA and DOLS.

To support the governance frameworks and our own assessment we would also like to see the introduction of additional detail on the ‘list of policies and procedures’ section of the revised Code (awaiting development following consultation review).

There are over 40 references to training, the same for monitoring and over 150 to the requirement to record. The policy and procedure section may be improved by adding a ‘recording, monitoring, training and auditing’ section which could act as a checklist for CQC monitoring but also offer a guide for hospital managers about the minimum quality and governance systems that we expect to be in place. The current approach is for the audits and recording to be highlighted throughout the Code and a central location could improve awareness and compliance with the expectations.

Examples of Audit Requirements

Privacy, safety and dignity

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

Police Powers and Places of Safety

16.32 The policy should define responsibilities for:

- record keeping (see paragraphs 16.57 and 16.60) and monitoring (see paragraphs 16.61 – 16.63) and audit of practice against policy
- 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 autistic spectrum disorders

20.24 • regular audits of incidents involving restrictive practices to see whether less restrictive methods could be used.

20.32 The specialist expertise and skills of staff should be regularly audited, particularly the ability to recognise social needs as well as health ones, specialist communication skills, and identify a range of care options.

Receipt and scrutiny of documents

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.

Functions of Hospital Managers

37.42 Hospital managers should from time to time audit the timeliness with which they comply with their duties to refer patients to the Tribunal.

Consultation Question

4. In your opinion, does the proposed Code provide adequate guidance on local complaints and resolution procedures, specific to the Act? If it does not, please indicate any additional guidance that should be provided.

Chapter(s) of the Code

<table>
<thead>
<tr>
<th>General Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Introduction</td>
</tr>
<tr>
<td>Chapter 4 Information for patients, nearest relatives, carers and others</td>
</tr>
</tbody>
</table>

General Comments

Following the recommendations made from the Francis Public Inquiry, the Clwyd Hart report and the review of Winterbourne View we have been working on a programme to embed listening and responding with compassion to all complaints, concerns and feedback from patients. This has included how we inspect services, improving our own processes and working with strategic partners to improve people's experiences.

CQC believes that every concern and complaint is an opportunity to improve the safety and quality of care. We have drawn on external expertise and good practice to develop our approach including working with the Patients Association, Parliamentary and Health Service Ombudsmen and Public Concern at Work.

Through this work we have begun to identify some key areas of focus for our own inspection of services including whether people who use the service know how to make a complaint or raise concerns, how easy systems are to use and if complaints are handled effectively and confidentially with people being given the help and support they need to make a complaint.

We also look for examples of how staff listen, learn and improve the service as a result of feedback and complaints and if there is openness and transparency about how complaints, concerns and information from whistleblowers are dealt with.

We would recommend that the Code could include a reference to ‘encouraging patients to provide feedback’ within the introduction and Chapter 4. This use of more positive language may help to reduce some of the barriers that people have in reporting their experiences of care, locally and to national bodies.

Paragraph xxii should also reference the support available from an Independent Mental Health Advocate (IMHA) in progressing a complaint. This should be repeated in the IMHA section and patients offered referral to the IMHA service if they raise a concern with their care or treatment. This section should also reference the further information within paragraphs 4.50-4.54.

The Code should require all areas to display information on how to complain about their care and treatment. Specific information about the right of detained patients to complain to the Care Quality Commission should be included and the local support available if they wish to raise a concern or complaint.

4.52 It is usually best for initial concerns to be raised locally. It is expected that the organisation that is being complained about has had the opportunity to
respond to the concerns. To ensure this happens 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.

This addition is suggested to strengthen the expectation that before escalating to CQC or ombudsman’s the hospitals should provide every opportunity for the patient to raise complaint and receive a response locally. The wording has been aligned to the Parliamentary and Health Service Ombudsman resources and information for people wishing to complain.

4.54 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).

Paragraph 4.54 could be further strengthened by noting CQC’s statutory duty to review, and where appropriate, investigate complaints relating to patients who are currently subject to the MHA or where the complaint relates to a period when they were detained. Complaints may be referred to the CQC by a patient or any other person, with the patient’s consent, who may wish to raise a concern about the application of the MHA. The draft regulations on fundamental standards will give us further regulatory powers beyond the MHA for complaints. These will include Regulation 16 that will apply to all patients and MH services. This regulation includes a requirement for service providers to provide CQC with information, on request, about the complaint they have dealt with and set standards for receiving and acting on complaints (draft regulation below for information).

Receiving and acting on complaints

16. (1) Any complaint received must be investigated and necessary and proportionate action must be taken in response to any failure identified by the complaint or investigation.

(2) The registered person must establish and operate effectively an accessible system for identifying, receiving, recording, handling and responding to complaints by service users and other persons in relation to the carrying on of the regulated activity.

(3) The registered person must provide to the Commission, when requested to do so and by no later than 28 days beginning on the day after receipt of the request, a summary of—

(a) complaints made under such complaints system,

(b) responses made by the registered person to such complaints and any further correspondence with the complainants in relation to such complaints, and

(c) any other relevant information in relation to such complaints as the Commission may request.

Services should be required to have information available in "easy read" format (and other formats suitable for people with learning disabilities), and ensure the staff are trained in supporting people with learning disabilities to access information about complaints and resolution procedures. People with learning disabilities are less likely to complain, and advocates could play a greater role in ensuring that any concerns they may have are raised appropriately.

Consultation Question
5. To what extent do the proposed guiding principles set the correct framework for care, support and treatment under the Act? Are there any additional principles which may be beneficial?

<table>
<thead>
<tr>
<th>Chapter(s) of the Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chapter 1 Guiding principles</td>
</tr>
</tbody>
</table>

To strengthen the guiding principles it would be helpful to understand the DH position of whether we would expect the use of the ‘principles of the Code to inform decisions’ to have the same meaning as ‘having regard to the Code’.

This ambiguity presents a challenge for CQC in how we encourage or enforce services’ compliance with the principles as they apply to decisions taken during care and treatment.

We are aware the consultation process has revived the debate of whether the ‘principles’ of the MHA should be given statutory status, in line with ‘having regard’. This would be in line with the MCA and we would support further discussion and exploration of this with DH going forward.

Views on the new proposed guiding principles have been variable with some responders noting improvements and others preferring to keep the specificity of the previous principles. Keeping the old principles was also said to avoid losing the work completed to improve people’s awareness and understanding of the principles since their introduction in 2008.

It should be noted as there are no requirements for professionals or agencies to record or document their use or weighting of the guiding principles, this will continue to limit the amount of scrutiny CQC will be able to offer on the application of the principles. We ask the DH team to consider expanding on their expectations in this regard.

1.4 Restrictions that apply to all patients in a particular setting (blanket restrictions) must have clear justification for the particular group that they apply to and should not be indiscriminate for the convenience of the provider.

It would be useful to see this strengthened to say blanket restrictions may only be established by Hospital Managers and subject to the formal governance procedures and documented rationale that would accompany this. We offer this suggestion with the caution that the governance procedures cannot in themselves be a blanket procedure i.e. must always consider the unique circumstances of each individual area to which they apply – level of security, case mix etc. However we are committed to avoiding practices developed by individual wards or staff and increasing the ability of CQC to request evidence of the process used to develop the policy. To support this point we looked to the Munjaz judgment which stated “the procedure adopted by the Trust does not permit arbitrary or random decision-making. The rules are accessible, foreseeable and predictable.” We would recommend encouraging a wider recognition of the specific criteria that a court would expect to identify in circumstances that depart from the Code and particularly in relation to restrictive practices.

Empowerment and participation: Patients, their families and carers should be fully involved in decisions about care, support and treatment.

CQC have adopted the language of ‘significant others’ to recognise the potential for people other than families and carers in patients care and treatment. Patients may seek to involve friends for example who do not offer any level of care. The determination of the significant others and whether or not to involve them and to what extent should always be the choice of the patient or informed by their previous wishes if they are not able to decide at the time (see
1.6 Patients must be given the opportunity to be involved in planning, developing and reviewing their own treatment and care to help ensure that it is delivered in a way that is as appropriate and effective for them as possible.

We suggest that the following additional text should also be added to this section: Patients should be encouraged and supported in seeking the involvement of significant others who have an interest in the patient’s welfare (unless there are particular reasons to the contrary) and their views taken seriously.

Our Service User Reference Panel felt this paragraph could be strengthened by adding the above text. The panel members were very clear that the involvement of others in a patient’s care and treatment should always be at the request of the patient and they should be empowered and enabled to seek that involvement.

1.7 …A patient’s views, past and present wishes and feelings (whether expressed at the time or in advance), must be considered so far as they are reasonably ascertainable. There must be no unlawful discrimination.

The views and wishes of a patient must be considered in accordance with the MCA. As the Code can apply to patients before and after detention this paragraph should be amended to an absolute rather than an optional statement.

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

This is not an optional requirement and is supported by the Equality Act 2010 and the Human Rights Act.

1.12 “Physical healthcare needs must be assessed and addressed including steps to reduce any potential side effects associated with any treatments.”

In relation to people with challenging behaviour, emphasis should be placed on ensuring that professionals have excluded physical causes for this. This may require expert assessment, but people should not be detained under the Act without ensuring that there is not a physical cause for their challenging behaviour.

Consultation Question

6. In your opinion, does the proposed Code ensure that equality and human rights are adequately protected in the use of the Act? Do you have suggestions on where and how the Code could be further strengthened in this regard? Can you provide evidence or examples of the equality impact of the Act?

Chapter(s) of the Code
- Introduction
- Chapter 3 Equality and human rights

General Comments

CQC comments across all other consultation questions have been informed by our focus on the prevention of negative impacts to peoples human rights. A reference to the role of CQC would be welcome in this chapter. Suggested text;
CQC has a duty under the Act to monitor how services in England exercise their powers and discharge their duties in relation to patients who are detained in hospital, or subject to CTOs or guardianship. The primary purpose is to provide a safeguard for individual patients whose rights are restricted, and to review how legal powers of compulsion are being used.

The UK ratified the United Nations Optional Protocol to the Convention against Torture (OPCAT) in 2009. This requires participating states to prevent torture and other forms of inhuman or degrading treatment through regular visits to places of detention by bodies known as National Preventive Mechanisms (NPM). As the visiting body to places of psychiatric detention in England, CQC is part of the UK’s NPM and their work helps to fulfil the UK’s legal obligations under the Convention. The prevention of negative impacts on human rights standards is a core function of the CQC’s monitoring and inspection visits.

The Equality Act 2010 and the Human Rights Act should be included in the ‘Related Legislation’ area on page 7 of the Code to increase awareness and strengthen the links between the MHA and equality and human rights issues.

The Code could usefully recognise the additional difficulties faced by people with learning disabilities, in ensuring that their human rights are upheld. The scale of the abuse inflicted at Winterbourne View demonstrates this.

### Consultation Question

7. In what ways could the Code say more to ensure that people have a say in their own care and that their wishes and feelings are taken into account?

### Chapter(s) of the Code

- Protecting patients’ rights and autonomy
- Chapter 9 Wishes expressed in advance
- Chapter 23 Appropriate Medical Treatment Test
- 32 Detention and CTO: renewal, extension and discharge
- Chapter 34 Care Planning

### General Comments

DH attended our Service User Reference Panel during the consultation period and they offered the following feedback to the DH Team:

- Key to good care and treatment is to always involve the person, including the use of advance decisions and statements
- Be clear on what is a ‘must’ do and what would be good practice so people using services know when they can raise complaints or concerns
- The involvement of others including families, carers and others must be with the person’s agreement, if they have capacity to give or withhold such agreement. The language in the Code should require the patient offered support with involving their families and carers rather than imply involvement will be carried out by the professionals unless individual patient’s ask or need this to be done on their behalf.
- Make it clear in the Code where people retain an ability to choose. This would support the principles of greater involvement and empowerment

We also offer the following suggestions for change:

- **9.10 Clinicians should 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.

If there is any doubt about the validity or applicability, a clinician should consider seeking legal advice or a ruling from the Court of Protection, and continue to treat the person if necessary to prevent the person’s condition getting seriously worse, or to sustain life, while the court decides.

9.14 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 – e.g. 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.

An Advance Decision Refusing Treatment (ADRT) can be valid and applicable despite not being written down as long as it’s not refusing life-sustaining treatment, when specific criteria must be met. It can be overruled by use of the MHA. See Mental Capacity Act (MCA) s.24, MCA code 9.10.

Research and NICE guidance has repeatedly advocated the importance and direct positive impacts of offering and using advance decisions in care planning and discharge. We strongly believe chapter 32 and 34 should have a clear expectation that patients will be supported in understanding their right to complete a binding advance decision or discuss their wishes and feelings for future arrangements of care. CQC would be able to monitor this and look for the discussion and existence of any such statements where patients have previously been detained. The current lack of expectation in the Code makes this a difficult area in our MHA monitoring processes but is something we are committed to improving. This is also an area our Service User Reference Panel have raised as critical to empowering and involving people in their care and potentially reducing the number of restrictions necessary.

In Chapter 23 of the Code we make the following observations;

The MHA requires appropriate medical treatment to be available to the patient in order to meet the criteria for s3 detention or CTO. In addition to a shared understanding of the definition of appropriate treatment, the Code needs to make a statement about ‘availability’ and what this means in practice. It can’t be acceptable, in terms of principles of least restriction, purpose, freedom and personal control, to detain someone for treatment that may become available next week or next month – or worse for treatment that’s not reflective of current best practice guidance.

The section on this in the current Code completely omits any reference to the patient’s own views and experiences on what works for them.

Consultation Question
8. What additional information in relation to the provision of independent mental health advocates would it be helpful to include?

Chapter(s) of the Code
Chapter 6 Independent mental health advocates

General Comments
CQC have been involved in the DH’s Independent Mental Health Advocate: Right to be Heard research programme and ask that the chapter authors ensure the learning from the research is fully considered for inclusion in the relevant chapter.

The issues we have regularly found in our MHA monitoring and reported in annual reports are the patients awareness of the IMHA, accessibility of the IMHA service and resourcing of the IMHA services. We have also found issues with the ability or support for IMHA’s to offer feedback to hospital services to improve patient experience. In our own approach to inspection we have found the contribution from IMHA’s to be a valuable source of information to inform our assessment of services.

To improve and strengthen the Code should be clear from the beginning of chapter 6 that the requirement to provide IMHA’s is a statutory duty and not merely recommended.

The Act and the Code do not provide guidance on the availability of IMHA’s commissioned by Local Authorities. We suggest this is amended to reflect the expectation in para 14.31 for AMHP’s and the responsibility of the Local Authority to ensure a ‘sufficient number are available to carry out the role’. We have observed areas where insufficient numbers have led to visits only being completed once a quarter or not responding to requests in a timely manner

Practice issues have also highlighted a lack of process for the IMHA’s to raise concerns or issues with hospital management. A reference to the expectation that IMHA’s will be provided with a feedback mechanism or to use the same process as set out in Chapter 4 would help to resolve this matter.

Another recent practice issue reported through our new approach to inspections has highlighted that there may be some areas where the Local Authorities have delegated the commissioning of IMHA’s to the provider organisation. This raises concerns for us of the independence of the service and should be addressed through a specific reference in the Code or through separate guidance being issued by DH.

Patients who are on CTO’s are particularly at risk of not being able to access IMHA’s. This is increased where insufficient IMHA’s are available. An additional paragraph to strengthen the expectation that CTO patients will be regularly reminded of their right to access and IMHA and offered alternative options of access such as telephone contact would be welcomed.

There are no requirements for the hospital managers to ensure a record is made of referral to IMHA services or the refusal of a patient to accept IMHA involvement. This would be beneficial for our own inspection and monitoring and also useful for local discussions between providers, commissioners and advocacy services.

6.18 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’s case stays open.

This paragraph could be further strengthened by offering a description of what is meant by a person’s ‘case’. In some areas we have heard that patients must be re-referred for each type of support they require. For example, a patient who asks for an IMHA to be present for a tribunal would have to be referred back to the IMHA if they wanted involvement in a care planning meeting or treatment review. The case staying open should be dependent on the patient’s needs.
Consultation Question
9. How should the Code be updated to reflect the use of electronic media in a patient’s correspondence and communications under section 134?

Chapter(s) of the Code
Chapter 8 Privacy, dignity and safety

General Comments

Our own monitoring reports tell us that some hospitals have had difficulties implementing the old code, and have misused the, ‘privilege’ of phone calls. We suggest significant changes to this part of the code with the aim of preventing further abuses and improving safeguards.

Communication with family and friends is integral to a patient’s care be it via phones, mobiles, email or social media. This should only be limited or restricted in certain risk-assessed situations. Consideration also needs to be given to deaf people who have special communication needs.

Consultation Question
10. How can the Code be more specific about aspects relating to the right to have visitors and access to family and friends?

Chapter(s) of the Code
Chapter 11 Visiting Patients in Hospital
Chapter 8 Privacy, dignity and safety

General Comments

11.5 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 has access themselves.

This paragraph should include DoLS assessors. MCA s.39A, s.39C and s.39D IMCAs if appropriate, where P is subject to a request for DoLS authorisation or one is in place should also be added.

11.16 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 an authorisation under the deprivation of liberty safeguards of the Mental Capacity Act (MCA DoLS) may need to be sought, or if there is an intractable dispute about the informal incapacitated person’s best interests, an application should be made to the Court of Protection, or formal admission under the Act (see chapter 13).

Previous case law involving disputes with a person’s interested relatives, carers or friends has suggested that the Deprivation of Liberty Safeguards cannot be used. In this situation we would expect the dispute to be referred to the Court of Protection.

In the ‘related material’ for this chapter a reference to the Deprivation of Liberty Safeguards COP should be included.

11.11 and 11.14 should include a reference to a requirement for the hospital managers to ensure the patient and visitor know how to raise concerns with the decision to exclude them.
This could be cross referenced to chapter 4.

11.19 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.
This could be strengthened by adding that alternative environments should be considered where a local option is not available.

11.3 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 refreshment and pleasant surroundings will all contribute to a sense of respect for the patient’s entitlement to be visited.

We suggest strengthening the Code to ensure visiting times and arrangements are communicated to the patients as soon as possible following arrival to the ward or unit. Hospital Managers should also be asked to ensure visiting arrangements are clearly communicated verbally and displayed in the wards.

Consultation Question

11. Is any further guidance required to ensure the avoidance of blanket restrictions? If so what guidance is needed?
Chapter 8 Privacy, dignity and safety

General Comments

Our proposals in this matter are in addition to our previous narrative on this core issue in our MHA monitoring reports. We are also involved in the wider DH Positive and Safe programme which looks at all restrictive interventions.

1.4 Restrictions that apply to all patients in a particular setting (blanket restrictions) must have clear justification for the particular group that they apply to and should not be indiscriminate for the convenience of the provider.

This should be strengthened to say blanket restrictions may only be established by Hospital Managers and subject to the formal governance procedures and documented rationale that would accompany this. This would avoid practices developed by individual wards or staff and allow CQC to request evidence of the process used to develop the policy. To support this point we looked to the Munjaz judgment which stated “the procedure adopted by the Trust does not permit arbitrary or random decision-making. The rules are accessible, foreseeable and predictable.” We would recommend encouraging a wider recognition of the specific criteria that a court would expect to identify in circumstances that depart from the Code and particularly in relation to restrictive practices.

The consultation document refers to paragraphs 8.37 – 8.48 being the new guidance to avoid blanket restrictions. These paragraphs only seem to address the issue of locked doors and not all the various ways in which a person can be restricted including the range listed in consultation paragraph 5.6 “through allowing or forbidding access to telephones, water and other drinks, outside space, external visits, use of internet and mobile telephones. The CQC report on the Act 2013/13 reported that during a focussed review of some wards they found blanket restrictions (applying to all patients in a particular ward or hospital) being applied in 74% of cases. In 65% of cases where blanket restrictions were employed the ward were unable to give adequate reasons for their use”

To address this a paragraph which is clearly headed ‘blanket restrictions’ in chapter 8 would be welcome. This could include the wording from Chapter 26 or our suggested
Consultation Question

12. In your opinion what additional guidance is required in relation to the rights and roles of families and carers?

Chapter (s) of the Code

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

General Comments

See our response to question 31 for additional information on the specific powers of a Nearest Relative.

The involvement of others including relatives and carers should only be where the person wants this to happen. All references throughout the Code to the rights and roles of families and carers should reflect that the person is helped to involve them as much or as little as they prefer.

Early reports from our inspections of mental health services has highlighted a lack of guidance in the Code regarding the ongoing identification, recording and involvement in the care and treatment as required by the Code of Nearest Relatives (Section 26) after the AMHP’s initial assessment and application (Section 11). We found that where a Nearest Relative had not been identified this was not followed up by the hospital managers during the detention. Due to the importance of the safeguard provided by the Nearest Relative and potential of change to the Nearest Relative following initial AMHP assessment we would like to see a specific reference in the Code. This may be added to Chapter 4, 5, 14 and 37. We offer the following form of words;

Following initial detention the ongoing identification and involvement of Nearest Relatives becomes the responsibility of the Hospital Managers. The identity of a Nearest Relative may change during the period of detention and Hospital Managers should take whatever steps are practicable to engage the person they believe is the Nearest Relative at any given time, unless the patient has asked that they should not be involved. This should, as a minimum, take place when the patients detention is being formally reviewed, discharge planning or appeal/referrals to the Tribunal are made.

Consultation Question

13. Is there any other guidance on the interface that you think would be helpful and if so, what? Do you think that this is sufficiently user friendly to help your professional practice?

Chapter (s) of the Code

Chapter 13 Mental capacity and deprivation of liberty
Chapter 14 Applications for detention in hospital

General Comments

We found the approach of chapter 13 to be inconsistent with the rest of the Code in many areas. We are aware of the commitment of the DH team to ensure the Code is in plain English and accessible for patients, staff and any other interested parties and feel this
Chapter does not hold true to that objective. The contents of the Code must be unambiguous to allow us to inspect its operationalisation in services, if we are unable to understand the intended application of this chapter then we would be limited in our ability to inspect against this.

The use of a summary of the contents of the chapter in 13.2 and signposting to other relevant chapters in para 13.3 could helpfully be applied to other chapters. The related material in 13.4 is not consistent with the use of this signposting to guidance or legislation at the end of other chapters. Headings throughout the chapter are also in the ‘question’ style that is found in the MCA and DoLS Codes and not consistent with the MHA Code.

Although we understand the positive and supportive intent of the chapter it may have a negative impact if its current structure is retained. The chapter tried to tackle the complex issue of summarising both MCA and DoLS then identifying where professionals and services may need to apply the legislation. The chapter itself falls into the grouping of ‘Assessment, transport and admission to hospital’ but extends to comment on care planning and treatment that go beyond initial admission. These topics are highlighted in the relevant chapters so it seems unnecessary to offer a summary here that could be confusing to people reading the Code. We suggest reviewing all areas of this chapter to ensure consistency with the other chapters and intent of the Code. This may lead to a decision that the information within the chapter is more appropriately addressed by adding specific sections into the more general chapters on application, treatment etc.

We have also offered more specific comments on the chapter in its current format for consideration:

13.2  
- provides guidance for determining whether a patient should be detained under the Act or under a DoLS authorisation/DoL order in the Court of Protection.

13.5 The DoLS authorisation can only be made in respect of an individual aged 18 or over. A DoL order can be made by the Court of Protection in respect of individuals aged 16 or over. Most of the MCA applies to individuals aged 16 and over, but a person must be 18 to make an advance decision to refuse treatment or create a lasting power of attorney.

13.6 The MCA provides the legal framework for acting and making decisions on behalf of individuals who lack capacity

There should be an explanation somewhere (as stated prominently in the MCA Code) that here, as throughout the Code, a person’s capacity (or lack of capacity) refers specifically to their capacity to make a particular decision at the time it needs to be made

13.8 Further, for such a patient, any advance decision by them under the MCA to refuse proposed medical treatment or any decision 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 unless the treatment is electro-convulsive therapy

An addition is recommended for clarity on the different legal position on electro-convulsive therapy

In 13.9 reference is made to the ‘fundamental principles’. This is not a term used in the MCA or the MCA Code. This should be removed and replaced with ‘principles’ s.1 of the MCA or ‘statutory principles’ chapter 2 of the MCA Code to avoid introducing new terminology.

13.11 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).

This paragraph is unnecessary as the Introduction to the Code already states this position across all areas of the Code and the use of legislation.

We ask that the deprivation of liberty safeguards is spelled out in full throughout the document. Our view is in referring to an authorisation given under MCA Schedule A1 we do not use DoL but DoLS – the point being that these are the safeguards and this would reflect other available guidance. In our own publications we avoid using phraseology “DoL(S) authorisation/DoL order” to mitigate the risk to the dignity of patients when DoL is used in isolation. This would also be consistent with the language in the MCA schedules and associated Codes of Practice. For example;

The code should encourage staff to know and work within the law. A clear statement could be made, such as: when supporting, caring for and treating a patient under the Act staff should be aware of the legal frameworks, and how they apply to individual patients. In particular they should be aware of the Act, the MCA, DoLS, the HRA, the Children Act, the Equality Act and relevant codes of practice and associated guidance. All staff should ensure that they are acting with legal authority.

The code refers to two groups of patients under the term 'informal'. Firstly those who have capacity to make a decision about admission and treatment and who are consenting (voluntary patients) and those who lack capacity to make these decisions, are compliant and are admitted under the MCA (informal patients). It is worth considering separating these groups out as admission processes will be different as will treatment processes.

The new code refers to the term 'capacity to consent'. We this is removed as may be confusing. The assessment of capacity relates to whether or not someone is able to make a decision (to either consent or dissent). Consent only applies to those who have capacity to make a treatment decision and consent to the treatment. The code, for example, talks about 'testing capacity to consent'. This is incorrect.

The definition of capacity given in the code is poor. It outlines the functional test but not the diagnostic test. The principles are mentioned in the code but more emphasis needs to be given to the second principle; steps which staff may take to maximise capacity.

Although it states that all assessments of capacity should be recorded in the notes it does not state how. We suggest that the following is covered:

- The decision for which capacity is being assessed
- The steps taken to maximise the persons capacity
- The information which was presented to the patient in relation to the decision
- How the diagnostic criteria was assessed
- How the functional test was undertaken, and how the assessor reached their conclusions
- If a person is unable to make a decision, whether this is (or is not) linked to the diagnostic test.

The code needs to be specific about what steps the provider should take if they find that someone has been detained of their liberty without legal authority. For example the patient should be informed of the illegal detention and advised and assisted to seek legal advice. A safeguarding referral should be made.
The code needs to make it clear that Responsible Clinicians should have a detailed discussion with patient to either inform consent (for those who have capacity) or to ensure the involvement, wishes, and feelings are taken into account for those who lack capacity.

The code needs to be more specific on how staff should support someone to appeal to the hospital managers or the Tribunal when they lack capacity to make this decision.

The code should state that all patients should be encouraged to make advanced statements if they capacity to do this. Advanced statements should be regularly reviewed with the patient.

The role of the deputee/LPA should also be referred to in relation to discharge especially as they are the decision maker.

The new code talks about the best interests of a child/young person. This is slightly confusing: The MCA does not apply to anyone under 16 (so it would not be a best interests decision for a child), and for those over 16 it would only be a best interests decision if they lack capacity).

The code considers treatment options for patients detained under emergency applications for detention but omits treatment options for patients detained under S136 and also patients liable to being detained who are being conveyed. This needs to be addressed.

13.31 A deprivation of liberty can occur in domestic settings where the state is responsible for imposing such arrangements. This includes where the state is aware of, of should be aware of, the imposition of such arrangements.

The text above has been suggested to meet case law which has established the precedent that on occasions the state may be accountable even for arrangements which it has not itself made.

13.33 An authorisation will only be given if the person concerned is assessed to meet all six of the qualifying requirements, on which detailed guidance is given in the DoLS [or deprivation of liberty safeguards] Code of Practice.

Consultation Question
16. What guidance could the Code give to local governance systems to ensure that AHMPs are not put in this position?

Chapter(s) of the Code
Chapter 14 Applications for detention in hospital

General Comments

The Code should ensure that local arrangements support the potential need to escalate issues when a bed cannot be found. This should refer to the s.140 notice provided by the Clinical Commissioning Group and the options available to the AMHP when they feel delays to admissions may impact upon the clinical needs of the patient. Local recording and reporting mechanisms should be in place to ensure the details of the delay and impacts on both patient and services are reported to those with responsibility for oversight of the MHA and health and care services. While the Code cannot seek to resolve the availability of appropriate beds it can ensure that a standard report and record system are a minimum requirement for AMHP services and local agencies. The absence of adequate records or escalation to hospital managers has been repeatedly noted through our own observations of this issue in services.
We suggest additions to the Code may be made in Chapter 14 that require AMHP services, Clinical Commissioning Groups and Hospital Managers to have local governance systems in place. As the admission of patients to hospital from community may involve several agencies we suggest the governance framework should be similar to that noted in the chapter on police powers and places of safety. We have offered a form of words for applications to hospital based upon the existing police powers chapter and the requirements of s.140 for review;

Jointly agreed local policies should be in place to govern the admission of detained patients. Good practice will depend 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 the safe and appropriate admission of people to inpatient units from the community within their localities
- 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 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.

The policy should define responsibilities for:

- commissioning and providing arrangements for the reception of urgent cases, including for people under the age of 18
- identifying and agreeing the arrangements in local areas, including contingency arrangements for those cases where the hospitals named in the policy are not available. This should ensure local agency boundaries should not be an overriding constraint, and there are arrangements to ensure children and young people can be admitted in special urgency
- escalating, recording and reviewing decisions, particularly in the event of disagreement.
- providing prompt assessment (including how soon the doctor and AMHP should attend)
- arranging for the attendance of police officers in urgent situations, where appropriate, for the patient’s health or safety or the protection of others
- the safe, timely and appropriate transport of the person to hospital from the community
- 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
17. To what extent do the changes to Chapter 16 on police powers, address concerns around the use of sections 135 and 136? What further changes are required?

Chapter(s) of the Code
Chapter 16 Police powers and places of safety

General Comments

Our report on Health based places of safety is expected for publication in October 2014. We will be working with DH separately to the consultation to offer additional learning points in this area. CQC are also involved in the steering group for the s.135 and 136 consultation and have offered a detailed response to the consultation team that should be inform the final review of this chapter of the Code.

Consultation Question

18. In relation to the ‘zone of parental control’, do you think that this is a helpful term? If not, do you have any suggestions for an alternative term or is it sufficient to explain that there are limits to decisions that parents can take for their children?

Chapter(s) of the Code
Chapter 19 - Children and young people under the age of 18

General Comments

The term, “zone of parental control” is not helpful, and it is proposed that the term is amended to, “Range of parental control.”

We consider that a zone of parental control is a misleading term and that the code should explain the limits to the decisions a parent can make on behalf of their children.

Consultation Question

19. Further guidance has been provided on when a young person who has capacity might not be able to consent, but the term ‘overwhelmed’ has been removed as this was thought to be confusing. Are the relevant sections clearer?

Chapter(s) of the Code
Chapter 19 - Children and young people under the age of 18

General Comments

The removal of the term “overwhelmed” is welcomed since this was felt to be excessive. Its removal has made chapter 19 of the new draft Code clearer.

One additional point in Chapter 19 is the reference to ‘serious untoward incidents' in paragraph 19.95. We understand this term has been replaced with ‘serious incidents requiring investigation’ in the Serious Incident Framework produced by NHS England.

Consultation Question

20. Does the Code provide sufficient information in relation to individuals where additional safeguards or considerations may be required, e.g. due to age, or disability? Please note any instances where information is not sufficient.

Chapter(s) of the Code
Chapter 20 - People with learning disabilities or autistic spectrum disorders
Chapter 16 – Police Powers and Places of Safety
Chapter 26 - Safe and therapeutic responses to disturbed behaviour
General Comments

This chapter will be used in our regulation and monitoring of all areas that provide care and treatment to people with a learning disability. CQC is currently developing its own approach to the regulation of learning disability services and will be using the MHA Code to determine our own measure of what ‘good looks like’ in the services we regulate.

The update to chapter 20 of the Code to further promote equality and inclusion considering reasonable adjustments under the Equality Act 2010 in the provision of care for people with learning disabilities or autistic spectrum disorders is welcomed. The emphasis within this chapter for professionals and practitioners to also be familiar with the key issues identified within the Mental Capacity Act is fundamental.

We included references to the approach for Learning Disability in our previous return and asked for the wording of the Code to be strengthened to ensure access to specialists during assessment. The response was the updates offered a stronger position but we do not agree this is the case. Specifically;

2008 Code
10.29 – In relation to people with learning disabilities detained under s.136: it is merely ‘desirable’ to involve a doctor or AMHP with ‘knowledge and experience’ of learning disabilities.

2014 Code
16.46 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.

We would like to see this further strengthened and suggest;

In all cases either a consultant psychiatrist in learning disabilities or an AMHP with knowledge and experience of working with people with learning disabilities should be requested to make the assessment where it appears that the detained person has a learning disability. Any reasons why one or both could not carry out should be recorded and efforts made for the assessing professionals to discuss the assessment via telephone with a specialist.

We would be able to look for variations and exceptions to this practice and also ask to see records of the rationale when this could not be done.

20.1 Professionals and practitioners working with people with learning disabilities should also be familiar with Mental Capacity Act (MCA), Human Rights Act 1998 and the Equality Act 2010.

Professionals should also be aware of the Human Rights Act (HRA) since any implementation of domestic law can be challenged in line with whether it aligns itself with the HRA.

20.2 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’.

20.3 Although defined as a mental disorder in this way, learning disability shares few features with the serious mental illnesses that are the most common reason for using the
Act. Relatively few people with learning disability are detained under the Act, and where they are this must be for treatment.

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.

Although we recognise the definition is taken from Section 1 of the MHA, the diagnostic classificatory system is currently undergoing changes (ICD revision by the World Health Organisation). Developments here should be monitored and may need to be reflected in future statute changes.

Additionally the broad definition of LD may lead to the more likely inappropriate use of the Act. ‘Relatively few’ people with LD being detained may not be true. Comparing data, 0.2% of people with LD are detained in hospital (LD Census 2013) compared to 0.3% of general population (CQC MHA Annual Report 2012/2013)

20.4 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. Where a learning disability is identified, then three further issues have to be considered:

- whether the MCA has to be applied in addition to the Act and, if so, how,
- whether reasonable adjustments would assist the person with learning disabilities, and
- what the inclusion and promotional person’s human rights would add to the wellbeing of the person

Diagnosis guided by professional practice is in a state of flux. The English system is moving towards IQ measurement (BPS 2014) and the international system moving away from intelligent quotient ceilings (Greenspan & Woods 2014). This should be considered within the section.

20.5 In addition to the information in chapters 3 and 13, for individuals with a learning disability the following should be taken into consideration:

- where a decision is being made for a person with learning disabilities in their best interests, an independent mental capacity advocate (IMCA) must be involved, particularly if the person has no family or friends to be consulted.

We suggest added a specific reference to IMCA here if there is a difference of opinion between families and professionals with regards to what is in the best interests of the patient where the MCA applies to the decision in question.

It was also challenged that the explanation for when to involve an IMHA is more complicated than reflected here - a patient must be facing a major decision about where to live or serious medical treatment, lack capacity for that decision at the time it needs to be made, and have nobody except paid carers to be consulted. In those circumstances an NHS body or local authority MUST instruct and IMCA. See MCA code ch.10 for consistency across the Codes. A reference in this paragraph to the location in the MCA Code or requirement to get further information from the MCA Code may be useful for staff and patients.
In addition to the information in chapter 3, for individuals with a learning disability the following should be taken into consideration in relation to the Equality Act:

- if restrictive interventions may be used, the person should have a behaviour support plan that sets out what type of restrictive interventions may be used (chapter 26). People with learning disabilities need behaviour 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.

Behaviour support plans are mentioned in relation to restrictive practice – restrictive practice should be part of the plan but should not be the only item on the behaviour support plan.

This means, for the purposes of admission or treatment under the Act, a person may not be considered to be suffering from a mental disorder simply as a result of having a learning disability: the disability must be associated with abnormally aggressive or seriously irresponsible conduct.

Neither term is defined in the Act, and it is not possible to define exactly what kind of behaviour would fall into either category. It will, inevitably, depend not only on the nature of the behaviour and the circumstances in which it is exhibited, but 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.

The definition of “abnormally aggressive or seriously irresponsible conduct” was clarified in R v Trent MHRT ex parte Ryan [1991], Nolan MJ said that “when the conduct amounts to abnormally aggressive or seriously irresponsible conduct, it seems to me, that it raises issue other than that of a clinical nature”.

The 2008 MHA Code states at paragraph 34.8 that abnormally aggressive behaviour is “behaviour which leads to a conclusion that the actions are outside the usual range of aggressive behaviour which causes actual damage and/or real distress occurring recently or persistently or with excessive severity”. Irresponsible conduct is “behaviour that shows lack of responsibility and disregard of the consequences of the action taken where the results cause actual damage or real distress either recently or persistently or with excessive severity”. In Lewis v Gibson [2005], it was established that such conduct need not be current and some regards must be had to the past history on the future propensity of that behaviour. The courts have been quite lenient with the amount of time in the past when a previous abnormally aggressive or seriously irresponsible conduct had occurred.

We recommend paragraph 34.8 of the 2008 Code is reinserted to the draft Code.

A patient with a learning disability cannot be informally admitted if they do not have capacity to consent to that admission and treatment. If the patient 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 deprivation of liberty order by the Court of Protection (DoL order) must be in place to authorise the deprivation of liberty (see chapters 13 and 14). CQC must be immediately notified if there is a risk that such a patient may be unlawfully deprived of their liberty.

CQC must be notified of all applications for authorisation of deprivation of liberty, whether by use of DoLS or by the Court of Protection, and the outcomes. The above scenario is not an urgent notification.
If a person with a learning disability is detained under the Act, a comprehensive assessment of their needs must be undertaken to ensure that any reasonable adjustments are made. This must include:

- communication support
- positive behavioural support (PBS) (see chapter 26)
- adapted treatment programmes including psychological therapies
- adapted therapeutic environment
- 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.

The assessment for mental illness should be part of any assessment period under detention and should be included within this section.

Providers cannot assume that people with learning disabilities 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 must take such steps as are practicable to ensure people with learning disabilities can access information and advice, including access to additional support such as independent mental health advocates (IMHAs) or independent mental capacity advocates (IMCAs) (see chapter 6).

Information about medications in accessible format should be made available and should be used routinely and also as part of T2/T3 MHA requirements. This should include reference to good practice points such as those set out in the current NHS England Consultation on Making Health and Social Care Information Accessible.

In our MHA annual report 2009/2010 we made the following observation:

Page 72: The Code states that mechanical restraint should never be a standard way of managing disturbed or violent behaviour in acute mental health settings. But it is silent about its use in other types of mental health or learning disability service. This is unhelpful, as the examples of mechanical restraint encountered by Mental Health Act Commissioners have rarely, if ever, taken place in acute mental health services. They are usually confined to learning disability units, forensic services and services for older people.

In our report - CQC and the Challenging Behaviour Foundation. 3 Lives: What have we learned, what we need to do (2014) we raised the following issues and key themes that have been relevant to our review of this chapter/question;

- Individuals are in long-term hospital placements and repeatedly detained under the Mental Health Act (MHA).
- The MHA Code needs to set out parameters of acceptable practice about long-term detention under the MHA.
- The law is not used effectively and efficiently to ensure that people’s rights are upheld.
- Individuals do not routinely have access to high quality independent advocacy services that meet needs.
- People end up in services that are available and more secure – rather than in places where they get the support they need.
- Whole life approach to support and services with seamless transitions,
Child and Adolescent Mental Health Services (CAMHS) must provide assessment and intervention when indicated to individuals with a learning disability.

Additional learning from our inspection of long stay establishments has also highlighted:

- The routine re detention by hospital managers for people where there is no current effective treatment options.
- Hospitals are being used for people who are not being actively treated as there is no alternative accommodation.
- Recall beds local provider insisting that these are provided by the originating detaining authority before agreeing to the use of CTO’s

Section 2 to Section 3
The requirement for clinical records of the assessment completed while a patient has been on section 2 and outcomes should be considered. This would be the responsibility of the Responsible Clinician but form part of the patient records so available for inspection by CQC or the patient. We believe this would strengthen the safeguards and allow transparency and scrutiny of the decision making involved when discharging or assessing people for further detention. The specific record of this decision would improve our ability to review against the guiding principles and inform the shared understanding of the findings of the assessment under s.2.

20.4 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. Where a learning disability is identified, then three further issues have to be considered:

- whether the MCA has to be applied in addition to the Act and, if so, how,
- whether reasonable adjustments would assist the person with learning disabilities, and
- what the inclusion and promotional person’s human rights would add to the wellbeing of the person

The diagnosis of learning disability in adulthood is not a matter for clinical judgement only. It requires formal assessment of intellectual and social functioning, an appropriate developmental history and sufficient skills and expertise to integrate information from these assessments, in order to determine whether or not the individual has a learning disability. We are aware the British Psychological Society plan to publish guidance on the Assessment and diagnosis of intellectual disabilities in adults which may be helpfully reviewed by the DH team.

20.11 This means that people with a learning disability cannot be detained under the Act simply because they have a learning disability or autism, or they are displaying behaviour which is challenging due to an unmet physical health need, unmet social or emotional needs, or unmet support needs. They must meet the criteria in the Act for detention. Detaining a patient with a learning disability if they do not meet the criteria is unlawful.

Learning disability is frequently given as the reason to detention under the Act, and this is frequently to do with challenging behaviour. (The Code needs to acknowledge this, and that it is inappropriate). The lack of definition of what constitutes abnormally aggressive or seriously irresponsible behaviour results in inappropriate admission; this can then result in excessive lengths of stay. The Mansell reports showed clearly that treating an individual’s
challenging behaviour in a hospital setting is not appropriate. It could therefore be seen to
be in breach of their human rights, is they are likely to be subjected to an unlawful detention.
The Code needs to be strengthened in relation to this issue, stating very clearly that
clinicians need to be able to justify how they have come to the conclusion that the individual
is exhibiting abnormally aggressive or seriously irresponsible behaviour; the Code currently
still allows for learning disability (associated with challenging behaviour) to be a "catch-all"
category. Experience shows us that is frequently used in emergency situations, which can
also result in the individual being placed far away from home.

The Code could usefully take this opportunity to ensure that this practice no longer
continues. It could require clinicians to justify how the criteria of abnormally aggressive or
seriously irresponsible behaviour has been met – and how these criteria differ from (and
exceed in terms of severity) challenging behaviour; also how it relates to the mental disorder
as opposed to other factors.

This needs to be clarified – the criteria for detention (in the absence of another mental
disorder – are still behavioural, even though apparently categorized as different to
challenging behaviour. Clinicians should be able to justify detention for behavioural reasons
in a form that is auditable and able therefore to be inspected by the CQC. SOADs should
also question detention for this reason.

20.28 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
understand the Tribunal's role. An individual (and family or friends 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, IMCAs or other advocates.

We do not believe this to be a part of the IMCA role. We recommend this is checked to
ensure the expectations of staff or services are not incorrectly informed by this reference.

Chapter 26
The term ‘behaviour support plans or equivalent’ should be used throughout the chapter to
avoid confusion for patients and providers. While this may be an accepted term in LD
settings it is not understood to be common terminology for other settings and a care plan
would be the usual location for the requirements of para 26.13.

26.3 The primary focus of any provider which treats patients who are liable to present with
behavioural disturbance should be the provision of a positive and therapeutic culture which
focuses on preventing behavioural disturbances, early recognition, and deescalation

It would be useful to describe the different types of restrictive practices at the beginning of
the chapter rather than later in 26.6. It should be made clear that the indication for restrictive
practice is not just to prevent harm from patients to others but also to prevent patients
harming themselves.

Stages of a restrictive intervention reduction programme should include prediction,
prevention, intervention, post-intervention analysis / debriefing and learning and informing
care plan.

26.5 A key indicator that a plan is being delivered well will be a reduction in the use of
restrictive interventions, reductions of injuries as a result of restrictive interventions,
Improved patient satisfaction and reduced complaints.

Suggest:
A key indicator that a plan is being delivered well will be a reduction in the use of
restrictive interventions. Other expected indicators include reductions of injuries as a result of restrictive interventions, improved patient satisfaction and reduced complaints.

26.6 Each provider should have one or more policies that guide the day-to-day operation of services:

- workforce development, including training requirements relating to the application of restrictive interventions

The key issue is to acknowledge restrictive interventions in health and social care settings as a therapeutic intervention and the need for this to be care planned, evidence based, legal, in the best interests, proportionate and dignified. The therapeutic intent should underlie any training for staff.

- local recording and reporting mechanisms around the use of restrictive interventions

When reporting and recording incidents, local policies should dictate triangulation of the different types of restrictive practices and compare it to baseline measures of complexity of mental disorders and their presentations – i.e. there should be meaningful interpretation, analysis and response to restrictive interventions. Local recording should also offer distinction between the different types of therapeutic interventions and the varying requirements for recording e.g. are full records expected for each intervention made, are there different procedures expected for different settings?

26.9 Particular care needs to 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 presenting with behavioural disturbance.

How providers and CQC interpret this in practice? How could we demonstrate this was or was not happening? Recommend the CoP offers additional information about including this in audits / governance arrangements.

26.10 There may be times where a patient has good reasons for feeling angry

This has to be re-worded. No-one has a right to judge whether there is ‘good reason’ for an emotion.

26.15 Patients, their families and advocates must be as fully involved as possible in developing and reviewing behaviour support plans. The preparation of behaviour support plans provides an important opportunity to record the wishes and preferences of families and carers and what involvement they may wish to have in the management of behavioural disturbances. For example, family members may wish to be notified and involved in a review of the use of the restrictive intervention.

We agree with this statement, but involvement of families and/or advocates must be with the person’s agreement, if they have capacity to give or withhold such agreement (see response to questions 1-3)

26.15 For example, family members may wish to be notified and involved in a review of the use of any restrictive intervention.

Suggest word change above to avoid implicit suggestion that behaviour support plans will always involve restrictive intervention.

26.17 Behavioural disturbance can be minimised by promoting a supportive and therapeutic
culture within the care environment. Unless a patient is subject to specific justifiable restrictions (eg for security reasons), primary preventative strategies should typically include many of the following, depending on actual assessed needs.

There is no mention of the appropriateness of meeting the security needs of the patient i.e. structural, relational and procedural risks. All three risks have to be assessed and needs met with admission to the appropriate hospital facility e.g. high, medium, low secure, rehab, PICU, open ward.

There is no mention of the use of other agencies especially for physical restraint like the police – this does happen when the person is not managed in an appropriately secure unit or when the level of aggression is too high (use of weapons, barricading, hostage situation etc.). There needs to be an inter-organisational policy covering this and cross referenced to the chapter on police powers and local engagement.

26.17c Engaging with service users and their families:

- in all aspects of care and treatment planning, involving the patient’s nearest relative, family, carers, advocates and others who know the patient and their preferences

We agree with this statement, but involvement of families and/or advocates must be with the person’s agreement, if they have capacity to give or withhold such agreement (see response to questions 1-3).

- ensuring that significant meetings occur in a format, location and at a time of day that promotes engagement of patients, families, carers and advocates

The use of the word ‘significant’ here gives the opportunity for providers not to do this for meetings they regard as ‘non-significant’. Suggest it is replaced with wording such as ‘meetings to discuss a patient’s care’.

- ensuring that patients are able to meet visitors in private convivial environments, as well as to maintain private communication by telephone, post and electronic media, respecting the wishes of patients and their visitors, subject to security considerations

We are concerned that the use of ‘subject to security considerations’ here provides a broad interpretation. This could be re-worded to fit with other parts of this section that talk about avoiding blanket restrictions.

Any restrictions on access to private communication and visits should be based on an individual assessment and should be regularly reviewed, with the emphasis always on seeking the least restrictive option.

26.17d Care and support:

- supporting patients to develop or learn new skills and abilities by which to better meet their own needs

This should cover development of alternative coping strategies as part of the behaviour support plan and associated care plans to decrease the likelihood of ‘disturbed behaviour’. This would be a therapeutic plan developed from the functional analysis referred to in 26.12

- developing a therapeutic relationship between each patient and a key worker or nurse

This may be read to imply only one therapeutic relationship is necessary. We suggest re-
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.

- ensuring that patients’ are supported with the feedback and complaints procedures which are accessible and available and that concerns are dealt with quickly and fairly.

26.19 Whilst some psychological treatments (sometimes referred to as ‘behaviour modification’ or ‘behavioural 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 automatically 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; treatments should always be individualised, and subject to discussion and review by the whole clinical team. The patient’s consent should always be sought where the patient has capacity, even if a refusal may be overridden (eg because the patient may be given compulsory treatment under the Act).

26.20 Restrictions associated with such programmes must be reasonable and proportionate to the risks associated with the behaviour being addressed and consistent with the guiding principles of the Code (and the MCA, where it applies). Access to food and drink, fresh air, shelter, warmth, a comfortable environment, confidentiality or reasonable privacy should never be restricted or used as a ‘reward’ or ‘privilege’ contingent upon the presentation of ‘desired’ behaviours.

Both of the above paragraphs refer to behavior modification and restricting access to preferred activities. It would be helpful if the term “behavior modification” is removed, as it can result in the use of aversive (punishment) responses. Behavioural interventions should be based on an analysis of the function of the behavior for the individual (functional or applied behavioural analysis), and interventions are then based on enabling the individual to learn more appropriate ways of meeting their needs.

Behaviour modification is a term that has a specific theoretical meaning, and there have been developments in methods of behavioural intervention that are more holistic in their approach and more responsive to individual needs. The Code appears to sanction the use of “punishment”, as long as certain categories of activity are not used in this way. It may be helpful to place the use of reinforcers within the context of a functional behavioural analysis, where they are less likely to be misused.

26.25 Staff should ensure that they do not exacerbate behavioural disturbance e.g. through dismissing genuine concerns, failing to act as agreed in response to requests, unreasonable or repeated delays, except where such behaviour is unavoidable.

To avoid a broad interpretation of unavoidable behaviour we suggest replacing with: ‘where such failures are unavoidable, every effort should be made to explain the circumstances of the failure to the patient and to involve them in any plans to redress the failure.’

26.30 Continuous observation should be carried out when intermittent observation is seen as insufficient to safely manage risks, if this does not compromise the attention given to other patients.

If a patient is assessed as being at sufficiently high risk to need continuous observation, this is what should be delivered and arrangements should be made to ensure safe staffing.
levels. The wording here implies that the availability of staff should be a deciding factor in whether to move to continuous observation rather than individual need.

26.63 Where possible, an explanation should be given to the patient of the consequences of refusing the request from staff to desist.

Consider adding: Any such explanation should be provided calmly by a staff member who has a positive relationship with the patient. 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, must be recorded in an open and transparent manner.

Records should include clear evidence that less restrictive options were considered and reasons they were not used or were ineffective.

26.143 Following any significant episode of behavioural disturbance that has led to the use of a restrictive intervention, a post incident review/debrief must be undertaken in order to ensure that involved parties, including patients, receive appropriate support and that there is opportunity for organisational learning.

We would welcome additional factors or explanation on what may be considered ‘significant’. This would address our own observations on inspections and monitoring visits where we have challenged the lack of debrief to be told ‘the episode was not significant’. A standard approach to identifying significant would be helpful to inform local practices and offer increased opportunity for review and monitoring.

26.144 If the patient is willing, 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 at staff justification for the decision to use a restrictive intervention may be counterproductive.

26.145 Patients’ accounts of the incident and their feelings, anxieties or concerns following the restrictive intervention must be recorded in their notes. 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 they would or would not like to be used in an advance statement (see chapter 9).

Suggest adding: Patients with limited verbal communication skills should be supported to participate in de-briefing. Where a patient is not able to participate in de-briefing, methods for assessing the effects of any intervention on the patient’s behaviour, emotions etc. should be explored as part of their assessment(s) and recorded in their behaviour support plan.

26.146 If patients wish to formally raise a concern they should be reminded of how to access the local complaints system and independent advocacy services. The hospital’s safeguarding lead should be informed of whenever a patient raises concerns about restrictive interventions.

We suggest adding: “Patients who need support (e.g. alternative format, additional explanation) should be offered appropriate support to access and use the complaints procedure.”
Consultation Question

21. What are your views on how the process for transferring restricted patients under Section 19 of the Act 1983, between secure hospitals be improved?

Chapter(s) of the Code

Chapter 22 - Patients concerned with criminal proceedings

General Comments

It is felt that there is better clarity in the new draft Code, explicitly in relation to who should accompany the patient during transfer between secure hospitals, however, some further clarity is required in the following sections:

22.30 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. 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.

22.31 When a patient has been admitted on remand or is subject to an interim hospital order, it is the responsibility of the hospital to return the patient to court as required. The court should give adequate notice of 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 necessary staff to do this. 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 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.

It is proposed that the above sections should list the safeguards required to be in place in the instance of a private company being commissioned to provide transport.

Our MHAR reviews offered the below following their desktop review;

22.4 States that - 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 where there is one. Such 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.

Who should carry out assessment is there is no Liaison and Diversion Service?

22.7 States that: - Liaison and diversion (L&D) services aim to identify and assess individuals of all ages who have mental health problems, learning disabilities and other needs
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.

The service should have specialist in Learning disabilities or Children Services within the service or specialist available to them to assess/discuss appropriate people.

22.8 states that :- 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

• 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 and the most suitable disposal for the offender.

- This should include learning disability specialist beds.

22.26a A hospital direction, 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.

should states that A Hospital Direction under S45A……

22.27 Transporting patients - should include provision under the Equality Act in relation to necessary adjustments.

22.31 - Suitable escort - provision should be made under the Equality Act as to necessary adjustments to provide an escort who is appropriately qualified. If the patient is under 18 and/or suffering from a learning disability or disability this should be taken into account when ascertaining who is an appropriate escort.

22.38 - Medical assessments in the case of a defendant under the age of 18, should be undertaken by a professional with current clinical expertise, including specialist knowledge of child and adolescent mental health services (CAMHS). If this is not possible, professionals with the appropriate expertise and experience should be consulted.
This should also include those who are under 18 and have a learning disability.

Consultation Question

22. In your opinion does the Code adequately address the issues surrounding restrictive practices to ensure their minimisation and safe application? If not, what further guidance do you recommend?

23. In your opinion do the proposed review requirements relating to mechanical restraint, seclusion and long term segregation adequately help safeguard patients? If not, what further guidance do you recommend?

Chapter(s) of the Code

Chapter 26 Safe and therapeutic responses to disturbed behaviour

General Comments

Our proposals in this matter are in addition to our previous narrative on this core issue in our MHA monitoring reports. We are also involved in the wider DH Positive and Safe programme which looks at all restrictive interventions.

Para 26.13 Patients who are assessed as being at risk of being exposed to restrictive interventions should have either a behaviour support plan or incorporate its elements within an alternative form of care or treatment plan (see paragraphs 34.2 – 34.5). A behaviour support plan enables therapeutic responses to a patient. It is based on an understanding of a patient’s needs and includes circumstances that are likely to predict behavioural disturbance. Behaviour support plans are individualised care plans and should be made up of the following elements:

• primary preventative strategies which aim to enhance a patient’s quality of life and meet their unique needs, thereby reducing the likelihood of behavioural disturbances
• secondary preventative strategies which 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 26.22 – 26.25)
• tertiary strategies which guide the responses of staff and other care givers when there is a behavioural disturbance, including clear instruction on the pre-planned use of any restrictive interventions. Instructions should ensure that the restrictions are used in such a way as to minimise distress and risk of harm to the patient.

The Code needs to emphasise that Positive Behaviour Support plans are required, as opposed to Behaviour Support Plans. A PBS plan focuses on developing alternatives to the individual’s challenging behaviour (based on a good formulation of the reasons for its occurrence), and in the context of developing skills and improving quality of life. It is based on a proper formulation of the person’s current difficulties, and a treatment plan based on this formulation. The Code need to “de-couple” PBS plans (which seem to have been renamed Behaviour Support Plans) from the use of restrictive interventions, although restrictive interventions might be part of such a plan. A number of service providers equate BSPs with a plan for restrictive interventions and the Code should be clear that this is not acceptable.

It should also emphasise that restrictive interventions should be a last resort, and only to be used when all other interventions have been tried. Service providers frequently bypass the use of other interventions and go immediately to the use of restrictive practices. This means they are not using the least restrictive intervention, and this could raise human rights issues.

For paragraphs 26.20, 26.50 and 26.56 we ask that the MCA definition of restraint is added.

Someone is using restraint if they:
• use force – or threaten to use force – to make someone do something that they are resisting, or
• restrict a person’s freedom of movement, whether they are resisting or not.

We would also welcome clear guidance in the Code as to what constitutes a restrictive intervention and what is seclusion.

Consultation Question

24. Should the Mental Health (Conflicts of Interest) (England) Regulations (2008) be amended so that where a patient is to be admitted and the doctor providing one of the medical recommendations is on the staff of that hospital, the other medical recommendation must be given by a doctor who is not on the staff of that hospital, regardless of whether the hospital is an independent hospital or an NHS hospital?

Chapter(s) of the Code

Chapter 32 Detention and CTO: renewal, extension and discharge

General Comments

Agree with the proposal to amend the regulations to improve independence of decision-making. No further comments made.

Consultation Question

25. What are your views on the options proposed as a means of increasing and improving the transparency of decision-making for discharge and reviews?

Chapter(s) of the Code

Chapter 32 Detention and CTO: renewal, extension and discharge
Chapter 34 Care programme approach

General Comments

CQC have been engaged with the Healthwatch Inquiry into unsafe discharges. It is recommended the author of this chapter seeks early findings and learning from the Inquiry team to inform their final review of this chapter if this has not already been done.

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. They must also consult one or more other people who have been professionally concerned with the patient’s medical treatment.

A specific point should be added that the RC should discuss the process with the patient while they are making their decision. Although this seems to be an obvious stage to the process my personal experience is that patients would only be made aware on receiving the information regarding the managers’ panel.

This area of the Code should also be informed by our learning from our report - CQC and the Challenging Behaviour Foundation. 3 Lives: What have we learned, what we need to do (2014) and specifically where we found clinicians renewing sections in long-term settings without exploring whether the treatment plans remain appropriate. We would welcome the additional requirement that for all renewal decisions clinicians must decide not only if the criteria for detention under section 20 is met but also to assess and record their opinion on whether the patients care plan remains suitable and appropriate treatment is available.

32.14 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.

Request an addition to this paragraph or preceding paragraphs to “It is good practice for all involved to speak with the patient about the renewal process and their own roles in the decision making. Responsible clinicians should ensure the second professional and AMHPs are notified as early as possible in the renewal process to allow this to happen.

### Consultation Question

**26. Does the revised chapter provide as much guidance as possible, within the current legislative framework, to ensure that CTOs are used effectively and appropriately to support patients to maintain stable mental health outside hospital and to promote recovery, in line with the principle of least restrictive option and autonomy? If not, what further guidance do you suggest?**

<table>
<thead>
<tr>
<th>Chapter(s) of the Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chapter 29 – Community Treatment Orders</td>
</tr>
</tbody>
</table>

### General Comments

The Code continues to say SCT in the Key Words and Phrases and Appropriate Medical Treatment chapter but it does not appear in Chapter 29.

The transfer from inpatient to community consultant should be recognised in this chapter. The Code should include a paragraph after 29.22 that notes if the care team or responsible clinician will change upon discharge then they should be informed and involved in the discussions as early as possible.

### Consultation Question

**27. What further information in relation to the care programme approach (CPA) in chapter 34 would be helpful to include in the Code?**

<table>
<thead>
<tr>
<th>Chapter(s) of the Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chapter 34 – Care Programme Approach</td>
</tr>
</tbody>
</table>

### General Comments

CQC have been engaged with the Healthwatch Inquiry into unsafe discharges. It is recommended the author of this chapter seeks early findings and learning from the Inquiry team to inform their final review of this chapter if this has not already been done.

Research and NICE guidance has repeatedly advocated the importance and direct positive impacts of offering and using advance decisions in care planning and discharge. We strongly believe chapter 32 and 34 should have a clear expectation that patients will be supported in understanding their right to complete a binding advance decision or discuss their wishes and feelings for future arrangements of care. CQC would be able to monitor this and look for the discussion and existence of any such statements where patients have previously been detained. The current lack of expectation in the Code makes this a difficult area in our monitoring processes but is something we are committed to improving. This is also an area our Service User Reference Panel have raised as critical to empowering and involving people in their care and potentially reducing the number of restrictions necessary.
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. Included within the CPA care plan (which may incorporate requirements for behaviour support plans – see paragraphs 26.13 – 26.16) 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.

It is proposed that discharge planning should be included within the list of requirements for a care plan. This was identified within the CQC’s pre consultation proposed changes document submitted to DH in which we proposed that, “Care plans should have long and short-term goals, and include a ‘road map’ that is used to help patients towards discharge. It is not enough to simply log a patient’s mood and compliance with medication.”

34.19 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 19.5 – 19.9 and 19.89 - 19.103).
• 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.

It is proposed that paragraph 34.19 should also include that account should be taken of a learning disability / autistic spectrum disorder and that appropriate specialist services should be involved.

**Consultation Question**

28. How clear is the drafting on how the provisions of the Measure apply to individuals receiving services across the English/Welsh Border? What further guidance would be helpful and why?

**Chapter(s) of the Code**

Chapter 34 – Care Programme Approach

**General Comments**

Clear – no further comments
Consultation Question
29. What additional guidance on the role of hospital managers should be included to assist them fulfil their role under the Act?

Chapter(s) of the Code
Chapter 37 Functions of hospital managers
Chapter 38 Hospital managers’ discharge power

General Comments
This area will link to our monitoring and regulation of the Well Led Domain and specifically our Key Line of Enquiry - W2: Do the governance arrangements ensure that responsibilities are clear, quality and performance are regularly considered and risks are identified, understood and managed.

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 which their constitution or (in the case of NHS providers or NHS commissioners) NHS legislation allows them to delegate their other functions.

Can 'should' be changed to 'must'? CQC would expect to see a scheme of delegation in place and this is a requirement of the MHA itself.

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. 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

This paragraph should be split to recognise the requirement for ensuring people are competent (training, tools, reviews) and then move to a new paragraph of ensuring appropriate governance arrangements. Would prefer to see a requirement for the steering or scrutiny group to have representation from the Board or reporting to the hospital managers so we may check this during inspections. During the Wave inspections we have been asking members of the Board to what extent they understand or are familiar with the MHA and local practices. The responses have been variable. This may indicate a need to ask that the Boards and managers themselves undertake periodic training on the MHA. This area links directly to our Well Led – Key Lines of Enquiry.

37.11 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. Hospital managers should also 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.

It would be preferable to include a good practice point that hospital managers should ask for a copy of AMHP reports as well – including transferred in patients.

37.13 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 the 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 on IMHAs).

Suggest rearranging this paragraph to start with ‘must give information’ or remove the underlined section above.

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

This should say ‘request’ and not ‘arrange’ to recognise that the hospital managers are not accountable for a failure of an IMHA to attend. Their responsibility is to ensure they request the IMHA which CQC would be looking at their processes for doing this and engaging with local advocacy and commissioners. Would also strengthen by saying ‘must’ to clarify this is not an optional process.

37.15 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 22.23 – 22.27). Decisions on transfers may be delegated to an officer, who could (but need not be) the patient’s responsible clinician.

This should recognise that the scheme of delegation in 37.9 should include the responsibilities and roles of transfer delegations.

37.17 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.

To say ‘transfers are potentially interference’ is not helpful for patients or providers – are there any references or examples that we could add here or reference elsewhere in the Code?

37.19 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 other family or friends, and to record them. Only in exceptional circumstances should patients be transferred to another hospital without warning.

We should ask for the reasons, discussions and family views to be recorded so CQC can monitor this.

37.25 Nearest relatives’ consent to transfers is not a statutory requirement. But 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.

Add that they should be offered advice on support or raising a complaint or appeal if they disagreed with transfer. Notification should occur as soon as practicable after the decision is made. And the outcome of the conversation / their views recorded.

37.26 When a patient is transferred, the documents authorising detention, including the authority for transfer, should be sent to the hospital to which the patient is transferred. The transferring hospital should retain copies of these documents. Should this include any original AMHP reports? CQC currently looks for copies of AMHP
reports but no current reference in the COP to identify if the AMHP report should form part of
the record on transfer. Good practice would also require including risk reports, tribunal
information and care plans (or is this dealt with in other guidance?)

37.30 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.
This is a recurrent area of difficulty in practice. We have been contacted several times to
intervene when patients on CTO wish to relocate or to be placed back in local areas and the
local hospitals refuse to accept responsibility for the patient. Is there any other guidance that
should govern this and could be linked to the process for transferring CTO patients?

37.32 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
independent mental health advocate (IMHA). If a patient lacks capacity to decide whether to
seek help from an IMHA, an IMHA should be introduced to the patient so that the IMHA can
explain what help they can offer.
See previous comment that this should recognise that the hospital managers are only
responsible for requesting the IMHA. Would also be helpful to require a record of the
outcomes of discussions with the patients and their understanding so CQC can monitor.

37.36 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, and the patient must be informed in accordance with the regulations.
It should be recognised here that the hospital managers must appoint a member of staff to
discharge this function in the scheme of delegation. That person should also discuss any
decision to withhold mail with the responsible clinician.

37.37 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.
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.
Patients should be informed of their right to receive a notice from the hospital managers
when post is withheld within 7 days and their right to apply for a review by CQC and this
should be made within 6 months of the notice.

38.29 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. Relatives, carers and any other relevant
people may be invited to put their views to the managers’ panel in person. 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.
Can we add put the views to the managers’ panel in person or in writing.

38.37 The presence or absence of adequate community care arrangements, including a DoL
authorisation or DoL 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.
This should refer to a ‘Deprivation of Liberty Safeguard authorisation or order’ and not a DoL
This would reflect the DOLS Code.
38.34 The patient and the other people giving views to the panel should, if the patient wishes it, 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).

This comment applies to allow the patient to secure the attendance of others and other areas of this chapter – a requirement on the hospital managers to take all reasonable steps to prepare the patient for the meeting and engage them in the process should be added. This may go at the beginning of the chapter and say “Hospital Managers must have a process in place that seeks to involve the patient in the manager’s hearings. This will include offering information and advice on the process and ensuring the scheduling of hearings is discussed with the patient to improve the likelihood of them being supported by others during the hearing.”

38.41 Where a different procedure is used, patients, if they request it, should be interviewed by at least one member of the managers’ panel considering their case, or if the panel thinks it desirable after reading the renewal or extension report.

The wording of this should be changed to “hospital managers should offer patients the opportunity to discuss their case with at least one member of the panel. If the panel considering the case think it would be desirable to speak to the patient after reading the renewal report they should also ask for this request to be made to the patient and arrangements put in place if they agree”

38.45 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. Copies of the papers relating to the review, and the formal record of the decision, should be kept in the patient’s notes.

This should say “and the formal record of the decision and reasons should be shared with the patient and kept in the patient’s notes.”

To consider adding a paragraph to identify good practice for supporting the patient following an unsuccessful hearing – “Following the hearing hospital managers should ensure patients are offered an opportunity to discuss the hearing and any necessary support in understanding their rights. This may include discussions with any person that the patient so chooses or who they had requested to attend the hearing but was unable to do so”

37.13 - 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 the 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 on IMHAs).

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

The above paragraphs should reference there may be a need for specialist services to be available for those with learning disabilities / autistic spectrum disorders.
Consultation Question

30. What are your views on how to ensure victims do not miss out on their entitlements to receive statutory victim contact, particularly where the responsibility for this lies with hospitals, and that victims’ concerns and views are given appropriate weight and consideration when managing patients subject to a hospital order?

Chapter(s) of the Code

Chapter 40 - Support for victims

General Comments

It is proposed that a statement should be made within chapter 40 to clarify that after initial contact the victim may find it useful to know additional information such as the location and time at which the patient will be released.

40.9 Under the VCS, victims must, as a minimum, be:

- offered the opportunity to engage with the VCS by the VLU
- assigned a victim liaison officer (VLO) (for restricted patients)
- offered the right to make representations about the patient’s discharge conditions such as geographic exclusion zones or ‘no contact’
- informed of discharge conditions which relate to them
- informed about any other key information about the patient’s progress, which it is appropriate to share in all the circumstances of the case, and
- offered the opportunity to make representations (about the patient’s discharge conditions) to the Tribunal.

It is proposed that section 40.9 should clearly state that it is appropriate to consider the views of the victim at all stages.

Consultation Question

31. What specific issues would you like to see addressed within the Code, which are not covered in the proposed draft? What are your views on the new chapters that are proposed in this revision of the Code?

Chapter(s) of the Code

General Comments

The work completed by NHS England on Standards for Doctors attending Mental Health Assessments should be considered for addition to the Code. The seven standards proposed could offer clarification on the expectations upon Doctors in the same way the Code currently sets standards for AMHP’s carrying out assessments. A copy of the standards can be forwarded to the consultation team if required.

25.40 During a visit, SOADs should:

- satisfy themselves that the patient’s detention or CTO papers are in order (where applicable)
- 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).

We believe that it is the provider’s responsibility that the detention or CTO papers are in order. We disagree that the MHA requires the SOAD to look at whether the papers are in order and feel that this wording implies that a scrutinising of the papers would be expected of the SOAD. The SOAD’s position in Law is that they provide an opinion on a patient who
prima facie is detained, and who is represented to them as being detained; they are not the final arbiter on whether or not a detention is in order. It might be contended that SOAD scrutiny would provide an extra level of safeguard – we disagree. Detention papers are already subject to scrutiny by the provider, by MHA reviewers, and by patients' legal representatives. We conclude that one additional layer is unnecessary.

25.75 Circumstances in which certificates cease to authorise treatment, even though they have not been withdrawn.

- The SOAD specified a time limit on the approval of treatment, and the time limit has expired."

For a SOAD certificate under section 57, the tabulated information for circumstances in which the certificate ceases to authorise treatment should include the following additional point as it is vital that the SOAD is able to specify a time limit for section 57, within which the treatment should begin.

25.77 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 revoked to hospital, even if the certificate remains technically valid. A new certificate should be obtained as necessary.

The wording needs to be updated to replace, “Recalled,” with, “Revoked.”

On the issue of concurrent T2 and T3 forms we offer the following information for review by the DH team. Further discussion of this complex area is invited:

It is possible to have concurrent forms T2 & T3 for the same patient, however this is potentially problematic and should be the exception. The situation may arise if a patient’s consent status is believed to vary between medications.

This is possible because to be “capable of understanding” the “nature purpose and likely effects” of treatment, a patient has to have capacity – and capacity is issue-dependent and may alter over time. It is also possible for a capacitous patient competently to consent to one medication and competently to refuse another.

It is therefore theoretically possible for a patient to have a valid T2, signifying consent, and a valid T3, signifying either refusal or incapacity, relating to different medications.

The scenario of interest to SOADs will be where, at the point of assessment, a SOAD concludes that both situations obtain.

It is essential that the SOAD considers the appropriateness of the totality of the plan they propose to certify. It may be, for example, that they are minded to be specific in terms of a named antipsychotic, or to avoid a type of antidepressant, because of interactions with other components of the overall plan.

For this reason it is important that the SOAD’s certification encompasses the entirety of the plan they deem appropriate – therefore a SOAD should, if necessary, issue both a T3 and a T2. It would not be satisfactory to leave the issue of the latter to the RC since the content of it would not be under the control of the SOAD. The SOAD should make it clear that the certificates are interdependent and that when one is superseded the other is rendered void. This may be done by including wording on both certificates such as “This certificate is issued
in conjunction with the Tn dated xx/xx/xx and is cancelled if that other certificate is superseded”.

It would be undesirable and potentially bad practice for the RC to issue a T2, subsequent to the T3, adding to or amending the totality of the plan, since that altered plan is likely to impact upon the content of the T3, yet the SOAD will not have considered the amendments and may not have given the approval they did had the later medication been part of that plan. Such a practice is thus to be strongly discouraged. If an RC is faced with such a scenario, they should request a fresh Second Opinion.

When faced with the prospect of differential capacity, SOADs will have to consider very carefully how and whether the elements of capacity (understanding, retaining, weighing, communicating) can apply to one drug but differently to another, given that the thought processes may be interlinked. If the SOAD concludes that these elements do apply differently, their ‘reasons’ should include adequate explanation. As a result, SOADs are reminded that if they issue a Form T2 (in any circumstances, not merely in conjunction with a T3) they should also issue a separate sheet of ‘reasons’ explaining their decision, in the same style as they are mandated to do with the pre-printed legally-required ‘reasons’ portion of a T3. One of the two sets of reasons should include an explanation of the capacity differential – it is only necessary for one of the two forms to carry that explanation since the two forms will be interlinked with wording of the nature noted above.

25.6 Section 57 applies to neurosurgery for mental disorder and to surgical implantation of hormones to reduce male sex drive. It applies to all patients, whether or not they are otherwise subject to the Act.

“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”.

The COP should recognise that the Secretary of State may extend the treatments to which section 57 applies. There is professional debate on this topic, and it is recognised that there is some disparity between the devolved nations; it is not unlikely that future representations may be made to the Secretary of State in this regard.

25.42 The managers are also responsible for ensuring that all relevant documentation, including the patient’s full clinical notes, are available for the SOAD’s inspection.

25.43 SOADs have a right to access records without the patient’s consent, if necessary, but only those records relating to the treatment of the patient in the hospital or other establishment in which they are examining the patient. If a CTO patient with capacity to do so refuses the SOAD access to records which the SOAD thinks are relevant, the examination should be arranged in a hospital where the relevant records would be available.

It is suggested this section is amended to,

SOADs have a right to access 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”.

Care Quality Commission 2014
Plainly a SOAD has a right to access records in the hospital where the patient is currently detained. It is commonly the case that such records will include copies of notes from previous hospitals. As currently written, the draft suggests that such records could not be accessed by the SOAD, even though they form part of the material available to the current treating team. The draft is therefore misleading. We consider that what is intended is to illustrate that this power of access extends only to the present hospital, and that the SOAD has no right to travel to other units and require production of old notes. We consider that an explanation of this will be unnecessarily wordy, and would amount to an attempt to define a circumstance which no reasonable person could expect would obtain.

This would allow section 25.42 to be removed, avoiding duplication within the text and making the COP more succinct on this matter.

In areas of the draft COP (sections 25.44 and 25.46) there are references to pharmacists. It is felt that this detracts from the intent to recognise the wider holistic purpose & nature of the consultees and the information they provide.

The SOADs also seek consultees from non-medical & non-nursing staff such as Psychologists, Occupational Therapists, Art Therapists, Dieticians, Physiotherapists, and many others, to help provide information to assist their decision-making on the patient’s capacity and medical treatment.

25.46 SOADs are required to consult two people (‘statutory consultees’) before issuing certificates approving treatment. Where section 57, 58 or 58A applies, one of the statutory consultees must be a nurse; the other must not be either a nurse or a medical doctor. Both must have been professionally concerned with the patient’s medical treatment, and neither may be the clinician in charge of the proposed treatment or the responsible clinician (if the patient has one). Where a SOAD is considering giving a part 4A certificate, at least one of the statutory consultees must not be a 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).

The definition of “consultee” should be included within the COP glossary.

The wording “may not” in the draft Code implies an alternative possibility – we consider that the wording “must not” more properly reflects the legal position. The addition of the word “medical” is so as not to narrow the interpretation of the Code – since its last revision there are a far greater number of consultees (especially but not exclusively psychologists) who can properly be titled ‘doctor’.

25.47 The Act does not specify who the statutory consultees should be, but they should be people whose knowledge of the patient and the patient’s treatment can help the SOAD decide whether the proposed treatment is appropriate. People who may be particularly well placed to act as statutory consultees include the patient’s care co-ordinator (if they have one) and, where medication is concerned, a mental health pharmacist who has been involved in any recent review of the patient’s medication.

We consider there is a need to include a comment that, except for part 4A certificates, the consultees are specifically required to not be medics, and that this should be accompanied by an explanation which focuses upon the purpose of the consultee.
We note that representations as to pharmacists has resulted in the inclusion of this professional group as a specified possible consultee. We consider that this concentrates excessively upon one group, to the exclusion of others. SOADs find substantial value in all professional groups. It seems inappropriate to highlight one group, and their contribution, without also including the many other groups and their contribution. Pharmacists, though valuable, are numerically in the minority in terms of their participation as consultees, and are not necessarily more valuable than other members of the multidisciplinary team – whether for medication issues or otherwise.

A wide spread of consultees will ensure that an holistic view of the patient is received by the SOAD; in many cases we prefer the consultees to be from a discipline which does not espouse the medical model, so as to balance the SOAD's own opinion and the information provided by the RC.

We suggest that the wording should be:

25.47 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 and the appropriateness of the proposed treatment, and will commonly be members of the wider multidisciplinary team. People who may be particularly well placed to act as statutory consultees are those who have knowledge of the patient which is either detailed, or up-to-date, or both. Except for part 4A certificates, the consultees are specifically required to not be medical staff; this is to ensure that an holistic spread of professional views is obtained which do not refer solely to the medical model of mental health. For part 4A certificates, it is permissible for one of the two consultees to be a medical doctor, but that person cannot be the RC; typically a GP may be consulted.

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

The consultees should be prepared to answer questions posed by the SOAD – these may be those included in the list, but we would not wish such a list to constrain the consultees or for them to come to a discussion with only those matters in mind. We therefore suggest modifying the wording:

25.49 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:

25.51 Consultees should ensure that they make a record of their consultation with the SOAD, which is then placed in the patient’s notes.

Consideration should be given to change the wording to:

25.21 SOADs should make a record of their consultation with statutory consultees, which will become part of the patient notes.
We are firmly of the view that the discussions with the consultees do not offer any additional contribution to patient care beyond the record made by the SOAD, within the statutorily required forms which are the outputs of the process. Nor, for the most part, do the entries made by consultees consist of any information beyond the fact that they were consulted. Indeed, many providers, mindful that CQC reviewers look for such entries, have devised forms for the purpose which essentially comprise box-ticking. It is felt to be unnecessarily bureaucratic to expect multiple records to be made where the discussion has not directly impacted on the care information available – beyond the record made by the SOAD. This requirement focuses both CQC reviewers and providers on entirely the wrong aspect of the process. We are aware that DH has suggested that such entries are an important safeguard – we reject this contention, and consider that removal of that requirement will have no negative impact upon patient care.

25.58 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.

As the ultimate responsibility will lie with the Responsible Clinician so we propose the following wording:

25.58 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 RC should take into account this view when reaching the decision, which is for them to take, on whether or not disclosure should not be made. The expectation is that in the overwhelming majority of cases the patient should be able to see the SOAD’s reasons.

Chapter 17 – Transporting Patients and the section on General Considerations

This should include a reference to preparing the patient and explaining the reason for any transfer to them. Patients should be given as early notice as possible for any transfers planned and their views taken into consideration. They should also be offered support to communicate the planned transfer to anyone they believe needs to be informed of the transfer. A record of this discussion should be made in the patients notes.

Chapter 33 – Aftercare

We ask that a reference is added to this chapter to acknowledge the responsibility of CCG’s and Local Authorities to ensure there is a central record of all patients in receipt of aftercare. This may in practice be a delegated responsibility to hospital managers but a record should be available locally for production to the CQC if required. The absence of any such records has been raised during our MHA monitoring and we have not been able to refer local services to any requirement in the Code of the MHA.

Treatment and the Physical Consequences of Mental Disorder

We ask the reviewing team to consider the learning from case law, inquiries and policy relating to self-harm and the application of the MHA. The widely reported case of Kerrie Wooltorton and the medico-legal issues that arose from the refusal of life saving treatment...
and an advance decision should be specifically addressed in the Code. To ensure clinicians are supported by the Code in this area of misconceptions and complexity we believe there needs to be clarity in the Code that also draws on the more recent case law from the Court of Protection in this area - *Nottinghamshire Healthcare NHS Trust v RC (2014) EWHC 1136 (COP), (2014) MHLO 20*

**Briefing Notes**

The following information has been taken from our withdrawn briefing notes for our staff but made publicly available for the use of providers. The briefing notes were originally developed by the Mental Health Act Commission and we withdrew the notes in 2013 as the majority had been superseded by updated guidance including the Code. We will also be reviewing all guidance as part of our new approach to inspections and MHA programme Board. However, we believe there remain some areas that we believe could strengthen the Code and these are set out below. Full copies of the guidance notes are available on request.

**Nurses, the administration of medicine for mental disorder and the Mental Health Act 1983**

Flowcharts from this guidance note have been added to the appendix in this document. We had very positive feedback on these from providers and professionals and would recommend for consideration in the Code.

The guidance note stated "Where a nurse administers prescribed medication to a patient who is detained under MHA 1983 and subject to the provisions of Part 4, s/he should ensure that s/he is legally entitled to do so and that all legal requirements have been met." This was added to strengthen para 24.41 of the 2008 Code but no such paragraph exists in the new draft. We ask this is added back into the Code.

**Scrubinising and rectifying statutory forms for admission under the Mental Health Act 1983**

Some of the information taken from this guidance note may be too detailed for the Code but the team reviewing the reference guide may find this useful information.

**Documentary irregularities**

After a patient has been admitted to hospital under MHA 1983, the requisite statutory forms should be scrutinised by the hospital managers to ensure that any irregularities are identified and, if permissible, rectified within the period prescribed by the Act.

Documentary irregularities fall into three broad groups:
- Those that are both incapable of retrospective correction and sufficiently serious to render the patient’s detention invalid.
- Those that may be rectified within 14 days after admission, but which, if not rectified, are sufficiently serious to render the application invalid at the expiry of that period.
- Errors and omissions that, even if they are not corrected within the statutory period, are not sufficiently serious to render the admission application invalid.

The appendix to this note describes some of the most significant irregularities found in applications and medical recommendations, and the legal consequences that may follow.
Ultimately, however, the lawfulness or otherwise of a patient’s detention can only be determined by the courts.

**Rectifying mistakes**

MHA 1983, section 15 provides a mechanism for rectifying applications for admission to hospital that are not in the correct form. MHA 1983, section 8(4) makes similar provision in respect of Guardianship applications.

**Defects and errors**

MHA 1983, sections 15(1) and 8(4) are concerned with applications and recommendations that are found to be “incorrect or defective.”

**Applications for admission under Part II**

MHA 1983, section 15(1) provides that an application or recommendation that is found to be incorrect or defective may, with the consent of the hospital managers, be amended by the person who signed it. However, any such amendment may be made only within 14 days of the patient’s detention in hospital. Once amended, an application or recommendation is deemed to have effect as if it had always been in its amended form. The managers may authorise an officer to consent to the amendment of a document on their behalf.

**Guardianship**

MHA 1983, section 8(4) makes similar provision for amending a guardianship application, or a medical recommendation given in support of such an application, which is found to be incorrect or defective. Any amendment must be made within 14 days of the date on which the application was accepted, and it requires the consent of the local social services authority. Provided it does so in writing, the authority may authorise a designated officer to consent to the amendment of a document on its behalf.

**The ambit of sections 8(4) and 15(1)**

The Reference Guide to the Mental Health Act 1983, para 2.98, states that remediable defects include the leaving blank of any spaces on the form which should have been filled in (other than the signature); failure to delete one or more alternatives in places where only one can be correct; or discrepancies in the spelling or recording of a patient’s name in the documents that do not raise any doubts as to whether the documents refer to the same person.

The common opinion over the limits of rectification is expressed by Hoggett:

“‘Incorrect’ probably means ‘inaccurate’ in the sense of mis-stating names, dates, places or other details which had they been correctly stated would have justified the admission. It does not mean that a document which accurately reflects the facts can be rectified if those facts do not fall within the legal requirements. For example, a frequent fault is that the medical recommendations are undated or dated later than the application … If in fact they were signed on or before the date of the application, the mistake can be rectified. But if they were signed later, then the application is invalid and the detention illegal.

‘Defective’ probably means ‘incomplete’ in the sense that all the information required in the forms has not been given. It cannot mean that forms which are complete and accurate
statements of the facts can be falsified in order to provide legal justification for detention where none exists...”

Recommendations insufficient to warrant detention

MHA 1983, sub-sections 15(2) and (3) provide that a fresh medical recommendation may be completed during the 14-day rectification period, where it appears to the hospital managers that one of the original recommendations, or their combined effect, is insufficient to warrant the patient’s detention.

One of the recommendations insufficient

Medical recommendations should be scrutinised by someone with appropriate clinical expertise to check that the reasons given appear sufficient to support the conclusions stated in them. 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.

MHA 1983, section 15(2) provides that where it appears to the managers that “one of the two medical recommendations” on which the application is founded is insufficient to warrant the patient’s detention, they may, during the 14 days following the patient’s admission, notify the applicant in writing of that fact. If such a notice is given, the medical recommendation will be disregarded and the application deemed always to have been sufficient, provided:

a fresh medical recommendation, which complies with the relevant statutory provisions (other than those relating to the time of signature and the interval between examinations), is furnished to the managers within that 14 day period; and

that recommendation and the other recommendation on which the application is founded together comply with those provisions.

Voting rights for detained patients

The issue of voting for patients and the responsibilities of hospital managers to support people to exercise their right to vote is not covered in the Code currently. We are happy to provide the full text of our briefing note for information and reiteration in the Code.

The treatment of anorexia nervosa under the Mental Health Act 1983

Specific reference to anorexia is not found in the Code beyond the definition of mental disorder. Inpatient’s with severe eating disorders form a very vulnerable group and independent monitoring of their welfare, particularly in specialized units can be important. Additional guidance may be developed using the following extracts from our briefing note;

It is likely that it is only in its most severe manifestations that anorexia nervosa may be considered to require compulsory admission under MHA 1983. Detention is justified in rare

---

11 B Hoggett (2010) Mental Health Law, Sweet and Maxwell, p.128

Care Quality Commission 2014
cases of serious threat to health, where compulsory feeding may be necessary to combat both the physical complications and the underlying mental disorder.

Where a patient is detained under MHA 1983 so that s/he might be assessed and/or treated for anorexia nervosa, the Commission recommends that his/her detention and treatment be subjected to regular, multi-disciplinary review, and also that artificial feeding be discontinued as soon as is practicable.

It should be noted that medical treatment under MHA 1983 “includes nursing, psychological intervention and specialist mental health habilitation, rehabilitation and care”... “the purpose of which is to alleviate, or prevent a worsening of, the disorder or one or more of its symptoms or manifestations” (MHA 1983, section 145). Therefore, ‘medical treatment’ will cover a broad range of activities, potentially including feeding by nasogastric tube or other means.

In connection with anorexia nervosa, Lord Donaldson of Lymington, M.R., indicated that although a patient may understand the treatment and the consequences of failure to accept the treatment, certain conditions are capable of destroying his/her ability to make an informed choice, and of creating a compulsion to refuse treatment or only to accept treatment that is likely to be ineffective. The Commission accepts that some patients with anorexia nervosa – who might have the intellectual capacity to understand the nature, purpose and likely effect of treatment – may be unable to give valid consent, perhaps because their capacity to consent is compromised by fears of obesity or by denial of the consequences of their actions. Consideration of the whether the treatment environment constitutes a deprivation of liberty might be an additional reason for considering compulsory treatment under MHA 1983 may be required.

Part 4 of the Act applies only to medical treatment for mental disorder. Treatment for physical conditions may only be given, therefore, if it is sufficiently connected to the treatment for the patient’s mental disorder. While MHA 1983 clearly allows the administration of medicines in the absence of consent as a treatment for mental disorder, food has not usually been regarded as a ‘medicine’. However, the House of Lords has ruled that feeding a patient by artificial means may constitute ‘medical treatment’. It follows, and has been accepted by the Courts, that naso-gastric feeding may be a medical process, forming an integral part of the treatment for anorexia nervosa – see Riverside Health NHS Trust v Fox.

---

2 See Reid v Secretary of State for Scotland [1999] 1 All ER 481, and Riverside Health NHS Trust v Fox [1994] 1 FLR 614-622 (see n.7 below).
4 Airedale NHS Trust v Bland [1993] AC 789. In this case, the patient did not suffer from anorexia nervosa, but was in a persistent vegetative state. The significance of the judgment is that for the first time, it was held that food was ‘medicine’ and could therefore be withheld as part of medical treatment.
5 Riverside Health NHS Trust v Fox [1994] 1 FLR 614-622. The patient was a 37-year-old woman with anorexia nervosa, who was detained under MHA 1983, s 3. The Trust sought a declaration that force-feeding would be ‘medical treatment’ under MHA 1983, s 63. At the full hearing, the Judge had “no difficulty in concluding that feeding is treatment within Section 145 of the [Mental Health] Act.” He found it more difficult to decide whether it would constitute ‘medical treatment for the mental disorder’, but he concluded that no other treatment could be offered until there was steady weight gain. Therefore, he held that “forced feeding will be medical treatment for the mental disorder.” By the time the appeal was heard, the patient’s condition
where the Judge observed: “until there is steady weight gain no other treatment can be offered for the respondent’s mental condition so I hold that forced feeding if needed will be medical treatment for the mental disorder”. A similar conclusion was reached in the case of *B v Croydon Health Authority*, which adopted a wide definition of ‘medical treatment’ within MHA 1983.

The clinician in charge of the compulsory feeding must be satisfied that the food refusal which is being treated food refusal is part of the mental disorder in order to use the authority of s.63. In these circumstances further diagnostic and monitoring procedures may be necessary, including venepuncture, as part of the medical treatment for the mental disorder of the particular patient. Authority for such additional procedures might also be found under s.63. In addition, it may be possible to justify under the common law action that is taken in an emergency as the minimum necessary to prevent serious injury or loss of life.

In certain circumstances, patients with severe anorexia nervosa whose health is seriously threatened by food refusal may be detained in hospital under MHA 1983. Further, there may be occasions when it is considered necessary to treat such patients for their self-imposed starvation without their consent. Such treatment might include compulsory feeding to address the physical complications of anorexia nervosa, insofar as this is a necessary precondition to the treatment of the underlying mental disorder. In these circumstances, it might be reasonable to regard artificial means of providing nutrition as medical treatment for mental disorder. However, such treatment must be carefully and regularly reviewed to ensure that it represents the least restrictive alternative, and discontinued when the patient’s compliance can be secured for normal methods of feeding to which compulsion would not apply. Such a review should be multi-disciplinary in nature, and should include the patient’s representative where appropriate.

In summary, in every case there will have to be:

proper consideration of the alternatives;

a multi-disciplinary decision as to the most appropriate way of managing the patient’s overall care (bearing in mind the importance of securing co-operation in the longer term);

a mechanism for ensuring that any compulsory treatment is given under the direction of the approved clinician in charge of the treatment;

a way to end use of the compulsory powers when they are no longer appropriate.

When caring for patients with anorexia nervosa, clinicians must give careful consideration to other aspects of their management, recognizing, for example that some patients might be had improved. The appeal was allowed on technical grounds, but the President of the Court recognised that if she deteriorated again a fresh application could be made.

---

6 B did not have anorexia nervosa but a psychopathic disorder. When detained under MHA 1983, s 3 and prevented from harming herself, she refused to eat and her weight fell to 32 kg. Tube feeding was threatened and B sought, and gained, an injunction preventing it. The Court dismissed the argument that MHA 1983, s 58 was relevant, but held that ‘medical treatment’ is that which, taken as a whole, is calculated to alleviate the mental disorder; that a range of acts ancillary to the core treatment may still falls within MHA 1983, s 63; and that tube feeding will constitute ‘medical treatment’ for the purposes of MHA 1983, s 63 and may be carried out lawfully without the patient’s consent.
nursed at times on non-psychiatric wards, where knowledge and experience of MHA 1983 is limited.

Identification and Rights of the “Nearest Relative” under the Mental Health Act 1983

Chapter 5 of the draft Code may also include;

What rights does the nearest relative have?

This list is not exhaustive.

- The power to apply for a patient's admission to hospital or reception into guardianship.
- The power to require that an Approved Mental Health Professional (AMHP) assess the patient with a view to making an application for hospital admission or Guardianship.
- The right to information and consultation before the patient’s admission to hospital, and the power to object to the making of a guardianship or section 3 admission application by an AMHP.
- Unless the patient objects, the right to information and consultation after the patient’s admission to hospital.
- The right to order a patient’s discharge:
  - from detention under sections 2 or 3,
  - from a Community Treatment Order, or
  - from guardianship that is not imposed by a court, by giving 72 hours notice in writing (although this order may be blocked within that time by the patient’s doctor on the grounds that the patient, if so discharged, would be likely to act in a manner dangerous to him/herself or others). An illustrative standard letter for this purpose is given in the Code of Practice, para 29.23.
- The right, in some cases, to apply to the Mental Health Tribunal.
- The right to be told when the patient is about to be discharged.
- The right to raise a formal complaint on behalf of the patient.
- If the Nearest Relative provides a substantial amount of care on a regular and unpaid basis, the right to request local authority assessment of such care (and the ability of

---

7 The Nearest Relative does not have an absolute right to be consulted. In *R (on the application of E) v Bristol City Council*, 13 January 2005, the High Court accepted that consultation with the Nearest Relative might not be “reasonably practicable” (and so, under section 11(4) of MHA 1983, might need not take place) where it would infringe a patient’s right to privacy and family life to an extent that could not be justified as beneficial to him/her.


10 Except where the patient is the subject of a Restriction Order under s. 41, or has been transferred from prison. The First–tier Tribunal (Mental Health) is discussed at Chapter 8 of the Code of Practice.
the carer to continue to provide it) as part of the patient’s future care plan.\(^\text{11}\)

- In addition to the information to which a Nearest Relative is entitled by statute, it is now widely accepted that, as long as the patient agrees, Nearest Relatives should be involved in discussions and decisions relating to the patient’s care and treatment.

**The Mental Health Act in Independent Hospitals**

This briefing note was almost entirely a summary of the Code, but there is one area that highlights a lack in the Code (both the current Code and the draft revision). At para 27.30 of the revision the Code talks of ‘leave to reside in other hospitals’ but in reality leave is sometimes also given on condition that the patient resides in a care home. The Code is silent about this, but it may be helpful to clarify in the Code that a place doesn’t have to be a hospital to be named as a place of residence whilst on leave.

“Independent Hospitals must be registered to provide care and treatment to patients who are “liable to be detained” at the hospital under MHA 1983. However, the definition of “liable to be detained” excludes anyone who is on leave from their place of detention under s.17 of the MHA 1983\(^\text{12}\). This is so as to allow such patients to be sent on leave to registered care homes or any other establishment.”

<table>
<thead>
<tr>
<th>Consultation Question</th>
</tr>
</thead>
<tbody>
<tr>
<td>32. Do you believe that the proposed changes to the Code address the concerns about access to safeguards, raised at Winterbourne View and other places? Is there any other guidance, within the parameters of the Act, you think the Code should include? If so, please give details.</td>
</tr>
</tbody>
</table>

**Chapter(s) of the Code**

**General Comments**

See response to Question 20

<table>
<thead>
<tr>
<th>Consultation Question</th>
</tr>
</thead>
<tbody>
<tr>
<td>33. How far does the proposed structure and order help you navigate the proposed Code? Do you have any suggestions on how the grouping or ordering of chapters could be improved?</td>
</tr>
</tbody>
</table>

**Chapter(s) of the Code**

**General Comments**

The length of the Code remains a concern for supporting easy navigation. We echo the views of stakeholders during the consultation that the Code needs to be clear and useable to ensure awareness for all impacted by the Code. The sheer scale of the Code may result in people not knowing what is expected for aspects of the care and treatment risk negative impacts on care because the service or the patient have not been able to sufficiently triangulate the expectations across the chapters.

We see the grouping of chapters as an improvement but due to the length of the Code we strongly support the DH plans to provide the Code and related guidance in a searchable

\(^{11}\) Carers (Recognition and Services) Act 1995, s.1.

\(^{12}\) Care Standards Act 2000, s.2(6)
online format to improve accessibility. We have asked to be represented on the Accessibility project group and involved in the work to improve access for all to the Code so we will continue to support DH in this regard.

**Consultation Question**

34. Are there any ways in which, the flowcharts or case study examples used in the proposed Code can be further improved? Are there additional places where they would help?

**Chapter(s) of the Code**

**General Comments**

It is recommended that including a flowchart to describe the circumstances for when a SOAD should be requested would be beneficial. This should include details for steps to be taken in relation to the recall of a patient from a community treatment order which is deemed to be a complex area.

To support this and other areas we have provided examples of flowcharts and matrices that may be considered for inclusion in this document.

**Consultation Question**

35. How far does the consultation stage impact assessment reflect the potential impact of the changes that will be introduced as a result of the proposed changes to the Code?

**Chapter(s) of the Code**

**General Comments**

We have no further comments in this area as we provided feedback during the development of the impact assessment.

**Consultation Question**

36. Are there any further impacts that you feel should be considered? Please provide evidence to help us assess and quantify this impact.

**Chapter(s) of the Code**

**General Comments**

We have no further comments in this area as we provided feedback during the development of the impact assessment.
**Appendix 1 Flowcharts and Matrices**

**Question 34:** Are there any ways in which, the flowcharts or case study examples used in the proposed Code can be further improved? Are there additional places where they would help?

Examples of CQC flowcharts are provided below for consideration.

---

**Treatment with medication for mental disorder of patients detained in hospital under the Mental Health Act 1983**

1. Is the patient detained under a section to which Part 4 applies?
   - yes
   - no

2. MHA 1983 provides no powers of treatment

3. Is it three months or more from the first administration of medication whilst the patient has been so detained?
   - yes
   - no

4. Treatment can be given under the direction of AC in charge (s.63)

5. Have emergency treatment powers under s.62 been evoked by Approved Clinician in charge of treatment?
   - yes
   - no

6. Treatment must be certified by SOAD on Form T3

7. Treatment must be certified by AC in charge or SOAD on Form T2

---
Is it three months or more from the first administration of medication when the patient was detained / one month or more since the start of SCT status?

- **Yes**: Treatment can be given under the direction of AC in charge
- **No**: Have emergency treatment powers been evoked by Approved Clinician in charge of treatment?
  - **Yes**: Is the patient capable of consent?
    - **Yes**: Treatment can be certified by AC in charge of treatment on Form CTO12
    - **No**: Treatment may be given under the direction of AC in charge
  - **No**: Is the patient refusing?
    - **Yes**: Treatment can be certified by AC in charge of treatment on Form CTO12
    - **No**: Is the patient consenting?
      - **Yes**: Treatment can be certified by AC in charge of treatment on Form CTO12
      - **No**: Is force needed to administer treatment?
        - **Yes**: No authority to treat in the community / consider recall to hospital
        - **No**: Treatment can be certified by SOAD on Form CTO11
Is it three months or more from the first administration of medication when the patient was detained / one month or more since the start of SCT status?

- **yes**
  - Have emergency treatment powers been evoked by Approved Clinician in charge of treatment?
    - **yes**
      - Treatment can be given under the direction of AC in charge, even if patient refuses consent
    - **no**
      - Treatment can be given under the terms of the Form CTO11 certification

- **no**
  - Was the treatment being given whilst the patient was in the community, and, if so, would its discontinuation cause the patient serious suffering?
    - **yes**
      - Treatment can be given under the terms of the Form CTO11 certification
    - **no**
      - Is the treatment explicitly authorised for administration upon recall on Form CTO11 including any conditions?
        - **yes**
          - Does the patient have capacity to consent?
            - **yes**
              - Treatment can be only be given once certified by a SOAD on Form T3
            - **no**
              - Does the patient consent?
                - **yes**
                  - Treatment may be certified by AC in charge on Form T2
                - **no**
                  - Treatment can be given under the direction of AC in charge, even if patient refuses consent
## Rectification of applications and recommendations

<table>
<thead>
<tr>
<th>Points for consideration</th>
<th>Irregularity</th>
<th>Rectification provisions</th>
<th>Effect on an irregularity</th>
</tr>
</thead>
</table>
| 1. Is the application duly made and founded upon the necessary medical recommendations? | • Unsigned application or medical recommendation.  
• Application made by AHMP with a conflict of interest (see Mental Health (Conflicts of Interest) (England) Regulations 2008) & therefore disqualified under s.12A.  
• Application completed by a person otherwise not qualified to complete it, e.g. not an AMHP, not the nearest relative, not a person authorised to exercise the relative’s functions. | None – fundamentally flawed applications cannot be retrospectively validated (see Reference Guide, 2.94). Unsigned documents and documents completed by persons not qualified to complete them do not constitute an application or recommendation. It is not so much that the application or recommendation is insufficient, rather the document is not an application or recommendation at all. | The application is of no effect. |
| 2. Is the recommendation sufficient to warrant the patient’s detention in pursuance of the application? | • Recommendation completed by a practitioner who is not fully registered: see Medical Act 1983, ss.47 & 48.  
• Recommendations which contain insufficient grounds/reasons for the doctor’s opinion that the statutory criteria are satisfied. | Section 15(2) provides that the hospital managers may notify the applicant of their opinion that the recommendation is insufficient, in which case the recommendation is disregarded. The applicant may then arrange for a fresh medical recommendation to be furnished within the statutory 14 day period. Section 15(2) does not apply to guardianship applications and no provision is made for a substitute recommendation in such cases. | If a fresh sufficient recommendation is provided within the period allowed, the application is retrospectively validated. If not, the validity of the patient’s detention depends on the correctness of the managers’ opinion that the recommendation is insufficient. In guardianship cases, the guardianship is always invalid if a recommendation is insufficient. |
| 3. When considered together, are the recommendations sufficient to warrant the patient’s detention? | • Neither medical practitioner is approved under s.12(2).  
• More than five clear days elapsed | Section 15(3) provides that the hospital managers may notify the applicant of their opinion and, in doing so; they shall | As before, if within the 14 day period the applicant furnishes to the managers a fresh medical |

Care Quality Commission 2014
in pursuance of the application? If both forms when considered separately are sufficient to warrant the patient’s detention, the next question to address is their combined effect.

- Both recommendations and the application were provided by doctors and an AMHP from the same clinical team, except where it is of urgent necessity that the application be made and delay would involve serious risk to health or safety of the patient or others (see regulation 6(3) of the Mental Health (Conflicts of Interest) (England) Regulations 2008).

Recommendations which, when considered together with the other remaining recommendation, is sufficient to warrant the patient’s detention, the application shall be deemed to have always been valid.

If not, the validity of the patient’s detention depends on the correctness of the managers’ opinion that the recommendations are collectively insufficient. In guardianship cases, the guardianship is always invalid in such cases.

4. If the application and both medical recommendations are sufficient to warrant detention, whether considered separately or together, are any other errors or defects in the forms apparent?

- Leaving blank spaces on the form, which should have been completed, other than the space for signing it or for recording the doctor’s reasons for believing that the statutory criteria are satisfied.
- Failure to delete one or more alternative clauses in places where only one can be correct.
- Errors in the spelling of names, addresses or places.

Sections 8(4) and 15(1) provide that an application or medical recommendation which is in any respect incorrect or defective may, with the managers’ consent, be amended during the 14 days following admission or reception into guardianship.

Once the amendment has been made, the recommendation is deemed to have effect as if it had been originally made as so amended. If the error or defect is not corrected, the validity of detention or guardianship depends on the significance of the error or defect. If trivial, the authority is unlikely to be affected.

6. Originally sourced from A. Eldergill (1997) Mental Health Review Tribunals – Law and Practice (Sweet and Maxwell) p 271, but revised to accommodate amendments made to the Mental Health Act 1983 since publication.
### SOAD role in certification, adult and child detained & SCT patients

The form to be used in certification is indicated in brackets. "AC in charge" = Approved Clinician in charge of the treatment in question

<table>
<thead>
<tr>
<th></th>
<th>Consenting</th>
<th>Incapable</th>
<th>Refusing</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Adult</strong> (Patient aged over 18 years)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Detained in hospital</td>
<td>ECT</td>
<td>AC in charge usually certifies (T4) SOAD may also certify (T4)</td>
<td>SOAD certifies (T6)</td>
</tr>
<tr>
<td></td>
<td>Meds</td>
<td>AC in charge usually certifies (T2) SOAD may also certify (T2)</td>
<td>SOAD certifies (T3)</td>
</tr>
<tr>
<td><strong>SCT in community</strong></td>
<td>ECT</td>
<td>SOAD certifies (CTO11)</td>
<td>SOAD certifies (CTO11)</td>
</tr>
<tr>
<td></td>
<td>Meds</td>
<td>AC in charge certifies (CTO12)</td>
<td>SOAD certifies (CTO11)</td>
</tr>
<tr>
<td><strong>Child / Adolescent</strong> (Patient aged under 18 yrs.)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Detained in Hospital</td>
<td>ECT</td>
<td>SOAD certifies (T5)</td>
<td>SOAD certifies (T6)</td>
</tr>
<tr>
<td></td>
<td>Meds</td>
<td>AC in charge usually certifies (T2) SOAD may also certify (T2)</td>
<td>SOAD certifies (T3)</td>
</tr>
<tr>
<td><strong>SCT in Community</strong></td>
<td>ECT</td>
<td>SOAD certifies (CTO11)</td>
<td>SOAD certifies (CTO11)</td>
</tr>
<tr>
<td></td>
<td>Meds</td>
<td>SOAD certifies (T5)</td>
<td>SOAD certifies (CTO11)</td>
</tr>
<tr>
<td>Informal</td>
<td>ECT</td>
<td>SOAD certifies (T5)</td>
<td>SOAD certifies (T6)</td>
</tr>
</tbody>
</table>
Certification of treatment under the revised Mental Health Act 1983 - all patients

- **detained patient**
  - medication after 3 months
  - ECT
  - patient over 18
    - patient consents
      - Form T2
    - patient refuses (D)
      - Form T3
  - patient under 18
    - patient consents
      - Form T4
    - patient incapable
      - Form T6
    - patient refuses (D)
      - Form T5

- **informal patient**
  - ECT
  - patient over 18
    - patient consents
      - Form T4
    - patient incapable
      - Form T6
    - patient refuses (D)
      - Form T5

- **community patient (A)**
  - medication after 1 month (B) or ECT
  - patient over 18
    - patient consents
      - Form CTO11
    - patient incapable
      - Form CTO12
  - patient under 18
    - patient consents
      - Form T6
    - patient incapable
      - Form CTO12
  - patient refuses (D)
    - Form CTO12

Notes:
- T3, T6 and CTO11 can only be completed by a SOAD: T2 and T4 may be completed by either the Approved Clinician in charge of the treatment or a SOAD.
- CTO12 can only be completed by the Approved Clinician in charge of the treatment.
- i.e. patients subject to a Community Treatment Order (Supervised Community Treatment) who have not been recalled to hospital
- After one month, or the end of the three-month period relevant to s.58(3), whichever is later
- See s.62.
- Refusal in these circumstances includes, for patients aged over 16, refusal by advance directive, or conflict with a decision by a deputy, donee or the Court of Protection.
Certification of treatment of adults under the revised Mental Health Act 1983

- **detained patient**
  - medication after 3 months
    - patient consents
      - Form T2
    - patient refuses/incapable
      - Form T3
  - patient consents
    - Form T4
  - patient incapable
    - Form T6

- **informal patient**
  - ECT
  - medication or ECT
    - patient consents
      - Form T4
    - patient incapable
      - Form T6
    - patient refuses(D)
      - Form T6

- **community patient(A)**
  - medication after 1 month(B) or ECT
    - patient consents
      - Form CTO11
    - patient incapable
      - Form CTO12
    - patient refuses(D)
      - Form CTO12

MHA cannot provide authority for treatment

Notes:  
- T3, T6 and CTO11 can only be completed by a SOAD: T2 and T4 may be completed by either the Approved Clinician in charge of the treatment or a SOAD.  
- CTO12 can only be completed by the Approved Clinician in charge of the treatment.  
- i.e. patients subject to a Community Treatment Order (Supervised Community Treatment) who have not been recalled to hospital  
- After one month, or the end of the three-month period relevant to s.58(3), whichever is later  
- See s.62.  
- Refusal in these circumstances includes refusal by advance directive, or conflict with a decision by a deputy, donee or the Court of Protection.
Certification of treatment of *child / adolescent patients* under the revised MHA 1983

```
<table>
<thead>
<tr>
<th>Detained patient aged 17 years or less</th>
<th>Informal patient aged 17 years or less</th>
<th>Community patient (A) aged 15 years or less</th>
</tr>
</thead>
<tbody>
<tr>
<td>medication after 3 months</td>
<td>ECT</td>
<td>medication after 1 month (B) or ECT</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>patient consents</td>
<td>patient consents</td>
<td>patient consents</td>
</tr>
<tr>
<td>Form T2</td>
<td>Form T5</td>
<td>Form T6</td>
</tr>
<tr>
<td></td>
<td></td>
<td>MHA cannot provide authority for treatment</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Form CTO12</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Form CTO11</td>
</tr>
</tbody>
</table>

Notes:  
T3, T6 and CTO11 can only be completed by a SOAD; T2 and T4 may be completed by either the Approved Clinician in charge of the treatment or a SOAD.
CTO12 can only be completed by the Approved Clinician in charge of the treatment.

(A) I.e. patients subject to a Community Treatment Order (Supervised Community Treatment) who have not been recalled to hospital
(B) After one month, or the end of the three-month period relevant to s.58(3), whichever is later
(C) See s.62
(D) Refusal in these circumstances includes, for patients over the age of 16, refusal by advance directive, or conflict with a decision by a deputy, donee or the Court of Protection.
```