

Mental Health Alliance response to the consultation on the draft code of practice (England) to Mental Health Act 1983 (as revised by the Mental Health Act 2007)

Introduction to the Alliance response

The Mental Health Alliance is a coalition of 75 organisations which came together to work to secure humane and effective mental health legislation. It is the broadest coalition in the mental health world – a unique alliance of service users, psychiatrists, social workers, lawyers, voluntary associations, charities, religious organisations, research bodies and carers' groups.¹ This response is based on policy worked out through extensive discussion and consultation during the process of reform of the Mental Health Act and on the contributions of member organisations.

Most of our comments are about specific points in the draft code but we have some general comments.

Potential for harm as well as benefit

The Code should remind professionals of the fact that treatment and care interventions are not risk free and that there is potential for people to be harmed as well as helped by contact with mental health services, and especially by compulsory treatment. Points at which this would be particularly relevant include chapters on treatment and supervised community treatment.

Race and culture

We welcome the inclusion of race and culture in the respect principle but consider that there are several places in the draft Code where it needs to say how these issues should be addressed in professional practice. Points at which this would be particularly relevant include chapters concerning communication, assessment, nearest relative and advocacy.

Accessibility

While it is primarily for professionals operating the Act we consider that the Code should, as far as possible, be usable by service users and those supporting them. Although parts of it are very clear, it would be helpful to have an edit with this in mind. The Mental Capacity Act Code of Practice provides a model in this respect. There should be an easy read version as well.

Clarity of language

The language used in the Code is not always clear in its use of the terms 'should' and 'good practice'. If the Code is setting out a duty imposed by the Act, the term 'must' would appear to be more appropriate 'should' and 'good practice' ought only to be used where this is what is meant. For example, the Mental Capacity Act Code of Practice uses a range of language (including the terms 'must', 'should' and 'good practice') as well as stating when something is

¹ The full membership is shown at the end of this document and published on www.mentalhealthalliance.org.uk.

a duty imposed by the Act or intends to provide advice on steps which might be helpful in complying with that legal duty. We recommend that the draft Code is checked for the consistent and accurate use of language.

Introduction

The draft Code states that any departures from the Code could give rise to legal challenge and a court, in reviewing any departure from the Code will scrutinise the reasons for the departure to ensure there is sufficiently convincing justification in the circumstances (paragraph ii). The Mental Health Alliance is concerned that this fails to clearly and accurately state the correct legal status of the Code as set out in the *Munjaz* judgement. This was clearly articulated by Lord Hunt in the House of Lords during the debate on the Mental Health Bill:

"The noble Baroness, Lady Barker, asked again about the status of the code and whether the principles can be departed from. The answer is yes, but only where there are cogent reasons for doing so that are demonstrably justifiable. That is consistent with the decision being proposed in relation to Munjaz. The judgment set out the circumstances which could provide cogent reasons for not following the guidance in the code."²

The Alliance believes that this position needs to be clearly stated in the final version of the Code of Practice. A commitment was given, again by Lord Hunt, on this point during the debates on the Bill:

"As I said to noble Lords in Committee, we will strengthen the introduction to the code. I readily accept that the current introduction and the draft introduction do not give sufficient guidance and clarity to professionals on the status of the code of practice. Therefore, in addition to introducing an amendment on the status of the code to be put in the Bill, we will clearly need to look carefully at the drafting of the code of practice in relation to its status. I am happy to share that with noble Lords who have taken part in this debate so that we may have the benefit of their advice and wisdom."³

² 6 Mar 2007 : Column 131

³ 27 Feb 2007 : Column 1586

Chapter 1 – The statement of guiding principles

We welcome the way in which the principles are reflected throughout much of the Code but consider that there needs to be more attention to ensuring that the principles of respect, patient participation and patient's wishes and feelings are consistently and fully applied in all circumstances in which there is a decision to be made. In places a reference should be also made to advance directives as well. This could all be achieved with small changes to wording. The importance of empowering patients (self determination and personal responsibility) is already part of the current Code of Practice and it is well documented in research that this aids recovery so reminding professionals of its importance would be beneficial. It is particularly relevant to the Chapter on patients with personality disorder and forensic patients. In these chapters greater reference to cultural factors would also be appropriate. We would recommend a full review of the chapters to ensure consistency of approach.

1.2 The Purpose Principle

The Alliance is extremely concerned that the very first principle states that "*decisions under the Act should be taken with a view to minimising the harm done by mental disorder, by maximising the safety and wellbeing (mental and physical) of patients and protecting the public from harm.*" This elevates risk into the overriding principle for decision makers – which is not in accordance with the views of the House of Lords in accepting the amendment. It is also of some concern that the statement of purpose (reduction of the harm of mental disorder) is both unhelpful and stigmatising for mental health patients. Reference to patient wellbeing and safety and protection of others are presented at the end of the list of principles and are simply factors to consider. The key principles presented above this are: respect for wishes and feelings; the right to participate in decisions; least restrictive option; respect for diversity; effectiveness of treatment; and views of carers. The reduction of risk is one component, and an integral one to the practice of mental health services but it is not the overriding objective of the 1983 Act which is to ensure that people receive treatment they need. At the very least therefore we believe that the words "*minimising the harm done by mental disorder, by*" should be deleted.

1.3 Respect principle

The principle of respecting patients' wishes and feelings is the first principle of the Mental Health Act 1983 – but we are disappointed that this has now been relegated to the end of the second principle. Earl Howe in debates on the Mental Health Bill in the House of Lords emphasised the importance of wishes and feelings and it was the first principle in the principles amendments.⁴ We support this view and recommend that the respect principle should begin with the need to respect the patient's wishes and feelings. However it should not only respect patient's wishes where that is "practicable and consistent with the purpose of the decision." If the purpose of the decision is to disregard the patient's wishes then there is no need to respect them. It is also a misuse of the word "respect" to take it as synonymous with "give effect to"

We welcome the inclusion of diversity within the respect principle. In particular, the reference to race directly touches on the persistent issue of over-representation of particular ethnic groups subject to compulsory treatment.

⁴ 19 Feb Col, 990

1.4 Least restrictive alternative principle

It is also of some concern that the least restrictive alternative principle attempts to allow clinicians to do what they wish so long as they have a purpose. As with patients' wishes and feeling, the least restrictive alternative principle is also limited by the purpose of the decision. This is the wrong way round – the point of principles should be to guide and limit the permissible purposes of those operating the Act.

1.5 Resources principle

We are disappointed that the resources principle has been given equal weight with other factors and is used extensively throughout the Code in examples in ways which would not have been expected (for example places of safety). It has therefore achieved a status not anticipated by the peers and not reflected in its place in the section of the Act – where it is placed at the end of the list of principles.

The Welsh Code

The two Codes take very different approaches to incorporating the principles. We believe that the English Code should be more consistent with the Welsh Code. For example the 'public safety' requirement of the 2007 Act is incorporated into the principles in such a way that public safety is seen as but one part of the overall mental health framework. For example, at paragraph 1.10 (under the Empowerment heading) the Code for Wales states: *"Patient wellbeing and safety should be at the heart of decision-making. Where relevant this incorporates ensuring the wellbeing and safety of others"*

The other principles in the Welsh Code also set out a more balanced and empowering view of mental health care – for example:

- Other paragraphs under the Empowerment heading highlight the importance of involving patients in creating risk management plans, the centrality of retaining the independence of the patient wherever practicable, using "least restrictive options", encouraging those subject to compulsion under the Act to participate actively in their own care, and so on.
- The 'Equity' heading basically guides practitioners to respect diversity and to pay due regard to the all legislation relating to equality and non-discrimination.
- The 'Effectiveness' heading states that any person subject to compulsion should be provided with evidence based treatment and care. Again, reference to protecting other people is contained within a statement advocating a balance between "ensuring the safety and wellbeing ... of patients and protecting the public from harm."
- Even the 'Efficiency' heading states: "Where patients are subject to compulsory admission, agencies should work together to plan a programme of care that as far as practicable takes account of the views and wishes of patients. Care plans should focus on seeking early discharge and the provision of aftercare, if necessary, at the earliest opportunity." (para 1.30)

- The principles of the Code for Wales reinforce the role of advocacy: “Independent advocacy has a significant role to play in empowering patients to be fully engaged in these processes, whether the individual is entitled to independent mental health advocacy as a qualifying patient under the Act, or is able to access other independent advocacy.” (para 1.13)

Chapter 2 – Communication

Although generally good, this chapter does not get across the importance of first trying to reach agreement with the patient, and that the patient should be as involved as possible in decisions about their treatment and care. There is no reference to communication with children and young people and their parents, guardians or carers, or to cultural competence. It would be helpful if it were merged, located with, or more cross-referenced with the chapter on information.

Communication with patients

Paragraph 2.2 reads as though the decision is a given, which is explained to the patient and which the patient is consulted about, rather than decision-making being a process in which the patient should be involved. Communication works both ways.

The introduction to chapter 16 rightly refers to “the importance of ensuring that previously expressed wishes and feelings of patients are made an integral part of the care planning and decision-making processes”. It would be helpful if this chapter conveyed the same message with respect to both currently and previously expressed wishes and feelings.

Communication is critical in ensuring appropriate equitable care. Acknowledging the fact that ‘BME’ does not represent a single homogenous grouping, it is important for decision-makers to consider the cultural context and dynamics that mediate interactions with patients.

However we welcome the specification that:

- decisions and the authority for them are explained to the patient
- all views expressed by the patient are considered
- views and wishes are recorded
- communication barriers are identified and overcome
- information be given both orally and in writing and in a way that the patient can understand.

We suggest the following **amendments and additions**:

Introductory statement

We suggesting adding: “Effective communication is essential in ensuring appropriate, equitable care and respect for patients’ rights. It is important that that language is clear and unambiguous and that staff check that what has been communicated has been understood.”

Detailed comments on communication with patients

Paragraph 2.2

We suggest amending so that it reads:

“Patients should be involved as far as possible in decisions that affect their care and treatment, whether or not their consent is required for that decision. Effective consultation with patients and consideration of their wishes should increase the possibility of reaching agreement and providing consensual care.

“Consultation with patients involves assisting them in understanding the issue that is being decided about, and their role and the role of others who are involved in their care. It involves seeking to understand the patient’s perspective and giving serious consideration to their views and wishes, reaching a negotiated agreement where possible.

“Where a decision is made that is contrary to the wishes of the patient, etc”

Paragraph 2.4

A specific reference to advance statements may be helpful, eg adding at the end of this sentence, “and professionals should attempt to establish whether the patient has an advance directive or statement”.

Paragraph 2.5

In addition to issues of language, this paragraph should indicate the need for cultural competence. Communication barriers may relate to different cultural understandings of mental distress and words used to describe it, not only language difference.

It is important that professionals working under the Act with people with a communication impairment have an understanding of alternative and augmentative communication methods. Methods can vary greatly from person to person and might include a communication aid, manual or electronic, a set of symbols, signs and/or objects of reference. The involvement of a ‘communication partner’ who knows the individual and is familiar with their communication method is highly recommended, as well as (not instead of) an advocate.

There should be reference to children and young people, for example,

“All staff should communicate with children and young people in an age-appropriate way that they can understand.”

Paragraph 2.6

Quite often a Deaf person is provided with a British Sign Language interpreter - but they use a foreign sign language. While we applaud the efforts to secure an interpreter, a bit of time spent establishing what communication support the person would like can save a lot of trouble. Therefore we suggest adding:

“For example, it should not be assumed that a Deaf person who uses sign language uses BSL; he or she may use a foreign sign language.”

As regards the provision of specialist help, the onus will be on decision-makers to request it. The last sentence might be better phrased as:

“Hospitals and other organisations should have systems in place to enable them to meet requests for the specialist help that staff require.”

Paragraph 2.8

Cultural competence needs to be included in relation to advocacy as well.

Paragraph 2.10

A major gap in the draft code is the lack of guidance on advising patients of their rights in relation to nearest relative. Even if this is not a statutory requirement, it is essential and needs to be included somewhere, probably chapter 18.

As information-giving is so central to patients' rights it may be helpful to move chapter 18 forward so that it sits with the chapter on communication. In any case there should be a cross reference to chapter 18 with this paragraph, and the necessity of informing patients of their rights, including the right to advocacy, should be given prominence in chapter 2.

Communication with others

We particularly welcome the reference to patients being able to nominate people of their choice to be involved in or informed of decisions and other matters to do with their care and treatment, and the prompts to remind people of their rights. We think it would be helpful to be explicit that patient requests to involve another person would normally be agreed.

Paragraph 2.16

We suggest amending this as follows:

"Therefore it is expected that clinicians will normally agree to patient requests to involve another person. In the case that such a request will not be, or has not been, observed clinicians should inform the patient. It may not always be appropriate etc"

And add to this subsection:

"Where the patient is a child or young person it is necessary to communicate effectively with parent(s), guardian(s), or carer(s)."

Keeping patients informed of their rights

Paragraph 2.17

We welcome the list of prompts to provide fresh explanations of rights, but consider that it is a Human Rights Act duty rather than simply "good practice" to keep patients advised their rights.

Paragraph 2.18

With respect to discharge, "... this fact should be made clear to them, and this should include being communicated in writing."

And add:

"The patient's rights in relation to aftercare and the care programme approach, and the options for provision of continuing care, should be explained to them."

Chapter 3 – Mental disorder

Definition of mental disorder

Paragraph 3.3

We are not convinced that it is helpful to include in a statutory document a list of conditions which 'could' fall within the definition. This could be interpreted unhelpfully as being either inclusive or exclusive.

Paragraph 3.7

Sexual behaviour between consenting adults is a matter that is part of private and family life and protected by the Human Rights Act. We think it is important that decision-makers are reminded of this.

Dependence on alcohol or drugs

Paragraph 3.8

"But it is recognised that alcohol or drug dependence may be accompanied by **another** mental disorder" – this is confusing as it has been stated that dependence on alcohol or drugs is not a disorder for the purposes of the Act. The word "a" would be preferable to "another".

Paragraph 3.10

It is not clear what kind of treatment could or would fall into the category of a treatment for alcohol or drug dependence which is also part of the treatment for a(nother) mental disorder. If this paragraph is to remain in the Code we think it should be clarified.

Learning disabilities and autistic spectrum disorders

Paragraph 3.13

It is important to guide practitioners on the meaning of 'abnormally aggressive or seriously irresponsible conduct' but the Code should also convey that the existence of such conduct does not automatically make use of the Act necessary or beneficial. In our view, compulsory hospital treatment is rarely (if ever) the most effective solution in responding to abnormally aggressive or seriously irresponsible behaviour of people with learning disabilities, or the one which best respects a person's rights. The needs of people with learning disabilities who do not also have a mental illness are best met through sensitive and expert social care, working in partnership with health professionals. Paragraph 3.13 discusses abnormally aggressive or seriously irresponsible conduct as sometimes being a form of communication. This is essential for professionals to understand, but at the same time the fact that behaviour is trying to communicate something does not make it any less 'abnormally aggressive' or 'seriously irresponsible' in terms of the Act.

We think that the Code should both explain 'abnormally aggressive or seriously irresponsible conduct' and encourage appropriate responses to people with learning disabilities, using the least restrictive alternative.

We suggest this part of the code be amended to cross reference with paragraphs 37.6-37.10 and to include the following points:

People with learning disabilities may on occasions behave highly aggressively because they are angry, afraid or in pain, but with the provision of appropriate support such behaviour can usually be successfully managed without using compulsory powers. Professionals need to consider the range of alternatives for responding to such behaviour.

Examples that fall outside the definition of 'abnormally aggressive and seriously irresponsible conduct' include uncontrolled flailing, in someone with a profound learning disability, or a confusional state or lack of control due to a neurological condition, because there is no conscious intention.

The "learning disability qualification" should also be linked to the Mental Capacity Act principle that unwise decisions may still be valid.

Paragraph 3.14

This is correct in terms of the law but we should like to register the Alliance's view that in the absence of any other mental disorder or abnormally aggressive or irresponsible behaviour people on the autistic spectrum should not be detained. Please see our comments on Chapter 37 which reinforce the need for professionals to think of alternative less restrictive means for providing the treatment or support a person needs.

Personality disorder

Paragraph 3.16

The first sentence is clear and helpful. We welcome the inclusion of "or indeed providing services without using the Act". This statement may be very important for people who approach services seeking informal admission at times of extreme distress and often on the point of self harming, only to be refused admission on the grounds that they "do not meet the criteria".

However, the second half of this paragraph is unclear and as far as we can see unnecessary. It appears to conflate the need for services with the need for compulsion, and places the emphasis on risk management rather than meeting needs. In any case it adds nothing to the legislative wording and our preference would be for it to be deleted.

Only if it were felt necessary to elaborate further, we would suggest the following text:

"What matters is to meet the needs of the individual patient and, where relevant, manage risk in the least restrictive way compatible with the delivery of safe and effective care, taking account of the safety of other patients, carers and staff."

Chapter 4 - assessment and examination prior to applications for admission to hospital

The Alliance believes that this chapter is largely an improvement on the previous Code. There are however a number of missed opportunities as outlined below.

- The 1983 Act provides that the AMHP 'shall satisfy himself that detention in hospital is in all circumstances of the case the most appropriate way of providing care.' (13 (2)). However, unlike the new chapter on Supervised Community Treatment, no attempt is made in this chapter to define the cultural issues that should be considered when undertaking an assessment. We believe that consideration should be given to having a chapter on equality and diversity issues. This would provide a setting for more detailed practice guidance in relation to cultural issues, and the use of interpreters & signers, and would be a good place to include practice examples.
- Although the importance of maintaining a social perspective is mentioned – for example in paragraph 4.44 - the code misses the opportunity to define this. We recommend that the Code should provide further guidance on assessing a person within their individual, familial, cultural, social and political circumstances.
- In common with other chapters, the chapter does not address the issue of delays in admission – however, without requirements to monitor against pre-existing criteria, such general advice is weak. For example, paragraph 4.78 recommends that once an application for admission has been completed, the patient should be conveyed to hospital as soon as possible. We suggest that the following should be added:

“Where delays in admission occur in excess of 2 hrs between the signing of forms and admission of the person to a ward, these incidents should be recorded on the relevant risk governance forms by the AMHPs, and the number of such incidents considered by senior managers in MH trusts, PCTs and LSSAs as well as by regulators.”

- The Chapter makes a helpful start in enabling people to understand the importance of considering both frameworks of the Mental Health Act and the Mental Capacity Act (MCA). However, more work needs to be done to clarify issues. For example it needs to be clear that if an AMHP is wishing to rely on the protection of the MCA to justify the admission of an compliant incapacitous person to hospital – the test that needs to be applied is that of the person's 'best interests' under the MCA rather than the criteria for detention under the relevant sections of the Mental Health Act.

Comments on particular sections

Paragraph 4.3

This paragraph acknowledges the importance of communication when determining whether compulsion is applied. The overrepresentation of BME groups under compulsion suggests the need for a particular focus on this initial stage of patient-service contact. Accordingly, the code should make more than a passing reference to the need for sensitivity. The code should operationalise precisely the meaning of the term 'sensitive' – and what exactly constitutes 'sensitivity' in the context of the interactions between patient and clinician – and

the admission process. We recommend the use of distinct scenarios that could help guide clinician's use of the code.

We also suggest the following should be added to this paragraph:

"Even if the AMHP, or another member of the assessing team, speaks the language of the person being assessed, it will not be possible for a proper assessment to be carried out if one of the assessors is both assessing and semi-interpreting."

Paragraph 4.4

The word "assessments" should be replaced by "interviews" to make clear that the expectation is that the doctor & AMHP are in the same room together with the patient at the same time.

Paragraph 4.5

It is essential that one of the doctors discuss the patient with the person applying for the detention, not merely 'good practice'. This should be stated in this paragraph and also in paragraph 4.63 on medical examination.

Paragraph 4.4

The following should be added: "assessments should not have to be unduly delayed because of a lack of response of police."

Paragraphs 4.10 - 4.12

This section is a retread of the existing code and paragraph 4.9 says no more than the Act itself. We therefore suggest that this section should be rewritten to give a step by step guide to decision-making in the assessment process and the factors to consider in each step – for example:

- Does the person suffer from a mental disorder? What are the behaviours, signs & symptoms which support the judgement? What are the social & cultural factors which may be influencing the presentation? Examples from Suman Fernando's website would help to illustrate the point.⁵
- Is the mental disorder of a nature or degree which requires treatment or further assessment in hospital? What are the risk factors which require admission – health, safety, protection of others? The views of the nearest relative (this phrase does not appear in 4.10 but it should) & significant others. Again, a case example would be useful here.
- Is detention necessary? Patient's attitude to admission and/or treatment at interview, history of previous admissions. The potential impact of detention on this person's future support, care & treatment. Do all patients who present a danger to others need to be detained?
- Is appropriate treatment available? What factors to consider when deciding on admission to a particular unit.

⁵ www.sumanfernando.com

Paragraph 4.22

This section is unclear, it needs to be clear that the MCA only authorises the deprivation of a person's liberty, whereas any attempt to provide treatment would need to rely either on a person's agreement (if they have capacity) or the MCA (and best interests).

Paragraph 4.28

This has been written from an MCA perspective and does not help the AMHP to decide which of the MCA or MHA powers would be most appropriate. For example, guardianship is not mentioned as an alternative to admission, but MCA powers are.

A more comprehensive overview, building on paragraph 4.24, would be very helpful. In particular points i-iii at the end of box 2 are crucially important points to bear in mind and should have more prominence.

Paragraph 4.35

This paragraph refers to the need for specialist expertise for particular groups of patients. In addition to the examples given, there should also be reference to those for whom English is a second language.

Paragraph 4.36

This paragraph should recommend that AMHPs should attend a Communication Tactics or Deaf Awareness course.

Furthermore, even in the most straightforward of presentations involving a Deaf patient, it is still expedient that a specialist be contacted wherever possible. At the very least this paragraph should recommend that a specialist could check that certain considerations have been made and the local clinical team are pointed towards best practice. If the local service chooses, this link could prove very valuable and have a huge impact on the patient's care.

We suggest the following rewording:

"An AMHP or clinician examining or assessing a Deaf person should have had Deaf awareness training, including basic training in issues relating to mental health and deafness. They should know that some Deaf people can present as if they have a personality disorder, mental illness or learning disability despite this not being the case, that there are characteristic ways in which Deaf people with mental illness may communicate psychotic phenomena and that in taking the 'role' of another person as part of sign language their emotions or beliefs may be misunderstood. An AMHP or clinician examining or assessing a Deaf person should seek assistance from specialists with appropriate expertise in mental health and deafness. This may be available from one of the specialist hospital units for deafness and mental health. A telephone consultation would be sufficient as a minimum. Contact with such units may, in particular, help to forestall Deaf people being wrongly assessed as having a learning disability."

Paragraph 4.37

While it is easy for interpreters to be qualified (perhaps to Level 3) and registered (perhaps as Junior Trainee Interpreters), we do not believe this is sufficient. We are fortunate that a

recognised standard – membership of the Register of Sign Language Interpreters - exists, and it is worth being specific about it. The Code should state that despite the national shortage of interpreters, it should always be possible to use an appropriate interpreter. This may involve using an expensive agency that specialises in short-term bookings, but that is a small price to pay where someone's liberty and wellbeing is concerned.

It may also be helpful to explain in the text that a relay interpreter is a deaf person fluent and flexible in the use of sign language.

We suggest the following rewording:

"Unless different arrangements have been agreed locally, the AMHP involved in the assessment should be responsible for booking and using registered qualified interpreters with expertise in mental health interpreting. Interpreters must be Members of the Register of Sign Language Interpreters (MRSLI). Relay interpreters may be necessary, for example, when the Deaf person has a visual impairment, does not use British Sign Language to sign, has minimal language skills or a learning disability. The interpretation of thought disordered language is often impossible and less experienced interpreters may approximate a word-for-sign translation. This may enable a degree of understanding of the form of thought, or confuse by mis-interpretation or translation. Additionally there are disorders of form of sign language specific to deaf people."

Paragraph 4.38

We believe that the Code should make clear that although unqualified interpreters such as family members or health professionals with only limited signing skills should not be used, though occasionally someone who knows the patient's idiosyncratic use of language can assist communication through an interpreter or professional fluent in sign language.

Paragraph 4.39

We suggest the following rewording:

"Prelingual deafness may cause delayed language acquisition which may in turn influence social behaviour. People carrying our assessments under the Act should have an awareness and knowledge of how mental health problems present in such deaf people. Cultural issues also need to be taken into account as many Deaf people have a visual perspective of the world and may consider themselves to be part of a Deaf cultural and linguistic minority. This means that they may behave in ways which are misperceived as mental illness. For example, animated signing may be misunderstood as aggression, while touching a hearing person to talk to them may be misunderstood as assault. Deaf people's spoken or written English may be poor, giving rise to a false assumption of learning disability or thought disorder. It is just as important to follow the above Code in assessing whether a patient is ready for discharge as it is for detention – whether that be by clinicians or appeal bodies."

Paragraph 4.43

The Code should also recognise that in exceptional circumstances serious health and safety concerns might prevent all or part of this explanation being given. However AMHPs should bear in mind the person's rights under article 8.1 of Human Rights Act and ensure these are not compromised by failure to declare the nature and purpose of the assessment.

Paragraph 4.44

This paragraph should describe the AMHP as an “independent public body” not an “independent professional” in accordance with section 6 of the Human Rights Act. In this section, it would also be helpful to define what a social perspective might mean, ie to see an individual within the context of their family, cultural, social, financial and political circumstances.

Paragraph 4.45

This paragraph covers two separate issues – the presence of others with the AMHP and presence of others with the patient. We suggest having separate sections to give the latter more prominence.

Paragraph 4.51

It should also be stated that AMHP duty systems should ensure that AMHPs are informed of impending assessments earlier to be able to consult the nearest relative.

Paragraph 4.52

The issue of privacy and confidentiality is not the only issue that may prevent the involvement of the nearest relative. For example there may be concern that the nearest relative poses a threat to the patient. This paragraph needs to cover this issue more thoroughly.

Paragraph 4.53

An extra bullet point should be added: “whether the patient is trying to conceal information which would have an impact on the assessment”.

Paragraph 4.63

This states that a medical examination must take into account the principles in chapter 1 and involve direct personal examination of the person’s mental state. For clarity this should be amended to an examination of the patient – of which assessing their mental state and whether they meet the criteria for detention would be a part.

Paragraph 4.66

We are concerned that this section suggests that in circumstances where a GP knew a patient, but an RMO or other section 12 doctor(s) did not, the GP (who is likely not to be s12 approved) would be excluded from the assessment. This could be detrimental to the service user. This paragraph should be amended accordingly.

Paragraph 4.67

This paragraph should state that PCTs should have a policy designating the responsible bed-finder. When a mental health act assessment is requested the AMHP, if s/he considers it appropriate, should contact the designated bed-finder to secure a bed. The AMHP should not be put in a position of failing to arrange the assessment because of a lack of bed. If

necessary the AMHP should ask the s12 or other doctor to discuss the seriousness of the need with the bed-finder.

Paragraph 4.76

The draft Code for Wales refers to the possibility of circumstances when it would benefit the service user if the AMHP took their time within the 14 days available to complete their application, and we suggest a similar formulation:

“Most compulsory admissions to hospital require prompt action to be taken. However the AMHP, , has up to 14 days from having personally seen the patient to complete an application for admission under sections 2 or 3 and there may be circumstances where it will be in the patient’s interests to use this time to secure alternative arrangements that mean detention is not required.”

Paragraph 4.78

This should include a time limit of 2 hrs between the signing of the papers and the receipt of the person into a hospital bed. Times should be recorded on the application form and receipt form. Where it is not possible to keep to these time limits, reasons should be given, the information collated, and such reports monitored by senior managers within the organisation and by regulators. We suggest the following amended text:

“Where delays in admission occur in excess of 2 hrs between the signing of forms and admission of the person to a ward, these incidents should be recorded on the relevant risk governance forms by the AMHPs, and the number of such incidents considered by senior managers in MH trusts, PCTs and LSSAs as well as by regulators.”

Paragraph 4.84

Whilst the philosophy behind this change in the law is positive (that the local authority within which a person usually lives should maintain responsibility for undertaking future assessments), this does not take account of situations where a different local social service authority is responsible for the original section 2 assessment – for example, because the person has travelled into central London, or is on holiday in the west country. This section should suggest that in such circumstances, good practice would indicate that the LSSA of ‘ordinary residence’ should continue to be responsible for the s3 assessment, not the detaining LSSA.

Paragraph 4.85

We suggest that the provision of a 24hr 365 day a year service should be monitored by the regulators.

Paragraph 4.86

This information should be in the AMHP section of this Chapter, as the application is the AMHP’s responsibility (or there should be a cross reference).

Paragraph 4.38

We suggest an extra section should be included to remind PCT's of their duty to inform LSSA's of where to admit people in 'special need' and where to admit young people in an emergency. The provision of this information should be monitored by regulators.

Chapter 6 – Appropriate treatment test

We think this chapter is very problematic - we do not consider that it gives useful guidance and there are points at which the text seems to contradict or go beyond what Parliament agreed (which we have set out below). The application of principles to this critical aspect of decision-making is essential and we believe this chapter of the Code would benefit from well thought through and realistic case studies, which show how the principles would apply in practice.

Paragraph 6.8

This paragraph is very problematic as it undermines the requirement in 6.6 that treatment should have the purpose of alleviating or preventing a worsening of the mental disorder or one or more of its symptoms or manifestations. We agree that disorders should not be assumed to be untreatable. However, the idea of "cure" is not raised anywhere else and absence of cure is a false/unhelpful threshold to introduce. The focus on behaviour (rather than the range of manifestations) gives the impression that behaviour management meets the definition irrespective of whether or not its purpose is as defined in the Act (Code 6.6).

The paragraph is about where the line should be drawn between preventive and therapeutic detention – this is very controversial and we think should be left to the courts to interpret the intention of Parliament.

Our preference would be for this paragraph to be deleted. Alternatively, the following wording could be used:

"It should never be assumed that any disorders are inherently or inevitably untreatable. Treatment that can alleviate or prevent a worsening of one or more of the symptoms or manifestations of the disorder may be appropriate and necessary even if it cannot be demonstrated that long-term and sustainable changes can be made in the underlying disorder."

Paragraph 6.12

This paragraph is also very problematic. The law refers to purpose and not likelihood of outcome, but clinicians can surely only legitimately (or logically) have a purpose where there is some likelihood that what is purposed will be achieved. An anticipated benefit or outcome is implicit in "purpose", and without it the purpose and/or the treatment is invalidated. This is a self-defeating position. There is no requirement to demonstrate likelihood but the phrasing of the paragraph gives the message that the likelihood of the desired outcome does not matter. In fact it is or should be at the heart of decision-making.

We therefore recommend the following alternative wording:

"Where appropriate medical treatment is available, no one should be excluded from detention or discharged, solely because, despite its being right for the purpose, the likelihood that the treatment will achieve its clinical objectives cannot be demonstrated."

Paragraph 6.14

We welcome the warning against aiming only to prevent deterioration when it should be possible to alleviate the condition. However the second part of this paragraph appears to be

phrased in order to allow for detention in the circumstances of the Reid case. It needs to be made very clear that these are exceptional circumstances and should not be set out as a general rule.

An alternative form of words is as follows:

"Treatment which aimed merely to prevent a disorder worsening, is unlikely, in general, to be appropriate in cases where standard treatment approaches would aim and be expected significantly to alleviate the patient's condition."

"Exceptionally there may be circumstances where the nature and degree of the mental disorder and the risk that it poses, when considered with all other circumstances of the patient's case, lead decision-makers to conclude that specialist care under the supervision of an approved clinician in a safe and secure therapeutic environment with a structured regime may be sufficient to constitute appropriate medical treatment."

Paragraph 6.16

We should like to know for how long treatments that require patient cooperation could be offered and refused before they became clinically inappropriate. We are concerned that this effectively allows long term preventive detention.

Paragraph 6.17

The main point of this paragraph – the significance of the reason for detention – is fine but the way in which it is explained implies that treatment solely for the purpose of protecting others would be appropriate if it were consistent with the reason for detention. This could surely never be the case, and treatment must always be offered with the purpose of alleviating or preventing a worsening of the person's condition etc.

Paragraph 6.18

In the absence of appropriate treatment, clearly detention is not possible. However, we are concerned about the possibility of people being left without access to treatment because of gaps in service provision. Especially as the problem is service/treatment availability, and not necessarily the individual's willingness to accept it, we should like to see further guidance (whether in the Code or elsewhere) on how to proceed in its absence.

Chapter 7 - Conflicts of Interest

This chapter tries to explain the complexity of the conflicts of interest, but is hampered by the complexity of the underlying regulation. The fact that it hasn't been possible to change the difference between the levels of independence expected by DOLS and that expected by the MHA will prove to be problematic in practice. The chapter is too hospital- focused. It needs to refer more to community scenarios and managing conflicts of interest involving supervised community treatment and deprivation of liberty.

Independence

'The Bill is clear that an AMHP carries out their duties on behalf of the LSSA. This underlines the independence of the AMHP from the Trust that may employ the doctors who also examine the case for admission. It also ensures that the responsibility for providing the AMHP service still clearly lies with the LSSA.'

Quote from Hansard debate 17th Feb 07

We have outstanding concerns about the independence of AMHPs. Under the 1983 Act, ASWs employed by the LSSA made the applications, and doctors employed by the NHS trust provided medical recommendations, and the creative tension between these two independent professionals provided the safeguard for the patient.

With the coming of the AMHP, who may or may not be employed by the LSSA, what guarantees are there that a similar creative tension will exist, and how will the continuing vital independence of the AMHP be maintained?

The fact of being employed by a different agency provides a safeguard, a "protective factor" to ensure independence. Is there an increased risk of collusion between nursing staff functioning as AMHPs, who may not have the training and culture of independent thinking that characterises ASWs?

If the AMHP lead officer is employed by the LSSA, which agency is responsible for approving/reapproving AMHPs, and for the practice of the service, how will this officer exercise authority over non social work AMHPs? How will this accountability be embedded in the service? When do the responsibilities and accountabilities of non social work AMHPs end and begin? If the lead officer is responsible for inpatient services will this create a conflict of interest between these responsibilities and the imperatives of the AMHP service. For example, there are not infrequently tensions between admitting units and ASWs, and these could cause a conflict of loyalties.

Detailed comments

Paragraphs 7.5-7.9

These refer to hospital admissions, including admission to independent hospitals, but make no reference to e.g. where a service user is required by the Act to stay in a care home and there may be conflicts of interest arising because of financial or business reasons.

Paragraph 7.10

First sentence, 'not' needs to be deleted. The phrase, "the assessor may choose to withdraw" from the assessment is too weak, and should be replaced by, "must withdraw"

where their ability to exercise independent judgement may be compromised. Further clarification as to the constitution of the assessing team would be helpful. It should be clarified that where two doctors are from the same team, or locality, in what circumstances is it acceptable for them to act together.

Paragraph 7.11

The current position is one where it is felt to be beneficial for at least one of the assessing team to have previous acquaintance with the patient and at least one not to have. This balances the idea of previous acquaintance and the benefit of prior knowledge with the benefit of a fresh assessment, and not bringing preconceptions to the assessment. Because of resource issues it might not always be practicable to adhere to this position, if delay may result in serious harm to the patient or others. However having all three assessors from the same team would not be acceptable.

We recommend that the Code state that "under no circumstances can all the assessors be from the same team".

Paragraph 7.14

This indicates that in circumstances not covered by regulations where there may be a conflict of interest the assessor should withdraw/not be involved. We suggest that as a first step the assessor should seek guidance and advice, rather than withdrawing immediately as it may not be necessary. However if their ability to exercise independent judgement may be compromised they must withdraw. The Code is very weak in suggesting possible situations where these circumstances may apply and again fails to make reference to care homes.

Paragraph 7.15

In apparent contradiction to 7.14 and the Deprivation of Liberty safeguards, paragraph 7.15 states it would be "good practice" to ensure that decision-makers do not have a financial interest in the outcome of the decision relating to SCT. However a situation where an SCT required someone to be detained in an independent hospital or stay in a care home where the decision-maker had a financial interest in the establishment would be a very obvious conflict of interest. Similar issues to do with hierarchical and team relationships apply to SCT as with admission. In the absence of specific regulations, we think it should still be possible to strengthen and/or clarify the guidance in the Code on conflicts of interest in operating SCT.

Paragraph 7.16

It should be clarified what is meant by "undue pressure" on AMHPs, and what recourse they might have in these situations.

Chapter 8 - Nearest Relative

Paragraph 8.2

This paragraph should provide the definition of 'cared for' – since someone providing care is given preference in list of relatives. This is particularly important for many mental health carers who are on call and provide practical and emotional care but do not live with, or necessarily close to, the patient.

Paragraph 8.3

We believe there needs to be a stronger obligation on LSSAs to fund an application to displace the nearest relative (NR) where there is no NR. The AHMP is not always the best placed person to do this, and the LSSA usually make the decision to do so. The Code should therefore acknowledge this issue.

This section should also include a cross reference to paragraphs 4.52 – 4.54 which deals with whether the nearest relative should be consulted in circumstances where the patient objects.

Paragraph 8.4

We are concerned that NRs may have difficulty identifying another person to delegate functions to. Reference should therefore be made to a patient's advance statement as they may have suggested another practical choice of person. Advice should also be given on how will the NR be supported to delegate – since this may be difficult for them if they are not well.

Paragraph 8.10

This paragraph should clarify how and when is the patient informed of their right to displace the NR – since this is not included in chapters 8 or 18.

Paragraph 8.14

We are concerned that the court process may not be accessible for a patient wanting to displace a NR. The Code says the AMHP should displace - but they may not be the care co-ordinator and would have to be convinced to 'front' an application. There should be a stronger obligation on LSSAs to make the application. This may be particularly important for displacement on grounds of unsuitability where the LSSA may not consider displacement as necessary.

Paragraph 8.15

We believe that the list of sources of evidence is too prescriptive. In making an application to displace the NR, the sources of written evidence will vary according to the grounds for application.

Paragraph 8.16

It would be useful to refer to patient's suggestions in advance statements (regarding AMHP nominating a NR) in this paragraph. Also, the best option if no relative is known is to appoint an independent advocate. The LSSA should only be appointed if there is absolutely no other option. The Code should also clearly state that the AMHP should never be the acting NR due to serious conflict of interest.

Paragraph 8.18

This paragraph should also include some discussion here about the capacity of the patient to give views on the suitability of the nearest relative.

Paragraph 8.19

We do not agree that the definition of suitability should be left to the courts – and we strongly recommend that the Code should give some guidance on this definition or list the factors that should be taken into account. The Code gives advice the interpretation of other legal terms – such as appropriate medical treatment – and we do not understand why the Code is silent on this particular issue. We recommend that the interpretation of suitability should include consideration of a number of factors – such as the views of the patient (both past and present – and including consideration of any advance statement) and whether a more suitable person is available to act as the NR and willing to do so.

Chapter 9 – Places of safety and police powers

The Mental Health Alliance would welcome a statement at the beginning of this chapter which emphasises that places of safety powers must always be used with regard for the dignity and respect of the person concerned. Professionals should recognise that being taken to a place of safety by the police can be very distressing and powers should be used in such a way as to minimise any further distress. Professionals should use the minimum force necessary to achieve the aim of taking the person away from a place where they may harm themselves or others. In particular police officers and AMHPs should consider whether the person has an advanced directive or crisis card/plan, particularly if people are likely to have a reaction to, for example, flashing lights. Good practice should include the use of methods to de-escalate panic or distress, such as removing helmets and hats and switching off radio equipment if appropriate. The Code should also emphasise the need to explain the process before it happens – if at all possible. The chapter implies an assumption that the behaviour leading to the use of these sections means someone is incapable of a rational dialogue. This may well not be the case and it is important that wherever possible the person understands what is happening and why.

The Code should also provide clear guidance for the police that a person should not be arrested after being placed on section 136 unless new and compelling evidence comes to light at a later stage. The police should be advised to make the most appropriate decision at the time the person needs to be removed – i.e. either by using the section 136 detention or make an arrest in respect of an offence. We are concerned that on a number of occasions the power to detain under section 136 is being used as a 'police power', rather than being treated as intended in the 1983 Act as a 'medical emergency power'.

Paragraph 9.2

The LSSA guidance on when to apply for a warrant should also include guidance to AMHPs on the alternative legal options if access is needed but the terms of Section 135(1) do not cover these circumstances. See comments on paragraph 9.3 below.

Paragraph 9.3

It should be made clear that these criteria do not cover all the circumstances in which access might be needed, and that in particular:

- they do not apply if the prospective patient is not living alone, unless there is evidence that they are being or have been "neglected, ill-treated or not kept under proper control" by someone with whom they *are* living; and
- the criteria for admission under the Act i.e health, safety and the protection of other persons do not apply to this section and that, in particular, it does not provide for a warrant to be issued on the ground that the prospective patient is a danger to others.

Paragraph 9.6

It should be made clear that "patient" here means someone who is already liable to detention under another section of the Act.

Paragraphs 9.14 – 9.17

We note that much of this section is couched in terms of good practice. However this sends out the wrong message, that such joint-working protocols are preferable but not essential. We can see no reason why paragraph 9.14 does not instead state that all agencies *should* have joint protocols, all professionals *should* understand the policy etc and all professionals *should* receive training. We suggest the following should be added: "Without such protocols, agencies will be unable to deliver places of safety services to an acceptable good practice standard."

Paragraph 9.15

The second bullet point should be amended to read: "providing prompt assessment and, where appropriate, admission to hospital for *further assessment and treatment*". The fifth bullet point on deciding about a transfer to another place of safety requires clarification about who will or can agree this, and what happens if the hospital wants to send the person back to the police station.

Paragraph 9.20

This paragraph should give an example of a different second choice of place of safety, for example a residential care home.

Paragraph 9.2

The third bullet point should read: "contact should be quickly made" – it would also be helpful to suggest what is an acceptable time delay for this.

Paragraph 9.27

It is essential, not just desirable, for staff experienced in working with people with learning disabilities to be involved in any assessment of a person who appears to have a learning disability.

Paragraphs 9.29 - 9.30

The meaning of the term "mental disorder within the meaning of the Act" has changed with the 2007 revisions, to the point where it is effectively meaningless. Although the 1983 definition does include "any other disorder or disability of mind" it has conventionally been interpreted as requiring evidence that the person either does or at least *may* fall into one or more of the three major categories. As now defined, without these categories or any proviso as to severity, it is so broad that it will encompass very low levels of disorder which would not raise any issue about the need for treatment and care. There will, therefore, be very few occasions on which a doctor could honestly conclude that the person in custody showed *no* evidence of mental disorder "within the meaning of the Act" but many occasions on which they could quite properly conclude that the level of disorder was not such as to raise any question of the need for treatment or care. It should be made clear, therefore, whether the person can be released from custody at this point or must continue to be held pending the arrival of the AMHP.

It should also be made clear that where the person needs treatment on an informal basis as an in-patient, it is the duty of the doctor to arrange this, as in the case of a compulsory admission.

Paragraph 9.31

We are concerned that despite the chapter repeatedly stating that it is not good practice to use a police cell as a place of safety, and that police cells should only be used when all other options are exhausted and in emergencies, the example is of a person being detained in a police cell. The Alliance feels that this is unhelpful as it illustrates going against the Code's advice. If this example must be used, we would like to see a sentence inserted explaining why a police station was the only option at that time, what other options might have been available in other circumstances and stating that the police officers involved were concerned that this was likely to cause Fred further distress.

We are concerned that the case study needs to be rethought. Section 136 is a power invoked by the police, who are the detaining body until they hand over to another body which is willing to accept that responsibility (either the managers of a place of safety or an AMHP.) The decision as to whether or not to transfer therefore rests entirely with them, but whilst the Code "may also be of assistance to the police" it is not binding on them, so they could simply ignore stipulations such as those in 9.34. Therefore the case example is unrealistic because it appears to assume that the doctor and AMHP will be "making the decision" and it asks, "does the custody officer have any view about what should happen?" In reality, the custody officer would almost certainly have a very strong view, and that view would prevail; if there was a hospital willing to receive "Fred," and the police were able to take him there, then they would do so. If they were not able to take him, they would insist on the doctor and AMHP completing their assessment and making a decision as quickly as possible and would not be prepared to wait any length of time for staff to arrive from his home area. The police have made it very clear in recent pronouncements that they expect mental health services to take vulnerable patients off their hands as quickly as possible, and this would be even more so in the case of someone under 18.

If an AMHP and doctor actually attend at the place of safety, they then have a professional obligation to interview/examine the person in custody and to apprise themselves of whatever other information is available. It would otherwise be professionally improper for them to make any decision or to give the police any advice, and the AMHP does in any case have a clear duty under Section 13 to interview in this situation, since there is "reason to think that an application under the Act may need to be made". If the doctor is also the forensic medical examiner, they will also have a contractual obligation to examine. Once they have done so, however, the first "purpose" in Section 136 (2) has been achieved, and further detention is only justified insofar as it is necessary to allow for the making of "any necessary arrangements."

It is accepted that this includes securing the attendance of a second doctor with a view to Section 2, and it would appear also to be lawful to transfer the person to hospital for the same purpose (see para 9.49), but the case example seems to imply that it would be permissible for the AMHP and the doctor to decline to assess, but to transfer "Fred" to another service for this to be done. For the reasons given above, this would be a breach of their legal and professional (and possibly contractual) duty, unless they could argue "*force majeure*" i.e that Fred's condition or the circumstances in the police station made it impossible for them to carry out an assessment there. Once they *had* assessed, Fred could be lawfully transferred to hospital only if they had formed the view that detention under

Section 2 was the “necessary arrangement,” that use of Section 4 was inappropriate and that transfer was the most appropriate way of obtaining the second medical opinion. There is no legal basis on which Fred could be assessed *twice* under this power by different professionals.

By the same token, unless it was impossible to assess at the police station, the AMHP could not lawfully undertake a transfer other than for the specific purpose of obtaining a second medical examination (or two examinations, in the very unlikely event that it was not possible to get even a single doctor to the police station.) If the AMHP attended the police station, they would then have a duty under Section 13 to assess, and if having done so they concluded that admission under Part II of the Act was *not* appropriate, this would rule this out as a possible “necessary arrangement.” The AMHP could not simply take custody of the person without at least attempting to assess them, since they would need to do so in order (as per 9.34) to form a view as to the safety and appropriateness of transfer.

There also needs to be more clarity about responsibility for custody during transfer. The present practice is that, when the police take a person directly to hospital under Section 136, they have to remain until the hospital, having conducted some form of initial assessment, accepts responsibility. If the hospital does not, the person will in most circumstances still be subject to concurrent powers of arrest, and the police can decide either to take them back to the station or to “de-arrest” them. However, a person handed over to the custody of an AMHP, or even to a “person authorised by a police officer” will presumably have to be de-arrested at that point. If the hospital then refuses to accept them, the AMHP (or “authorised person”) will be in a very difficult legal position, since they will still be in the AMHP’s custody - refusal by a place of safety does not of itself terminate the detention - but the police may well decline to have anything further to do with them, and it is any case doubtful if Section 136(3) could be interpreted as allowing them to be taken back to the police station. It should be made clear, therefore, what AMHPs should do in this situation, and under *no* circumstances should an AMHP take custody of someone who, if released, would be likely to be a danger to others.

We also recommend that the transfer of people between places of safety should be closely monitored by governance arrangements and regulators. This should also monitor any problems encountered if the police or ambulance services refuse or delay return to support admission or other transfers.

Paragraph 9.32

This should cover the possible practical problems of who will provide conveyance. This needs to be addressed here to avoid an AMHP putting themselves at risk by conveying the person in their own car.

Paragraph 9.38

The code should state who should monitor the locally agreed policy needs to be specified. We believe it should be via trust governance systems, and made available to senior managers in Mental Health Trusts, PCTs, LSSA, Police Authorities and regulators.

Paragraph 9.44

This should also refer to the person’s right to an appropriate adult under the Police and Criminal Evidence Act 1984.

Chapter 10 – Conveyance of Patients

This chapter needs to include the new powers to convey people subject to guardianship, to the place where they are 'required to be' (s18).

Paragraph 10.3

The following should be added – “This would include 1) for persons under s.136, (2) for persons under SCT, (3) between places of safety (4) for persons under guardianship being taken to their required accommodation”.

Paragraph 10.17

This should be amended to read:

“If the patient is likely to be unwilling to be moved, the applicant should provide the ambulance attendant or *police or other* escort with authority to convey the patient on their behalf. It is that authorisation which confers on them the legal authority to transport patients against their will and (if necessary) to prevent them absconding en route. *All professionals involved may be conferred with the power to convey by the AMHP, but should only intervene physically within the remit of their professional experience and skills. For example, AMHP’s should use their authority to persuade the person to go to hospital, ambulance staff may be empowered by the AMHP to lift and remove a compliant, not resisting patient and take them to hospital, and the police should be involved where a person actively and physically resists attempts to remove them to hospital or the place they are required to be.*

Paragraph 10.18

This should include a cross reference to paragraph 9.32

The need to convey a patient out of the area of the ambulance service also needs to be addressed – for example by

- by giving authority to recharge the receiving hospital for the transport at a later date.
- By determining whether or not to admit locally in an emergency and transfer at a later date, according to patient need rather than financial imperative. (again, proving authority to recharge in such circumstances could facilitate admissions local to the point of assessment, and transfers back to the place of ordinary residence more efficiently than at present.)

Paragraph 10.25

This should state that LSSAs should monitor AMHPs’ timely compliance with completing and sending reports to the Hospital.

Chapter 11 – Holding Powers

Section 5(2) Doctors' and Approved Clinicians' Holding Powers

Nature and scope of the power

The language used in this chapter is an issue in that the doctors with holding powers under 5(2) may not be doctors working in mental health (ie doctors treating patients for a physical disorder in hospital who may be required to exercise their section 5(2) powers). As such, they may not be as familiar with the Mental Health Act and Code of Practice as practitioners working in the area of mental health. It is, therefore, particularly important, that the language in this chapter avoids using technical language and acronyms.

Paragraph 11.2

The use of the terms 'doctor' and 'approved clinician' need to be clarified here and throughout the chapter. An 'approved clinician' may also be a registered medical practitioner and this distinction might not be clear to health professionals not working in mental health.

Paragraph 11.7

The list of people who are not informal patients should include those detained under part 3 (e.g. s.37, s.38).

Nomination of deputies

Paragraph 11.15

This provides for the doctor or approved clinician with powers under 5(2) to nominate a deputy. All it states is that the deputy will 'then act on their own responsibility' and 'should be suitably experienced'. This raises a question about the responsibility of the nominating doctor or approved clinician. Arguably, they should have some responsibility for ensuring that the person who they nominate is capable of exercising the powers properly which is broader than simply being suitably experienced and would appear to encompass having the necessary skills and knowledge (and possibly qualifications although see further comments below about the split between individual and organisational responsibilities).

Paragraphs 11.17-11.18

This discusses junior doctors being nominated deputies and gives some guidance about their training. It would be helpful to have some explicit guidance about the level of experience that a 'Junior Doctor' should have before being nominated as a deputy (e.g. F1, F2, ST1) and indeed, what is meant by the term 'junior doctor' as this is insufficiently clear. This section is also silent on who else could be nominated deputies.

Does 'senior psychiatrist' mean a Consultant Psychiatrist or does it envisage that other psychiatrists might be senior enough for a junior doctor to consult?

Paragraph 11.21

This appears to address a particular problem in practice (which might help to explain the earlier two paragraphs and perhaps the order could be changed). However, it seems to

impose an obligation on individual practitioners which it would be impossible for them to fulfil. Ensuring that all doctors liable to be on duty are competent to act as a nominated deputy and that they are adequately trained would appear to be an organisational rather than an individual obligation and should, therefore be included in the later section on Duty of Hospital Managers (11.38-11.40). In terms of what can reasonably be expected of the nominating doctor or approved clinicians, it might be helpful to look at the obligations imposed by the various professional guidance and codes of practice. For example, individual doctors have an obligation to be satisfied that, when they are off duty suitable arrangements have been made for their patients' medical care. These arrangements should include effective hand-over procedures, including clear communication with healthcare colleagues (see *Good Medical Practice* paragraph 48).

Ending section 5(2)

Paragraph 11.23

This states patients 'should' be released from detention under section 5(2) as soon as either a decision is made not to make an application for admission or the doctor or approved clinician decides that no assessment for possible admission needs to be carried out. The previous draft Code of Practice stated that detention 'will end immediately' and set out the circumstances. This is preferable because it reflects the legal position – that once the legal basis for detention has disappeared the power must be lifted.

However current good practice would mean that the AMHP should be involved in making the decision. Therefore we recommend that this paragraph be revised further to indicate that it would be good practice to consult with an AMHP if they are already present, or to defer a decision until they arrive if the clinician is unsure, but that if the clinician has reached a firm view he or she cannot properly continue the detention.

Paragraph 11.24

This states that patients must be informed once they are no longer detained under the holding power although there is no corresponding guidance on informing patients at the outset of the assessment about the purpose and effects of detention under this power. This would, at the least, be good practice, and consistent with the guidance in paragraph 2.2 on communication with patients (and the Participation principle in the Code of Practice).

Chapter 12 – Receipt and Scrutiny of Documents

Paragraph 12.11

This paragraph is unclear and could be read as saying that a photocopy of the form filled in by the AMHP/doctor is acceptable as authority to detain, which it is not. It should be made clear therefore that this only relates to photocopies of blank forms being filled in by AMHPs and doctors.

This section also needs to point out the situation regarding SCT. Presumably, an error in a SCT documents would also invalidate the authority to impose conditions on those subject to SCT. This needs to be explicitly mentioned in the Code.

It also needs to cover the faxing of forms because when forms are not immediately available they are sometimes transmitted by fax. We feel that guidance on this would be helpful.

Chapter 13 – Allocating a responsible clinician

Paragraphs 13.1-13.2 and general comment

This chapter mentions treatment needs several times, but fails to mention assessment. As well as treatment needs, patients are very much in need of assessment, particularly at the beginning of admissions, and especially if detained for assessment under section 2.

Case study

This would be more meaningful if placed later in the chapter, after the explanation of choosing and changing a responsible clinician.

Paragraph 13.5

Assessment skills are different from treatment skills, and a holistic and broad minded approach is often most helpful in determining future needs for treatment and other interventions. Indeed, life threatening physical causes of psychiatric symptoms may be missed if they are not specifically looked for. As such, we feel that skills in assessment should be a factor in determining the responsible clinician, and reference must be made to this in this paragraph.

It would be very helpful if this chapter contained information or guidance on dealing with situations where the clinician who would otherwise be most appropriate as responsible clinician is actively rejected by the person and therefore has no therapeutic relationship with them. In particular, guidance on dealing with patients' requests to change responsible clinician should be included and this should state that such requests should be taken seriously.

Paragraph 13.9

In accordance with Sections 58(3) and 63, this paragraph should state that where the responsible clinician is not a prescriber and the patient is receiving medication then the clinician in charge of the medication should be an approved clinician.

Paragraphs 13.9-13.10

These situations will be very common once a broader range of professionals take on the role of responsible clinician. As this communication between professionals will be critical to patients' health and safety it would be worth emphasising its importance even if there is no further guidance necessary.

Chapter 14 – Safe and Therapeutic Responses to Disturbed Behaviour

Case study

In 'applying the principles' the first bullet point under 'least restrictive alternative principle' actually starts with a more restrictive alternative ie longer seclusion. If this should be included at all it should be at the end of the list.

Key priorities

The guidance set out under key priorities is extremely important so we should like to see the organisation and presentation of this information improved. In the draft it is not at all clear. This could be done by formatting, eg separating them out in a box, although it would need to be clear that this guidance still formed part of the core text. A single numbering or bullet point system and deletion of 'First..'. 'Second..' etc would help.

Paragraph 14.26

We suggest adding in, "taking account of cultural or religious needs".

Paragraph 14.39

This is fine as far as it goes but it would be helpful also to encourage support of the patient and learning from the incident. The formulation in the draft Code for Wales could be used. This states that service providers should have in place a system of post-incident support and review which allows them to learn from the experience of using restraint and which caters for the needs of patients, staff involved in the incident, carers and family (where appropriate), and visitors who witnessed the incident. This system could also assist people who do not come under 14.47 who wish to take forward a complaint.

Paragraph 14.44

Guidance on what types of circumstances would be considered 'exceptional' would be helpful.

Paragraph 14.47

We suggest that this procedure be extended to anyone who is subject to restraint more than once within a specific timeframe.

Seclusion

Paragraph 14.50

There is a footnote number but no footnote.

Paragraph 14.57

This is a repeat of 14.55.

Paragraph 14.58

Guidance on what is meant by 'suitably skilled professionals' would be helpful.

Paragraph 14.59

The number of hours is missing from the first bullet point – we assume this is 8 hours as in the current Code. This paragraph should be merged with 14.60.

This section should say more about assessment and review of the care needs of the patient during seclusion, and stress that reviews should address ways in which to bring the period of seclusion to an end. Given that some BME groups are disproportionately likely to be placed in seclusion (Count Me In census 2007) a specific reference to the need for cultural competence in decision-making about seclusion would be helpful.

We are concerned that the current guidance on review of seclusion (14.58) may not make practical sense during the night if the patient is asleep and that in these circumstances the guidance is often not followed. It is unacceptable for statutory guidance not to 'work' and for patients' rights to be undermined by Trusts' non-adherence.

We have not defined an ideal set of safeguards. However a revision of the guidance on review could be helpful if it were in line with good practice, involved multidisciplinary reviews, required frequent monitoring, review and recording, and was clear and sufficiently prescriptive for staff to understand their responsibilities, patients to understand their rights and for monitoring to be effective. Specific consultation on this would help to establish the best system of safeguards in this important area.

Paragraphs 14.65-14.69

We are concerned about the way in which the draft code separates out longer-term seclusion and uses the terms 'longer-term segregation' and 'long term dangerous'. We recognise that there is a small group of patients who do present grave risk and need to be secluded for longer than 72 hours and we have no issue with the code addressing this situation specifically. However the way in which it is done, which separates these circumstances from other seclusion has significant risks. Using different terminology with separate guidance conflicts with the guidance at 14.50, which requires all forms of seclusion to be treated as such regardless of what they are called. As currently drafted the guidance is less prescriptive about reviews for people subject to long term seclusion, and these patients may not be afforded the other safeguards connected with seclusion. The term 'long term dangerous' is helpful and is suggestive of indefinite seclusion.

We consider that this should be termed 'longer term seclusion', that the guidance should be placed within the 'seclusion' sections of the chapter, and that it should be more prescriptive about reviews. This would safeguard the patient and ensure that they are not kept in seclusion for longer than necessary and that their human rights are upheld.

For example, the code could require:

- after 72 hours, daily reviews by a doctor for the first 14 days and one multidisciplinary review each week
- thereafter to be determined according to the needs of the patient but –

- at least weekly multidisciplinary reviews with medical input and
- monthly consideration by senior hospital managers
- external review every six months.

We also recommend reporting requirements to the Mental Health Act Commission when people have been in seclusion for a specified period of time or when people are subject to seclusion on multiple occasions during a specified period of time.

Chapter 16 - Preferences and decisions made in advance

We welcome the inclusion of a chapter on advance decision making in the Code. Our specific comments are as follows:

Paragraphs 16.2 and 16.4

It may be helpful to specify what sections 58, 58A and 63 are about. It should be made clear that advance decisions apply only to treatment.

Paragraph 16.5

A box giving details about validity and applicability of advance decisions under MCA may be useful.

Paragraph 16.8

This should refer to Section 4 (6) (a) of the Mental Capacity Act which explicitly refers to wishes and feelings, including written statements, when determining the best interests of people who lack mental capacity. It is crucial that practitioners are aware of this to ensure they meet the wishes of a person who lack capacity and that they are compliant with the law.

Paragraph 16.8

This should spell out the relevance of advance statements of wishes to decision-making about SCT and wider aspects of the person's care.

Paragraph 16.9

We suggest adding, "Furthermore it is the person's wishes and feelings that are the starting point for acting in their best interests under the Mental Capacity Act."

Paragraph 16.10

"...treated without consent under the Act" – this should say 'Mental Health Act' for clarity. The last sentence here is long and confusing and should be rephrased, for example:

"In particular, it is important that patients and professionals understand the difference between statements of wishes and advance decisions to refuse treatment. The latter are valid and applicable advance decisions made under the Mental Capacity Act. They have a legal effect, although this may be over-ridden where patients can be treated under the Mental Health Act without consent (see Chapter 25 and paragraph 16.2 above)."

Paragraph 16.11

This assumes there is only one set of patient notes. However, in practice, notes about a patient may be kept in numerous different places with different teams. A person may therefore have made their wishes known to their GP or CPN, but then for example, at a time when they lack capacity and are admitted as an inpatient, the hospital team have no access to these notes. Good practice would ensure a process for information sharing about advance decisions where possible. Professionals should attempt to establish if a patient has an

advance statement and should encourage patients to keep a copy (or they should give them a copy of) any written statements.

Paragraph 16.13

For consistency with the MCA we think that 'competent patient' should be 'patient with capacity'.

Chapter 17 – Confidentiality and Information sharing

Specific comments on sections

Paragraph 17.2

This needs to start with a clearer statement about what confidentiality is and what the Chapter is covering.

It would be helpful if the draft Code was clearer on difference between the duty of confidentiality owed to patients and obligations to others (such as carers and family members) and how these could be balanced. There are too many cases where it is assumed that the carer or family cannot be given any information at all due to confidentiality, which is not always the case, and patients are discharged without their knowledge. This can leave the patient highly vulnerable to harm by accident, assault or self-harm.

Paragraph 17.5

We are concerned that this paragraph doesn't accurately reflect what the Mental Capacity Act and its Code says about sharing information when patients lack capacity. This should be based on the best interests - and not to 'take into account' their best interests – and follow the statutory checklist.

It would, also be useful here to refer to advance statements which can be used to find out which relatives/carers should be informed of practical arrangements.

Paragraph 17.6 – 17.9

We believe that the definition of the term 'public interest' places too much emphasis to the protection of others and needs also to recognise that disclosures in the public interest will also be justified where it is necessary to protect the patient from a risk of death or serious harm.

For example paragraph 17.7 should refer to protecting **the patient** or others from serious harm as should 17.8 and 17.9 – and this section should also expand what 'serious crime' means. We also advise that the Code include a reference in 17.9 to the NHS Confidentiality Code of Practice.

Paragraph 17.8

This paragraph should also cover disclosing information to a carer to protect the patient from harm

Paragraph 17.11

This section should start with a clear discussion of the issue of carers/family members etc and the value of them being kept informed and being able to express concerns. Carers often need to share information with professionals in the confidence that this will not be relayed to the patient, as this can be damaging to relationships between patients and their carers.

However, this can place professionals in a difficult position as to speak to carers without their patient's knowledge could undermine patient trust. While difficult, these issues should not be ignored and should be recognised in the Code with some thoughts or advice on how doctors should balance their duty of confidentiality to patients with the need to be sensitive to the needs/wishes of those close to the patient and some of the more difficult issues which arise particularly when a patient explicitly states they do not want information shared with others. If health professionals are not able to respect the confidence of a patient's carer or family member, the Code should make clear that this should be explained to the person, which may help to prevent later misunderstanding.

This paragraph should also refer to information sharing with carers and cross reference to the Department of Health's NHS Service Delivery & Organisation 2006 paper: *Sharing mental health information with carers: pointers to good practice for service providers*.

We also believe that the Code should recommend the need for information sharing protocols which should be jointly agreed between relevant agencies including criminal justice agencies, voluntary sector and housing, which should say what information can be shared and in what circumstances and how it should be shared.

Paragraph 17.14

We are concerned that the tone of this paragraph relating to 'modifying offending behaviour' is stigmatizing - the language should be that of illness and treatment, rather than rehabilitation. We would like to see added to the response a statement that information sharing is necessary for continuity of care and in order to provide appropriate care. Also the correct Act is the Domestic Violence, Crime and Victims Act 2004 and not 2005.

We recommend that this Chapter should also address the following issues:

- A section should be included on Court of Protection visitors and Independent Mental Capacity Advocates – both of whom have a statutory right of access to case notes in certain circumstances. A reference to the position of other advocates would also be helpful.
- Guidance would also be helpful on dealing with information being shared which is incorrect. This can be common and includes both factual information and information where an interpretation has been applied. Many service users are concerned that once something is written in the medical notes – it becomes true and very difficult to get it corrected. We would welcome a clear statement that clinicians should ensure that information is correct – especially with the patient.
- The need for confidentiality/privacy on wards - the Code should specify that interviews with staff should be in private where possible – and staff should not conduct private interviews in the day room or corridor etc.
- The Code should also warn against patients being asked to sign 'blanket' forms to consent to information being shared with relevant health/social care services. This should wherever possible be very specific and agreed with service users as and when needed (and with the involvement of the advocate).

Chapter 18 – Information for Patients and Nearest Relatives

Paragraph 18.3

The third bullet point should clearly state that a patient will not automatically be discharged with the period of detention or SCT ends because an order for discharge must be made.

Paragraph 18.4

The Act states that information must be given 'orally and in writing' but this is not made clear in this paragraph. The Code should clearly state that written information should be given to the patient proactively, and this must be appropriate and accessible for the patient to understand.

Paragraph 18.7

Patients should also be informed of their right to advocacy - which may be able to help them appeal against detention by accessing legal help -.

Paragraph 18.8

This should include an additional sentence stating that patients on SCT also need to be informed of their right to advocacy – which may be able to help them appeal against detention by accessing legal help - and that patients should be supported to access this service.

Paragraph 18.15

The item on information on IMHA does state that it must be given 'orally and in writing' but should also emphasise that it is given in such a way that the patient understands.

Paragraph 18.18

This paragraph also need to cover the rights of carers to share appropriate information confidentially. Merely 'listening to their concerns' and assuring persons of their statutory responsibilities' is not strong enough. Bad practice in sharing information is one of the most common factors leading to crises – and further guidance is needed.

Paragraph 18.15

This paragraph also needs to cover mental capacity issues – for example if the patient lacks capacity and does not consent information sharing – and/or there should be a cross reference to Chapter 17 on confidentiality and information sharing.

Paragraph 18.23

There should also be a reference to advance statements to see how parent patients would like this to be handled.

Paragraph 18.24

The hospital policy needs to address assessing mental capacity of patient in relation to understanding information about rights and treatment – and their ability to make an application to the MHRT. The item on attorney acting as an agent should also refer to the Mental Capacity Act Code of Practice.

Chapter 19 – Independent Advocacy

General comments on the implementation of IMHA advocacy

Advocacy is vital to allow people to exercise their rights, in particular their right to appeal against treatment and detention decisions and the right to have their wishes heard and their cultural needs fully respected.

The Alliance is deeply concerned that the Government is planning to introduce parts of the legislation before independent advocacy services are up and running. We understand that IMHA services are unlikely to be fully implemented until April 2009, a full six months behind the rest of the Act. The rationale for this is apparently that the IMHA role was a relatively late addition to the MHA amendments and not therefore accounted for in terms of cost impact in terms of 08/09 budgets. The Alliance feels this in itself is not sufficient reason to delay implementation.

If advocacy is not implemented along with the rest of the provisions of the MHA 07, it may result in people being exposed to a system in which the safeguards against the abuse of power are unacceptably weak. This is particularly the case given that some provisions of the Act, including supervised community treatment, may take some time to “bed in”. Patient support, information and representation is crucial if there are any initial problems in interpreting the law correctly. The importance of advocacy was recognised as part of the Mental Capacity Act with the implementation of advocacy prior to the full implementation of the MCA. We feel that detained patients should be afforded the same right to advocacy from the inception of the full implementation of the Mental Health Act amendments.

The Mental Health Alliance is also concerned about the lack of clarity around how much of the resource allocated to implementation of the Mental Health Act 2007 will be provided for independent advocacy. If the Government fails to allocate sufficient resource for IMHA, this is likely to result in community advocacy services and advocacy for informal patients in hospital losing funding. We seek reassurances that the Government has properly costed the IMHA advocacy service and that other services – which have an important role in preventing crises and keeping patients out of compulsory care - will not be compromised.

General comments on the Code chapter

The Mental Health Alliance believes that the IMHA chapter suffers from the continuing lack of clarity emerging from Government and implementation leads about how the IMHA service will be commissioned, run and delivered to patients under the Mental Health Act.

The chapter is very short indeed. It reads like a plain English version of the Act’s provisions, rather than a guide to the practicalities of working with advocates, working as an advocate and receiving advocacy services.

What is contained within the Code is very general, to the point where its vagueness does not serve the purpose of providing guidance for practitioners on how the advocacy service should work. For example, paragraph 19.4 refers to “qualifying patients”, but does not set out who those patients are. The same paragraph talks of “certain professionals” having a duty to inform qualifying patients of their right to an advocate, but again the professionals who are under such an obligation are not listed. Unless roles, responsibilities and rights are clearly defined and interpreted here, it is hard to see how those working with the Act will find the Code useful.

We recognise the Government's argument that the Code is not there to provide explanatory notes on new services set up through the Act. However, we believe that professionals need greater guidance for the long and reference material for the term operation of advocacy than is currently contained in chapter 19 of the Code.

We strongly recommend that the Department of Health takes advice from the IMHA expert group, mental health advocates and service users about: how IMHA advocacy will and should work in practice; where the guidance needs to be expanded upon; and where issues of clarity may arise in the delivery of the service. Much of this work has already been done through good practice guidance put together by the IMHA expert group and the relevant parts may be easily be incorporated into the Code.

Specific comments

It would be useful to have a clear statement of the role and purpose of an IMHA advocate at the beginning of the chapter. This paragraph should emphasise that advocates can reduce the distress caused to a person when they are deprived of their liberty, and the importance of advocacy in reducing tensions and aiding communication and understanding between patients and professionals working under the MHA. It should highlight the singularities of IMHA advocacy compared to other mental health advocacy, including its importance in allowing patients to exercise their legal right to appeal against treatment or detention decisions.

The Alliance feels that the current description of advocacy in paragraphs 19.2 and 19.3 is too narrowly defined. The role of the IMHA should not be limited to decisions about how compulsory powers are used, but should be broadly interpreted to include any powers or duties arising from detention. Therefore, advocates should be seen as having a role (where required) in assistance, support and representation (where necessary) so that patients:

- are engaged and involved in their care as a detained patient;
- are supported at any meeting regarding their detention status (e.g. meetings with a SOAD)
- are consulted in aftercare planning
- receive support around seclusion decisions
- have a means to challenge or vary any other restrictions which flow from compulsory powers.

The Alliance believes that the guiding principle should be restated that all qualifying patients have equal rights to an IMHA regardless of age, gender, level of impairment, sexuality, disability, race etc. The Alliance also recommends that there should be a strong statement that the right to an IMHA applies to all qualifying patients including those detained under the MHA involved in criminal proceedings and in independent hospitals.

Paragraph 19.2

At end add "and regulations".

Paragraph 19.3

A sentence should be added stating that all professionals with specific duties and responsibilities under the Act must understand the role of the IMHA.

After the sentence "Independent mental health advocates (IMHAs) provide help to these patients" add 'This does not replace Hospital Manager duties under s. 132'.

Paragraph 19.4

At the end of the paragraph add 'IMHA services should have regard to any special or particular needs (e.g. translation services, gender specific requests) and seek to meet these specific needs where resources permit.'

Paragraph 19.5

This states "when a patient is unable to agree to an advocate's involvement due to illness" – we see no reason why the language of "capacity" is not used here, as all professionals should be familiar with this terminology and how to assess decision-making capacity. The paragraph should also briefly state that where the patient lacks capacity and the advocate is unaware of the patient's feelings and wishes then the IMHA should work within the principles of the Mental Capacity Act.

Paragraph 19.6

Add the following 'The patient should be given information on the main differences between an IMHA and other advocacy services so that they can make an informed decision about their choice of advocate.'

Paragraph 19.7

Add 'However, any information about the IMHA Service should make it clear the service is for qualifying patients and not an advocacy service for the nearest relative'.

Paragraph 19.8

At the end of the first sentence the following should be added 'which meets the requirements of the Mental Health Act and any associated legislation'. This should ensure that the procedures comply with and reflect the requirements of the legislative framework.

Paragraph 19.10

This should state that good practice would involve local or hospital protocols that set out provision for private meeting rooms to be made available, access to wards and visiting hours and access to information/ medical records etc. All professionals working under the MHA should be aware of these protocols.

There may be reasons where it is not reasonable or practicable to meet the patient in private, for example where this might pose an immediate or serious risk to the IMHA. The Code should address this issue, making clear that this is likely to be the case only in exceptional circumstances and on such occasions, advocates should act upon the advice of ward staff. The Code also needs to include details of how IMHAs should safely visit patients subject to supervised community treatment. Community mental health teams must make rooms available in community facilities for this purpose and such provision should be included in local protocols.

At the end of the third bullet point add 'or where it is deemed appropriate if the patient lacks capacity'.

Paragraph 19.11

Add 'The mail of the IMHA should not be interfered with under Section 134 of the MHA'. It also needs to be made clear that it would be unlawful to try and obstruct the role of the IMHA under the circumstances prescribed under s.129.

Paragraph 19.12

The term *inspect* needs clarifying to expand on 130B 3c. It is unclear what is expected of the advocate in terms of inspecting records.

Paragraphs 19.13 - 19.14

19.13, 19.14 – We are unclear what the difference is between capacity and competence.

Paragraph 19.15

As a point of clarity, it would be useful to know whether the regulatory impact assessment and commissioning guidance will cost advocacy based on one case per detained patient or several cases. In our experience, people will find an advocate useful more than once during their journey through compulsion.

The Alliance also believes that the Code should include the following information, using headings in the MCA Code as a model:

- Who is responsible for delivering the Service? – this paragraph should include information on regulations under s.130A
- Who can be an IMHA? – this paragraph should include information on regulations under s.130A
- Representing and supporting the detained patient - this paragraph should include the responsibilities of the IMHA, organisational and individual responsibility
- What happens if the IMHA disagrees with the professionals? This paragraph should set out the following procedures:
 - Using local resolution first
 - Consult the PALS
 - Referral to Hospital Managers
 - Liaison with MHRT and MHA Commission or future equivalent where the disagreement falls into their jurisdiction
 - Complaint under NHS and Social Care complaints
 - Engage the services of ICAS
 - Supporting the patient to access specialist legal advice
- The interface between the IMHA and IMCA - this paragraph should state in summary the following differences and distinctions:
 - The IMCA does not generally deal with serious medical treatment where provided under the MHA but the IMHA would (if working on the patients authority or deemed appropriate)
 - The IMCA is limited to those patients who are unbefriended but the IMHA is not subject to these limitations

- The IMCA may deal with aftercare issues if a relevant change of accommodation is proposed.

Chapter 20 – Visiting Patients Detained in Hospital

Many patients, especially those in specialist units, are out of their home area and sometimes long distances from home. Some families cannot visit their relatives in hospital because of for example the cost, lack of transport, disability/illness or caring responsibilities, etc. The code should recommend that help should be given with these problems if possible e.g. help with costs and finding overnight accommodation.

We also believe that as well as visits, phone calls with family/carers and friends should be encouraged and supported e.g. if the service user needs help using the phone or hasn't money for long distance calls. Other methods of communication should also be recommended where possible such as email; skype; video links; photographs; letters, etc.

The Code should also address the needs of patients who don't have visitors and/or family – and staff should consider the use of befriender/volunteer visitor.

Chapter 21 – Privacy and security

Paragraph 21.5

Restrictions are also placed on the number of a patient's phone calls, so the guidance here should refer to that as well as to mobile phones. We suggest a more active approach to review than the wording suggests, such as review at regular or frequent intervals.

Camera phones raise issues of possible breaches of privacy. It may be helpful for the code to advise hospitals to include this in their policies but to do so in a way that ensures minimum restriction on patients' freedom to make telephone calls.

Paragraphs 21.9-21.12

The paragraphs on withholding of mail under section 134 are so brief as to be meaningless, potentially unhelpful and not reflecting the law fully, for example by not mentioning the authorities whose post cannot be interfered with. There is no reference to telling the patient about post being inspected and/or withheld.

Paragraph 21.13

The guidance on providing adequate storage should be phrased more strongly, not as 'good practice'. Theft is a major issue in hospitals; and hospital management should set out to prevent this as far as possible, and to deal with incidents seriously.

Paragraph 21.15

The code should make it clear that the guidance on separate facilities for men and women applies to wards for older people and for people with learning disabilities equally as to wards for other patients.

In addition we should like to see reference to ways of promoting patients' safety through policies and procedures that address bullying and harassment and take crimes in institutional settings seriously. Very high levels of harassment and assault have been found in separate studies by Mind, the National Audit of Violence and the National Patient Safety Agency.

Paragraphs 21.16 – 21.23

The guidance should advise against policies that allow a blanket approach to searches, for example regular random searches of patients' rooms even in the absence of a particular cause for concern, or routine frisking on return to the ward after outings and other activities.

Further aspects of privacy and security

Creating and maintaining privacy in an institutional environment is fundamentally important. The code should guide staff in ways of doing this. We suggest the following areas in the light of service users' current experience:

- wherever possible patients should have individual rooms that are lockable (with an override)

- privacy should not be compromised for institutional convenience – for example observation shutters on the doors to patients' rooms should not be fixed to the 'open' position
- hospitals should have policies on the use of CCTV that conform to legal requirements – we consider that CCTV should not be used in patients' bedrooms and that patients should be informed of its use.

Chapter 24 - Treatment Plans

Links with CPA

The Alliance welcomes the guidance that is given on how to produce treatment plans for people subject to the Act. We especially note the importance of paragraph 24.4 that a treatment plan should be part of the care programme approach (CPA) to which we would add a requirement that all patients subject to the Act should be offered CPA at the (current) enhanced level.

Evidence from recent surveys indicates that CPA can work well when implemented properly but that many service users are not properly involved in care planning, do not have comprehensive assessments and do not receive the care that is agreed for them (Sainsbury Centre/MHAC 2005).

We believe the Code should stipulate that as far as possible treatment plans are drawn up, agreed and implemented in accordance with the standards of the CPA.

Patients' views about treatment plans

Paragraph 24.5

Patients should be asked to sign the care plan after they have had opportunity to contribute to and comment on it. The absence of a signature would signal a possible failure to discuss the plan with the patient.

Paragraph 24.6

This sets out the role of advocates in helping patients to understand their treatment plan. It should be added that advocates also have a role helping patients influence their care plan and to challenge it if they are not happy with what needs have been identified and how these will be addressed. Advocates may speak on the patient's behalf when they cannot make representations in person.

Paragraph 24.7

This notes that clinicians should consult with people who are likely to know the patient's wishes. Advance statements have a key role in helping clinicians understand a patient's wishes and should also be mentioned in this section of the Code. Advance statements are also pertinent to paragraph 24.12: when deciding whether the 'best interests' of a patient conflict with those of a carer the presence of an advance statement of wishes should be given the most serious consideration.

Support for carers

Paragraph 24.10

This sets out the support carers should receive as part of the treatment planning process. For carers of patients on (or being considered for) SCT this is essential. Carers will have major responsibilities when a person is on SCT and provision needs to be made to offer them practical and emotional support

Chapter 25 – Treatment regulated by the Act

Overall this chapter is very complicated and technical, though we recognise that this is a technical part of the Act. It is not written in plain English and many of the sentences are far too long (eg paragraph 25.31). There are a lot of cross references to sections of the Act without adequate or clear explanations of what these sections cover.

Capacity and consent

Paragraph 25.2

We understand and agree with the decision not to develop separate guidance from that in the Mental Capacity Act code of practice. However, given the centrality of consent and capacity to the operation of the Mental Health Act we suggest either copying in the guidance from the MCA code or referencing it in a more directive way. The requirement for responsible clinicians to assess and record patients' capacity to consent should be made explicit.

Paragraph 25.3

We suggest the following addition (in bold) to the last sentence, "Nor does a patient's co-operation with treatment amount to consent if the patient **has not been given sufficient information about what is proposed and why**, lacks capacity etc".

Parts 4 and 4A - general

Paragraph 25.7

People do not always get good treatment for self harm injuries, and they may be very willing to consent to that treatment even though they may refuse psychiatric intervention. So if using this example it would be good to include another example as well, and to make it clear that a person may consent to one treatment and not another.

Approved clinicians

Paragraph 25.11

It might be helpful to refer here to what the professional/ethical obligations are, for example guidance from the relevant regulators or professional bodies of health professionals.

Treatment without consent – general

Paragraph 25.14 and elsewhere

There are various references to patients' 'ability' to consent, which we believe should be 'capacity' to consent, in line with the Mental Capacity Act. Reference to relevant parts of the MCA Code are needed here, and references to Department of Health guidance on consent may be helpful too. There must also be reference to clinicians' responsibility to determine patients' capacity to consent to ensure that people who lack capacity benefit from the safeguards in the Act.

Paragraph 25.17

With reference to potential breaches of human rights, we suggest that the Department of Health and/or trusts should provide suitable guidance on the application of the Human Rights Act to clinicians.

Section 57

Paragraph 25.24-25.29

Although the paragraphs on section 57 treatments refer to the process for approving treatment and the requirements of the section, they do not say what it is. This may be confusing when there is no direct reference to the second opinion process in the body of the text.

Section 58

Paragraph 25.35

Here, or as a separate point, we consider that the following statements should be included:

Clinicians are expected to adhere to good practice in prescribing medicines and to follow current guidance except where there are good clinical reasons for departing from it, including the views and previous experience of the patient. Reasons should be recorded in the patient's medical notes if a proposed treatment is outside current prescribing guidance, particularly that of the British National Formulary and the National Institute for Health and Clinical Excellence, or is outside the marketing authorisation for the medicine. (For example if the dosage is higher than that authorised or if it is being proposed for a different condition than that indicated in the marketing authorisation.) This explanation should form part of the discussion with the patient.

Paragraph 25.37

The certificate should state if the treatment being authorised departs from prescribing guidance (as described above) and reasons for this should be recorded in the patient's medical notes and made available to the patient.

There is a risk of prn medication raising dose levels beyond those intended. We recommend adding:

"Particular care must also be taken to ensure that medicines administered 'as required' do not raise the dosage above the maximum permitted on the certificate."

We would recommend that the certificates referred to in paragraph 25.37 should also include information about the person's expressed preferences in relation to treatment, and any known side effects that have occurred with that particular person.

Section 58A

Paragraph 25.45

There should be a reference to reminding formal patients of their right to advocate as well here.

Section 63

Paragraph 25.48

This paragraph should also refer to patient's wishes as well – a patient may have a preference for a particular treatment, which should be considered and recorded, separately from their consent or otherwise to the treatment being proposed.

Part 4A

It should be stated somewhere in this chapter and the SCT chapter that if an SCT patient has informal admission to hospital they remain on SCT and the part 4A certificate still applies.

Paragraphs 25.49-25.50

With reference to a person on SCT who lacks capacity being able to be forced to have treatment in the community when someone with authority to do so has consented on their behalf – we consider that this requires more guidance and qualification particularly in terms of proportionality.

Indeed we would seriously question altogether the use of force in the community (ie with reference to section 64G as well). The only situations where this could apply would be where there was an imminent danger to the person themselves or to someone else. Attempting to treat them (presumably with very powerful, quick acting sedatives) could be extremely dangerous in a non-clinical environment or place of safety if the person was actively resisting treatment. And if treatment were given to them it would be absolutely essential that they received the appropriate aftercare and monitoring – the paragraph makes no reference to this and we would question how realistic this would be in most situations.

Paragraph 25.53

The text could specify what s58 and 58A type treatments are.

Paragraph 25.54

It may be helpful to say something here about revising/reviewing the certificate and team-working between the responsible clinician and GP who may, for example, consider that a different medicine would be helpful in certain circumstances.

The patient's acceptance or compliance with the proposed treatment should be recorded in their notes.

Paragraph 25.55-25.56

The reference to recall at the end of 25.55 should be deleted as this is dealt with in the next paragraph and saying it here needlessly highlights this option.

These paragraphs should recognise the potential harms of treatment, whether that is physical, mental, emotional or affecting other aspects of the person's quality of life. Whether or not the treatment is crucial to the person's stability in the community should be a negotiated assessment, balancing the harms and benefits of treatment, considering what other supports are in place or could be provided, and taking full account of the patient's own assessment of what they need and what they getting from treatment.

Paragraph 25.57

This should also direct clinicians to take into account any written statements the person has made, and in particular any advance decisions to refuse treatment made under the Mental Capacity Act, and the views of any personal welfare attorneys or deputies, while acknowledging that these can still be over-ridden.

Certificates – exceptions in urgent cases

Paragraph 25.77

This needs more clarification in relation to how long urgent treatment can be continued for because the wording "as long as it is immediately necessary" could easily be interpreted very widely and subjectively.

Chapter 26 – SOADs

Paragraph 26.4

We welcome this paragraph about patients' wishes, but consider that there should also be a reference to present/contemporaneous requests for alternative treatment.

Paragraph 26.7

We would question whether anyone could ever be able to make a judgement on which to base advance approval of treatment without consent on recall to hospital.

Paragraph 26.9

We suggest the following additions to the list of matters that SOADs must take into account:

- authoritative guidance such as that from NICE and the British National Formulary
- the potential harms of the proposed treatment, their likelihood and severity
- whether psychological treatments have been fully explored.

Paragraph 26.15

This paragraph should also state that the SOAD should respect that a patient has a right to be supported by the Independent Mental Health Advocate as part of the meeting with the patient.

Chapter 27 – Psychological treatments

Paragraph 27.1

Despite the introductory statement, the chapter does not provide guidance on consent to treatment. This gap needs to be addressed. This chapter should include something about providing information to the patient about what is being proposed (aims of treatment, what is involved etc), and reference to patients' views, and specifically their views on outcome and progress.

Paragraph 27.2

We welcome the inclusion of psychological therapies in the code and would want to encourage their use. Greater consideration of and availability of psychological therapies may well increase the likelihood of consensual treatment. However the second sentence of this paragraph seems to imply criticism of psychiatrists, and possibly other clinicians, as though they were not concerned with the needs of individuals or in taking a holistic approach.

Paragraph 27.5

We welcome the inclusion of a requirement to consider psychological therapies at all stages of treatment planning. We also recommend that the option of psychological therapy should be fully explored before s57 treatments are given and before s58 treatments are authorised for a patient who does not, or who lacks capacity to, consent.

Paragraph 27.10

This paragraph says very little and should include something about the level of experience of and/or expertise in working with children and young people.

Communication issues should be discussed, for example with reference to cultural competence, Deaf people, other language difference and learning disability.

Chapter 28 – Supervised Community Treatment

The philosophy underlying this chapter should emphasise that SCT should support a person's recovery by enabling them to access a range of services, and that in the past they have not been able to comply with care and treatment plans and this has resulted in deterioration or other problems. At the moment the chapter tends towards a focus on compliance with medication, risk to self or others, and medical services. There should also be a far greater focus on consultation with the person concerned, given that a CTO will only be effective if the person agrees to co-operate, and on inter-agency agency working.

One of the fears expressed about SCT is that people will be placed on community treatment orders who would under the previous system have been discharged. Given that notions of dangerousness are disproportionately ascribed to people from Black and minority ethnic communities – African Caribbean people in particular, there are worries that SCT will serve as a 'half-way-house' for risk averse professionals to shift BME patients to, rather than discharging them entirely. Given this potential, the code should make reference to some sort of monitoring arrangement, from which the profile of SCT patients can be ascertained. Ideally, this monitoring would also capture the experiences of people on SCT. This would be useful as a basis from which to adjust the SCT provisions in light of what's learned about differential experiences across ethnic/cultural groups.

We would also welcome specific reference to the following in this chapter:

- The role of Independent Mental Health Act advocates during SCT. Given that this is a new role, their involvement in SCT should be clearly laid out in order to ensure this function becomes well integrated within the new systems and there is no ambiguity as to when or how they should be involved.
- As many service users are very fearful of being placed on a CTO and it never being removed, it would be very helpful if this chapter also gave very clear guidance about when a CTO is not appropriate.
- The Code should also cover prisoners who reach the end of the sentence and then are transferred to hospital and then they are made subject to SCTs.

Our specific comments are outlined below.

Paragraphs 28.2 and 28.3

We believe that the purpose of SCT should be to promote recovery and social inclusion for people who do not need to be in hospital - but need an element of compulsion in order to achieve this. The other purposes, relating to harm to the patient or others should be secondary.

These paragraphs also do not set SCT in the context of other options - in particular the discharge of the patient from formal powers. Paragraph 28.2 suggests a choice between living in the community safely or continued detention, whilst para 28.3 talks of maintaining stability outside hospital and promoting recovery – however each time it is necessary to firmly put this in the context of a small group of patients who remain in need of compulsion or who professionals are not yet happy to discharge from formal powers, but who may benefit from fewer restrictions on their liberty.

Paragraph 28.3 should be amended to read "the aim of SCT is to help the patient to maintain stable mental health" and "SCT may help to tackle the "revolving door" cycle". This reflects more accurately the findings of research on SCT.

Paragraph 28.5

The language of "eligibility" (particularly "patients can only be eligible if") implies that the choice is between SCT and a more restrictive option, ignoring the option of discharge. It would be less loaded to talk of suitability or applicability – for example "SCT is only a treatment option when / SCT is suitable for the following patients, as set out in the law:"

Paragraph 28.6

Consultation with the patients as well as those involved with their care will be important. The text states: "In making their decision, they will need to consider whether the objectives of SCT could safely and effectively be achieved in a less-restrictive way." It would be helpful to add "this should be considered fully with other members of the CMHT and/or other relevant community services."

Paragraph 28.7

Other examples in addition to refusing to take medication that might result in a person's deterioration would be useful. This would help to provide a balance between mediation and other aspects of a CTO.

Paragraph 28.8

The text in the Code appears to give insufficient weight to the amendment's intended effect in relation to revolving door patients particularly because it does not specify that the patient relapses as a result of failing to take medication. This is of critical importance if we are to recognise that people are entitled to try to make their own efforts at coping or recovering which may not involve taking medication or taking lower doses. Suggested additional bullet point:

"the patients history – this may show whether the patient is likely to fail to follow the treatment plan or continue to take medication in the community; and relapse may result."

Also in describing the assessment for an SCT in paragraph 28.8 and the role of the AMHP in paragraph 28.10 no mention is made of talking into account the views of the patient. SCT is more likely to be effective if the patient co-operates.

Paragraph 28.9

At end of first sentence, add "Otherwise, the patient should be discharged".

Paragraphs 28.11 and 28.12

There is also a question as to what happens next when an AMHP does not agree to SCT - eg does the clinician then use s17 leave, which could be seen as subverting process. If clinician waits a week or so and then starts the process again, saying circumstances have changed, and using a different AMHP, this is also subverting the process. Further clarification is needed or the provision of a flow chart would be useful.

Paragraph 28.13

We believe that a person's nearest relative should always be consulted since they play a crucial role in safeguarding the patient's rights. If it is not reasonably practical, then there is a question as to whether they are suitable to act in the nearest relative role. Therefore, "the patient may wish to consult with an IMHA" should read "the patient should be reminded of their right to access an IMHA and allowed such time as is necessary to engage with the advocate if they wish to do so."

Paragraph 28.14

It is possible that a different team will take responsibility for a person once they are placed on SCT. The wording of this section should reflect this.

There are likely to be a wide range of people who support an individual - their community advocate (as opposed to their IMHA), their housing support worker, their CPN, as well as their GP. This paragraph does not give an adequate reflection of the range of workers, including those from the voluntary sector, who should be involved and will be vital in ensuring adequate support for a person's needs is provided.

Case Study: John

We are concerned that this example focuses almost entirely on risk assessment, rather than care planning and promoting recovery. It also makes no actual reference to what the SCT would incorporate in terms of actual treatment – and which types of treatment would prevent the aggressive incidents.

The example should clarify how many previous admission the patient has experienced – and should conclude with how the decision is reached and what that decision might be. It would perhaps be more helpful to provide two scenarios, one where the decision reached is not to use SCT, the other where it is used.

Paragraph 28.19

There should be a caveat that professionals should always be conscious not to set conditions that are unnecessarily restrictive to the person's liberty or private life. Professionals should be advised to be clear and precise about what is expected of the patient.

This paragraph also states that patients should be "consulted" – whereas paragraph 28.50 states that a patient needs to accept the conditions. Further clarification is needed on the status of the person's wishes and whether "accepting" conditions is the same as "consenting".

Paragraph 28.19

Information for SCT patients should also include what services will be provided to the person on the SCT to support and monitor them. An SCT is much more likely to be successful if the person does not simply have conditions imposed upon them but where there is reciprocity in terms of services the person can expect to receive.

Paragraph 28.21

Hospital managers also have a duty to inform the patient of their right to an advocate.

Paragraph 28.19

"It will be important for the CMHT... to maintain close contact" should be changed to "It is the responsibility of".

Paragraph 28.23

There should be constant awareness that CTO conditions may no longer be necessary and these should be removed as soon as it is believed that this is the case. It should not only be when a person does not comply with a condition, but does not deteriorate, that the condition is reviewed.

This section should include "If the patient is not receiving the services set out in their care plan, that care plan and SCT decision should be reviewed".

In relation to deterioration, failure to comply etc - here and perhaps elsewhere in the chapter (eg paragraphs 28.28 and 28.38), it should allow for the possibility that admission to hospital may be beneficial and that the patient may agree to this.

Paragraph 28.25

This paragraph is not clearly written and contains too many acronyms.

The last sentence is also misleading. The patient's need for services may change during the course of the order, and the authorities are perfectly entitled to conclude via the care planning process that certain services (or indeed all services other than the supervision required by the order itself) can be discontinued as being no longer necessary. However, they remain liable to provide services under Section 117 if they *are* required; that liability cannot be terminated whilst the CTO remains in force. Paragraph 30.3 states this more clearly

Paragraph 28.27

There is reference here to "*the* AMHP", the assumption appearing to be that there will continue to be a specific AMHP involved with the case. That may or may not be so - there is no requirement that the AMHP who agrees to the making of the CTO should be from the relevant community team, indeed in some cases this may result in an unacceptable conflict. Nor is there any requirement that this AMHP should take a continued interest in the case thereafter.

This raises a more general issue of the lack of clarity about who will actually be doing what in relation to the supervision of a CTO. The legal powers are held almost exclusively by the Responsible Clinician (RC), but the RC may or may not also be the CPA care co-ordinator, and especially where they are primarily hospital-based it is most unlikely that they will be undertaking any of the hands-on supervision personally.

In the case of any statutory community power where risks are potentially high, it is essential, in order to ensure consistency and accountability, that responsibility for hands-on supervision

and enforcement of requirements and conditions is delegated to a named individual rather than collectively to a team. The Code, however, makes no reference to the appointment of a "community supervisor," there being only vague reference in paragraph 28.22 to monitoring by the CMHT, and to the need to agree "local arrangements" and to "set out respective responsibilities in the care plan." There is no comparable community power (and that includes the present Supervised Discharge) in which the professional responsible for hands-on supervision and enforcement does *not* have a personal statutory role with the right at least to be consulted about important decisions.

It needs, therefore, to be made clear whether there is an expectation that a designated supervisor will be appointed, and if not, how it is expected that CTOs will be effectively monitored and enforced if the RC is not undertaking the hands-on supervision in person. If a supervisor *is* to be appointed, there should be a requirement on the RC to consult fully with that person and have regard to their views before making any decision in respect of the CTO. In the absence of such a framework, there is a high likelihood of disagreements between them, for instance if the RC makes conditions with which the supervisor disagrees or thinks to be unenforceable, or if the RC makes a recall decision (or refuses to make one) against the advice of the supervisor.

More also needs to be said about the process for recall. In purely legal terms this is identical to the present process for returning an in-patient who has absconded or overstayed leave, but in practice it will be different. Patients who have simply overstayed leave are unlikely to be acutely disturbed and therefore to need police or ambulance assistance to return them, and the police will normally respond quickly to a request to return an absconder, especially if there is a risk to the public. However, patients who meet the conditions for recall from a CTO are likely to have a deteriorating condition and to pose a risk to themselves or others, but are unlikely to be treated by police and ambulance services as having the same degree of priority as an absconder or maybe even a new admission. Quite apart from the risks to the patient or others, the hospital and the Responsible Clinician would be legally extremely vulnerable if a patient who had been recalled was then allowed to remain at large for any length of time, and particular attention therefore needs to be paid to this when agreeing the local protocol for conveyance.

Paragraph 28.28

Reference should be made to what processes should be gone through if conditions are to be made more stringent.

The statements in Parliament by Lord Hunt show the need for agreement on conditions and this should be reflected in the Code:

"The noble Earl, Lord Howe, also asked whether a patient should be able to challenge the conditions of community treatment orders. We discussed this before. My right honourable friend Mrs Winterton, the then Health Minister, said in Committee in the Commons that for supervised community treatment to work a patient must accept and be ready to co-operate with the conditions of a CTO. There would simply be no point in setting a condition with which a patient would not comply, because nothing hangs on a failure to comply. I very much take his point about the code of practice. The code of practice will ensure that patients and those close to them will be involved in agreeing the conditions."⁶

⁶ July 2 Col 848

Paragraph 28.29

This section should include another reminder that any new conditions must be as unrestrictive and as reasonable as possible, as when conditions are varied there might be a greater chance of someone having more restrictive conditions being imposed.

Paragraph 28.31

Guidelines on how to decide when SCT is no longer needed would be beneficial. It should be clear that it means discharge from the order/regime and not discharge from care.

Paragraph 28.32

In general, concerns about a patient should be discussed with them unless there is good reason not to do so. Otherwise, a patient may find themselves recalled to hospital on the basis of a concern they were unaware of and may have been able to address, or on the basis of information which they do not believe to be true.

There should also be a process for the patient to raise a concern if they feel that the services they need in order to comply with the conditions of their order, or the elements included in their Care Plan, are not being provided adequately, or if they feel they will not be able to comply with a condition, for example, due to moving house or a poor relationship with a particular professional or service.

Case Study: Mary

We are concerned that this example focuses entirely on medication. Under a CTO it would be hoped that she had a broader package of care provided. A reflection of this would be useful.

We are further also concerned that this example is of someone who has already been on SCT for 12 months and who is not complying. This would suggest to me that there is something wrong with the treatment plan or that SCT is not working. This should be one of the questions asked.

We suggest the wording "Has anyone asked her?" is replaced with more specific questions such as : Who has spoken to her? What did she say? Might she be more willing to communicate with an advocate present? Has she been offered an advocate?

Paragraphs 28.35 and 28.36

We are concerned that these paragraphs make the power to recall if a person is not available for a medical examination too restrictive. There may be a whole range of reasons why a person may not be available for an examination but not necessitating a recall. This should be clarified in this section.

Paragraph 28.40

The people or professionals who become aware that a person is not complying with the conditions of a CTO or is deteriorating are likely in many situations to be different from the people who originally made the CTO. The CMHT will therefore need to go through a process of informing the responsible clinician, who will then need to assess the situation, make a decision about recall and send a written notice, etc.

Paragraph 28.43

'Released from hospital' should be changed to 'allowed to leave.'

Paragraph 28.48

This section is too brief – and should include at what point a person should be considered for discharge, and what factors should be considered.

Paragraph 28.50

This indicates that a person will need to be involved in decision and to accept and comply with conditions. It is unclear whether this is the same as consent, or whether there is a technical difference between consent and acceptance. Guidance should be given on to what extent consent or agreement is required, and whether a person needs to agree to all the conditions of their CTO.

This section is central to the CTO and should be placed much earlier, possibly in the section relating to Assessment for SCT.

Chapter 29 - Guardianship

Paragraph 29.6

This needs to make reference to the Deprivation of Liberty safeguards as these may apply in situations where people are assessed as needing residential care.

Paragraph 29.6

The term “nominated medical attendant” needs to be defined.

Chapter 30 - Aftercare

This chapter needs to make appropriate reference to Independent Mental Capacity Advocates in situations where accommodation is part of the aftercare plan and the person lacks capacity and has no-one with whom it is appropriate consult about their best interests.

Paragraph 30.13

Assessments and plans should take account of any person centred plans or health action plans that a person with learning disabilities has

Paragraph 30.20

This paragraph is not clearly written and should be redrafted.

Chapter 31 – Guardianship, leave of absence or SCT?

The tables of relevant factors to consider are helpful. It would be even more helpful if they also included the relevant factors to consider for using section 5 of the Mental Capacity Act and the Deprivation of Liberty safeguards so practitioners were also clear about when these powers were more appropriate to use.

Chapter 32 – Renewal, extension and discharge from detention and SCT by responsible clinicians

As many service users are very fearful of being placed on an SCT and it never being removed, simply as a way of making them accept treatment, it would be very helpful if this chapter also gave very clear guidance about when extending an SCT would **not** be appropriate.

Case study

The patient's name changes half way through the case study.

Paragraph 32.3

"Second professional" could be interpreted very widely. Being professionally concerned with the patient could mean a range of things. It should specify that the professional is concerned with the health or social care of the person.

Paragraph 32.6

This is *highly* unsatisfactory. Unless there is a clear formula for identifying the most appropriate second professional, there will be nothing to prevent the responsible clinician from simply approaching the colleague most likely to agree with him or her. This will be compounded if there is any provision for a further approach to a "more senior" professional. The Code explicitly advises against the responsible clinician seeking a further AMHP opinion if an AMHP does not agree with placing someone on a CTO (28.11). Nor is there any suggestion that it would be acceptable to use a different AMHP or doctor where there are disagreements over the initial decision to detain. The same principle should apply at renewal. Surely the legislation would have been worded differently if it were intended for a further opinion (or opinions) to be sought.

There should be a clear hierarchy for identifying the most appropriate second professional, which should start with the CPA care co-ordinator. If that person is unavailable or they are ineligible by virtue of being from the same profession as the responsible clinician, the next choice should be the most senior eligible professional who has had regular involvement with the patient. It should not be permissible to "draft in" someone who had not previously had such involvement in order to circumvent someone who has.

In general, it would be reasonable to expect a professional to act in this role if they are identified as most appropriate by the above system. However, the conflict-of-interest principles should also be applied here - anyone who considers that, by virtue of their relationship with the responsible clinician, they may not be able to exercise a completely independent judgement, should be permitted and indeed expected to decline.

It should be made explicit that the period of detention may not be extended if the second professional does not agree that the conditions for detention are met.

Paragraph 32.8

This needs to state one or other position, either that the patient must be discharged from SCT or that the patient's SCT cannot be extended beyond its expiry date.

Chapter 33 - Functions of the hospital managers

Paragraphs 33.2 – 33.3

PCTs do not manage mental health providers so this should be changed.

The Trust is a body corporate and cannot therefore be a manager per se – the Code therefore should explain this. A cross reference to 33.7 is also needed. Also an explanation of the difference between a Director of the Company, a non-executive Director and a hospital manager and the overlap would be very helpful.

Paragraphs 33.5

This needs a cross reference to chapter 28 on SCT.

Paragraphs 33.5

A full margin note is needed specifying which chapters these are.

Paragraphs 33.7

The term hospital manager is unhelpful as the scope of the Act goes beyond the hospital campus and similarly the managers duties relate to people under the clinical care of the Trust and its employees. This needs to be stated. It is also unclear what is meant by an 'equivalent of a non- executive director'.

Paragraphs 33.8

Regarding delegation of hospital managers' functions under the Act, words like "most" must be avoided and exceptions stated. Functions in addition to power of discharge also must be spelt out, eg document scrutiny etc.

Paragraphs 33.10

This paragraph is extremely unclear – for example what is meant by appropriate? And what types of posts are envisaged?

Paragraphs 33.11

As indicated above, PCTs do not have a role here. With reference to Foundation Trusts, they are moving away from having NED involvement in the same way as NHS Trusts have done, i.e. with NEDs chairing review hearings. So this paragraph needs to reflect these changes in practice.

Paragraphs 33.12

It is unclear what this means in relation to associate hospital managers. It sounds as if the position for Foundation Trusts is unduly onerous and unworkable as the Board will have to scrutinise the workings of the Mental Health Act Manager's Office in detail in order to discharge their NHS and companies responsibilities. The powers of the panel referred to in the last sentence need to be more clear clear.

Paragraphs 33.19

We are unclear how managers will be able to ensure this happens when it is often more than difficult even to receive relevant reports from professionals in a timely manner to inform actual hearings. We believe that at the very least relevant discussions need to be recorded in the case notes so that any decision can be made in an informed way.

Paragraphs 33.22

This needs to include reference to SCT and discharge as an option.

Paragraphs 33.23

Patients' case notes do not always accompany them, even from one hospital to another within the same Trust. Some specification about e.g. electronic, password protected, notes should be included.

Paragraphs 33.25

This section is not clearly written and the provision of a flow chart may help.

Paragraphs 33.35 - 36

We suggest that indicative timings are needed throughout this section.

Chapter 34 – the hospital managers' discharge (section 23)

Paragraph 34.2

This should include a cross-reference to Chapter 36 on Patients concerned with criminal proceedings.

Paragraph 34.3

This should make clear that these associate managers have been recruited and trained to an acceptable and professional level. The same is true for FTs.

Paragraph 34.6

This paragraph is not clearly written. It is vital that the Code includes a clear statement of the relative powers and relationship between hospital managers in the NHS and the independent sector. For example, if a Foundation Trust subcontracts to an independent hospital, do both sets of managers have power of discharge? What powers do the managers in the independent hospital have in relation to SCTs and guardianship and is it not illogical if a distant hospital provider can discharge to guardianship?

Paragraph 34.7

This needs to be redrafted to take into account of the PCT/SHA's powers as licensing authority to which the independent hospital must defer.

Paragraph 34.10

The bullet points should make clear that more than consideration is required – the wording should reflect the urgency and necessity of reviewing detention when a patient requests it – unless there has been a review within a specified timeframe - or the clinician bars a NR.

Paragraph 34.12

There should be a cross reference to chapter 36.

Paragraph 34.17

This paragraph should clarify that panels usually only comprise of three members. In order to make the necessary decision, panels must have up-to-date comprehensive reports from all key professional practitioners involved with the care and treatment of the patient.

Paragraph 34.21

This needs to clarify if this includes a paper review (ie where renewal is not contested by the patient).

Paragraph 34.23

This should state that according to best practice reports should be received at least three working days prior to the hearing. Also the patient's legal representative or advocate should

also have copies of the reports and can read through them with the patient in order to e.g. correct any inaccuracies.

Paragraph 34.26

We believe that all discussions should be couched within the requirements of the legal criteria. Managers are not clinicians and are not making a clinical decision and so all professionals should address themselves to the legal necessities of detention.

Paragraph 34.27

There should be cross reference with Chapter 28 on SCT. This should also state that best practice might include ensuring that there are a range of appropriate options such as community centres etc. that can be suggested to the patient beforehand and that will not delay proceedings.

Paragraph 34.30

If the detention is unlawful the patient must be discharged whatever the state of community care locally. The final sentence therefore seems fundamentally flawed. In theory at least, discharge planning is meant to commence on admission or detention. So any hearing that might lift a detention order should be informed by a full review and assessment of the patient's broader care needs.

Paragraph 34.31

This also appears fundamentally wrong as the Hospital Managers can surely only satisfy themselves that the patient does not object if they see him or her. According to best practice the managers should always offer a patient in these circumstances the opportunity of meeting with them. This should be stated in the Code.

Chapter 35 – The Mental Health Review Tribunal

The Mental Health Review Tribunal is a critical calibration element for the legislation. As such, it is essential that the tribunal be at the very least trained in cultural competency. Ideally the Tribunal will itself be ethnically and culturally diverse (there should be specific efforts to ensure this). Though the code cannot make specific recommendations on this, as a reinforcement of the basic premise, it would be helpful here to refer back to the 'respect' principle – specifically the reference to race and culture.

Paragraph 35.23

This section is generally unsatisfactory since it is based on a very narrow understanding of the purpose of a "social circumstances report". The MHRT's own guidance is far more comprehensive and makes it clear that they are looking for much more than just information about "local resources." At the very least a cross reference should be included in the Code.

Chapter 36- Part 3 of the Act – Patients concerned with criminal proceedings

We would welcome something in the Code about what happens when prisoners reach the end of the sentence and then are transferred to hospital and then they are made subject to SCTs. This is also not covered in Chapter 28.

We suggest the need for a recommendation that social workers involved in the care of patients under s45a or 47 who have yet to reach their release date have a duty to inform the patient that though not entitled to benefits like other patients under other sections of the Act, they are entitled to a subsistence amount from the hospital while they remain in hospital. They will not be entitled to any welfare benefits until they reach their earliest release date.

Paragraph 36.2

We would welcome comment on the important role of Mental Health Diversion and Liaison Teams based in courts and screening or receiving referrals from police and court cells in facilitating this access to assessment. It is important to reinforce the recommendation of the Reed Report (Review of Health and Social Services for Mentally Disordered Offenders and others requiring similar services, 1992, HMSO) and Home Office Circular 66/90 recommending the establishment of such schemes either in this guidance or in the Mental Health Act Guide. We would like to see a recommendation that courts and police custody suites have a responsibility to establish links with either a mental health liaison scheme or other named mental health professionals within their Mental Health Trust who could provide speedy assessment and advice to the Police, CPS and the courts. Some guidance on establishing local policies to create such diversion teams would be welcome here. Nacro have outlined such arrangements in their good practice guide *'Liaison and Diversion for mentally disordered offenders'*. Many police custody suites now have health provision from independent healthcare providers and these workers should also develop link with mental health providers.

Paragraph 36.3

We welcome the reassertion that prison healthcare centres are not hospitals within the meaning of the Act and prisoners cannot be treated involuntarily. We would like to see further guidance to practitioners that those prisoners diagnosed with severe and enduring mental illness, who have given their informed consent to treatment, should also be considered for transfer to a hospital for treatment, if the prison environment is considered to be contributing to their mental illness. An assessment of need and regular review should consider whether the prison healthcare centre is capable of providing for the prisoner's care, if they are considered too unwell or vulnerable to return to residential wings. We feel such a recommendation is important to avoid the use of prison healthcare centres being used as a mixed Psychiatric Intensive Care Unit/Medium Secure Unit function for those compliant with medication.

Paragraph 36.4

Included in the bullet pointed list we would wish to see a note that all professionals have access to the full range of services to prevent doctors recommending options in their report that they are not then able to make happen in practice.

Paragraph 36.5

PCTs should also have a responsibility to provide information and advice to police and the CPS. The Code should state that PCTs should work with courts to develop service level agreements for the provision of psychiatric reports.

Paragraph 36.8

We believe that doctors should, wherever possible, obtain the person's consent before gathering the information. In addition there should be information sharing protocols in place to allow for information exchange between criminal justice, health and social care agencies. Information gathered whilst in police custody or at the courts should follow the prisoner through the criminal justice system. Medical information, including the 'Detained persons medical form' and 'Detained persons medication form' and any psychiatric reports or assessments should be attached to the Prisoner Escort Record in a sealed envelope which would then be available for healthcare professionals at prisons and courts. This should be included in the Code.

Paragraph 36.9

If it is not possible for the doctor previously treating the patient to supply a report to the court, there should be a responsibility on that doctor to explain to the court why they could not supply the report and provide the name of another who is willing to conduct the assessment and report. This nominated doctor should also have access to a bed or take responsibility for referring the case to another doctor who does.

Paragraph 36.10

Some further guidance around appropriate sources of information about the person's previous history and particularly their 'patterns of behaviour' would be of use here. In particular this section should include a recommendation to involve carers/ families and the person being assessed to comply with the participation principle. Additionally doctors should seek information from other sources such as accommodation (particularly if in supported accommodation), social services and the police (with regard to the circumstances of the offence) as appropriate.

Paragraph 36.13

The Code should state that good practice would be that these rights are explained to the patient and a leaflet is made available with options for who to contact locally to arrange an assessment.

Paragraph 36.14

This paragraph implies the sentencing choice is between diversion or prison. There are two problems with the way this is phrased. Firstly it implies diversion to hospital treatment is the opposite of punishment and protecting the public, which implies high risk offenders should be in custody rather than medium or high security hospitals. The paragraph should be rephrased to reflect the public protection role that secure mental health provision also provide. Secondly, the phrasing of this paragraph implies that diversion to hospital treatment or a prison sentence is the only sentencing options and the only options particularly informed by medical opinion. Doctors should ensure that they consider the least

restrictive option when making recommendations and ideally, should set out a range of options including community disposal, and the services that need to be in place to allow this to occur⁷.

Paragraph 36.16

This should include a clear explanation that section 45a now applies to all mental disorder, not just psychopathic disorder.

Paragraph 36.22

The end of this paragraph should include a recommendation that the patient is under the supervision of police and prison officers at the court and supported if possible by the criminal justice mental health diversion and liaison team. The liaison team should also be informed of the hearing by the hospital in advance. As in other sections of the Code there should be a mention of joint protocols between mental health providers, police, ambulance trusts on conveying when assistance is needed to get a person to court.

Paragraph 36.25

We would like to see a recommendation here that if possible the prisoner should be transferred within 14 days when the request for the assessment of need for hospital treatment is made or as soon as possible thereafter. This should reflect recommendations in paragraphs 4.76-78. Reasons for delays in provisions of an emergency bed should be made in writing to the governor of the prison by the PCT's Mental Health Act Administrator and alternative arrangements sought as a matter of urgency. The patient and the patient's nearest relative (unless the patient requests otherwise), should be kept informed by the prison mental health in-reach team of the prisoner's condition, the outcomes of assessment, the transfer process and the availability of independent mental health advocacy services and how they can be accessed (in accordance with chapter 19). The patients' care co-ordinator if the patient is on the Care Programme Approach (or equivalent) and GP, as well as the doctors who made the assessment, should be informed of the outcome of assessment and arrangements for their care.

⁷ Community orders (introduced by the Criminal Justice Act 2003), for example, allow the person to retain contact with carers and mental health services with whom they may already be involved or establish links with community mental health services with whom they could continue to be involved at the end of their sentence. Such sentences also enable people to maintain their accommodation and contact with dependents and reduce the likelihood of compounding the social exclusion which may have contributed to offending behaviour and may contribute to a cycle of offending in future.

Chapter 37 – People with learning disabilities, autistic spectrum disorders

This chapter needs to be cross-referenced with chapters 2 and 3, or potentially parts of it could be merged.

People with learning disabilities

It would be helpful to provide guidance in this chapter on the connection between the Mental Health Act and the Mental Capacity Act, as referred to in chapter 4. This is a complex area and AMHPs will need guidance on the legal basis for decision-making.

People with learning disabilities whose behaviour is “seriously irresponsible” or “abnormally aggressive” will often lack capacity to consent to treatment. Particularly where there is no evidence of mental illness the AMHP will need to give very careful consideration to whether the person will gain benefit from admission to hospital, rather than support in a care home. It should be made clear that if a person is unlikely to gain therapeutic benefit from admission to hospital then best interest principles under the MCA should be applied.

Paragraph 37.2

We are concerned in the example by the absence in the ‘Participation principle’ of any attempt to ascertain Albert’s view about his care and treatment, in addition to those of his family and carers.

It may be that ascertaining his views requires skilled communicators, but this does not make it any less of an important part of the participation principle.

Paragraph 37.13

It would be helpful to add here that people with learning disabilities may find hospital settings frightening because of previous negative or abusive experience in hospital or other institutional settings. AMHPs should consider whether it might be possible, in the case of a person with a learning disability who appears to be frightened in a hospital setting, to conduct the assessment in the person’s own home or at a familiar setting in the community.

Paragraph 37.15

It would be helpful to add here that psychiatric disorders in people with learning disabilities are often undiagnosed and untreated because of an assumption that all of their behaviour or symptoms are due to their learning disability.

Autistic spectrum disorders

Paragraph 37.20

People with autistic spectrum disorders, including those with Asperger Syndrome, can be particularly vulnerable to being detained because of their difficulties with social interaction and communication mean their behaviour may be misinterpreted. Wherever possible a “communication partner” who knows the person well and can facilitate communication with them should be involved in their assessment, as well as an IMHA.

Compulsory treatment in a hospital setting is rarely likely to be helpful for a person with autism who may be very distressed by even minor changes in routine and is likely to find detention in hospital anxiety provoking. Sensitive person-centred support in a familiar setting will usually be more helpful. Professionals working under the Act should wherever possible think of alternative less restrictive means of providing the treatment or support a person needs.

In the last sentence of this paragraph 'or treated inappropriately with psychopharmacological agents' does not make sense.

Chapter 38 – People with Personality Disorder

The link between Personality Disorder and offending behaviour is made repeatedly throughout the chapter, this could reinforce the notion that people with PD diagnoses are “dangerous”.

The wording of “unusual unwise or repellent” in paragraph 38.9 again reinforces stigma against people with a PD Diagnosis.

There is no mention of the fact that PD is a much contested diagnosis. Perhaps the wording within the chapter should read “people with a diagnosis of personality disorder” rather than “people with personality disorder.”

Paragraph 38.12

This paragraph recognises that “individuals who have been labelled by various local agencies as having a personality disorder, may never, in fact, have had a thorough clinical assessment and formulation.”

It should state that for people with personality disorder admitted under a treatment order (e.g. section 3, section 37), a thorough clinical assessment and formulation needs to have been made prior to admission.

Paragraph 38.19

“The level of risk to the individual or others” is not properly defined. We recommend that it be risk that gives rise to “a high cause for serious concern”.

Chapter 39 – Children and young people under the age of 18

The Mental Health Alliance welcomed many of the changes to the Act in respect to children. For a detailed response to this chapter, we would endorse and support the points made in the joint response between the Royal College of Psychiatrists and 11 MILLION. It refers to areas in the draft Code that lack currently sufficient clarity for practitioners. This chapter highlights some of the issues raised in that response.

Consent to treatment

The guidance contained in the draft Code does not match guidance in the Mental Capacity Act code. Paragraph 12.14 of the Mental Capacity Code states: ‘If a young person has capacity to agree to treatment, their decision to consent must be respected. Difficult issues can arise if a young person has legal and mental capacity and refuses consent – especially if a person with parental responsibility wishes to give consent on the young person’s behalf. The Family Division of the High Court can hear cases where there is disagreement.’

The draft Code (paragraph 39.25) states:

'...However, unlike adults, the refusal of a competent person aged 16 – 17 may in certain circumstances be over-ridden by either a person with parental responsibility or a court...'

We believe that there needs to be more consistency with the Mental Capacity Act in the final Code for the Mental Health Act.

Confidentiality

Paragraph 39.55 states:

'All children and young people have a right to confidentiality... However, where a competent young person or child is refusing treatment for a life threatening condition, the duty of care would require confidentiality to be breached to the extent of informing those with parental responsibility who might then be able to provide the necessary consent to the treatment.'

We would expect that such cases of breaching confidentiality would be the most exceptional cases. However, the draft Code implies that any occasion serious enough to warrant a compulsory admission of a child would require confidentiality to be breached. We recommend that the Code is clearer about the circumstances where this would actually be necessary.

Over-riding competent refusals

We are concerned that the Code does not make it sufficiently clear that a Gillick competent child's decisions to consent to or to refuse treatment cannot be over-ridden by a person with parental responsibility. It was made clear in Parliament that the Code would provide sufficient guidance to this effect. As written it does not, and it places excessive emphasis on seeking court proceedings (39.36). We recommend use of the wording suggested by the Royal College of Psychiatrists and 11 MILLION in its response in place of the current paragraph 39.34-39.36.

Appendix: Mental Health Alliance members

Afiya Trust	ADSS
British Association of Social Workers	African Caribbean Community Initiatives
Ethnic Health Forum North West	Age Concern England
Hafal	Alcohol Concern
IMHAP	AWAAZ (Manchester)
MDF: The Bipolar Organisation	AWETU
Mental Health Foundation	Black Majority Church Consultative Consortium
Mental Health Media	BME Mental Health Network
Mind	British Institute of Human Rights
National Autistic Society	British Medical Association
NUS	Carers UK
Perceptions Forum	(Church of England) Archbishops Council
Rethink severe mental illness	Confederation of Indian Organisations
Revolving Doors Agency	Democratic Health Network
Richmond Fellowship	Depression Alliance
Royal College of Psychiatrists	Drugscope
Sainsbury Centre for Mental Health	East Dorset MH Carers Forum
SANE	Family Welfare Association
SIRI Behavioural Health	GMC
Together: Working for Wellbeing	Haldane Society
Turning Point	Having a Voice
UK Fed of Smaller Mental Health Agencies	Homeless Link
UKAN	HUBB Mental Health User Group
United Response	Imagine
Witness	JAMI
Young Minds	Justice
	Law Society
	LGA
	Liberty
	Manchester Race and Health Forum
	Mencap
	Nacro

NHS Confederation
Race on the Agenda (ROTA)
RADAR
Royal College of GPs
Samaritans
SignHealth
Social Action for Health
Social Perspective Network
Somali Mental Health Project
Southdown Housing Association
Supporting Carers Better Network
University of London Union (ULU)
UK Council for Psychotherapy
West Dorset Mental Health Forum
Women in Secure Hospitals (WISH)