



**Mental Health Alliance**

## Community Treatment Orders and second opinion approved doctors (SOADs)

### **Authority to treat community patients “**

- (1) Leave out clause 32 ( Authority to treat) and insert
  - (1) The 1983 Act is amended as follows
  - (2) In section 58(3) of the 1983 Act, after the first “patient” insert “who is liable to be detained under this Act
  - (3) After section 58 of the 1983 Act, insert—

#### “58(A) Consent to treatment of community patients

- (1) Subject to section 62A1 below, a community patient who has not been recalled to hospital shall not be given any form of treatment to which this section applies unless—
  - (a) he has consented to that treatment and either the approved clinician in charge of that treatment or a registered medical practitioner appointed for the purposes of this Part of this Act has certified in writing that the patient is capable of understanding its nature, purpose and likely effect and has consented to it; or
  - (b) a registered medical practitioner appointed as aforesaid (not being the approved clinician in charge of the treatment in question) has certified in writing that
    - i) the patient is not capable of understanding the nature, purpose or likely effects of that treatment; and
    - ii) he has either no reason to believe that the patient objects to being given the treatment, or he does have reason to believe that patient so objects, but it is not necessary to use force against the patient in order to give the treatment; and
    - iii) he is satisfied that the treatment does not conflict with a valid and applicable advance decision, or a decision made by a donee or deputy or the Court of Protection; and
    - iv) it is appropriate for the treatment to be given.
- (2) Where a patient who has been liable to detention under this Act has been administered medication for mental disorder to which this section applies for less than three months prior to becoming a community patient, the period mentioned in Section 58(1)(b) above shall be read to extend for no longer than one month beginning with the day on which the community treatment order is made.
- (3) The Secretary of State may by order vary the length of the period mentioned in subsection (2).
- (4) Certification under subsection (1)(b) above may take place whilst a patient remains liable to be detained, but will not come into force until the responsible

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1 “62A” in the tabled amendment here is an error: the text should read “62”.

clinician discharges the patient from detention in hospital under the terms of section 17A(1) above.”

- (5) Before giving a certificate under section 58(3A)(b) above the registered medical practitioner shall consult two other persons, who have been professionally concerned with the patient’s treatment, but of those persons
  - (a) at least one shall be a person who is not a registered medical practitioner; and
  - (b) neither shall be the patient’s responsible clinician or the approved clinician in charge of the treatment in question.
- (6) In section 61 (1), leave out “or “58(3)(b)” and insert “58(3)(b), or 58A(1)(b)”
- (7) In section 61(1)(a) after “20(3) ” insert “ 20A(4)”
- (8) In section 61(3) for “responsible medical officer” substitute “approved clinician in charge of the treatment in question”
- (9) In section 61(3), leave out “or “58(3)(b)” and insert “58(3)(b)”, “or 58A(1)(b)”
- (4) After Section 62(2) of the 1983 Act insert—

“(2A) Section 62A below shall not preclude the continuation of any treatment or of treatment under any plan pending compliance with section 58 above where a community patient is recalled to hospital or a community treatment order is revoked and

  - (a) the patient is capable of understanding its nature, purpose and likely effect of that treatment and has consented to it; or
  - (b) the patient is not capable of understanding its nature, purpose and likely effect of that treatment, but it is not necessary to restrain the patient in order to give the treatment.”
- (5) After section 62 (Urgent Treatment) insert—

“62A Treatment on recall of community patient or revocation of order

  - (1) This section applies where—
    - (a) a community patient is recalled to hospital under section 17E above; or
    - (b) a patient is liable to be detained under this Act following the revocation of a community treatment order under section 17F above in respect of him.
  - (2) Subject to section 62 above, a patient to whom this section applies shall not be given any form of treatment to which section 58 applies without its certification under section 58(3)e following that recall or revocation.”
- (5) In section 64 (supplementary provisions for Part IV), after subsection (2) insert—
  - (3) In this Part of this Act, references to “not capable of understanding the nature, purpose and likely effects of treatment” are to be read in accordance with the test established at section 3 of the Mental Capacity Act 2005 (c. 9).
  - (4) References to a donee are to a donee of a lasting power of attorney (within the meaning of section 9 of the Mental Capacity Act 2005) created by the patient, where the donee is acting within the scope of his authority and in accordance with that Act
  - (5) References to a deputy are to a deputy appointed for the patient by the Court of Protection under section 16 of the Mental Capacity Act 2005, where the deputy is acting within the scope of his authority and in accordance with that Act.
  - (6) Reference to the responsible clinician shall be construed as a reference to the responsible clinician within the meaning of Part 2 of this Act.
  - (7) For the purpose of this section a person restrains the patient if he –

(a) uses, or threatens to use, force to require the doing of an act which the patient resists, or

(b) restricts the patients liberty of movement, whether or not the patient resists.’

(8) References to a hospital include a registered establishment.”

- (7) In section 119 (practitioners approved for Part 4 and section 118)—
- (a) in subsection (2)(a) for “in a registered establishment” substitute “ hospital or registered establishment or any community patient in a hospital or establishment of any description or (if access is granted) other place”
  - (b) in subsection (2)(b), leave out “in that home” and insert “there”
  - (c) after subsection (2) insert—
    - “(3) In this section, “establishment of any description” shall be construed in accordance with section 4(8) of the Care Standards Act 2000.”
- v)
- (8) The Mental Capacity Act 2005 (c. 9), is amended as follows
- (9) In Section 28 ( Mental Health Act matters) after subsection (1) insert (1A)Section 5 does not apply to an act to which section 58A of the Mental Health Act 2007 (c)applies.”

## **Purpose of the amendment**

To replace the Bill’s provisions for treatment of community patients not recalled to hospital (Part 4A) with a simpler set of provisions that retain the effect of Part 4A except for those provisions which deal with second opinion approved doctors (SOADs). Because of the complicated drafting of the Bill it has been necessary to redraft the clauses completely in order to make these changes. The redraft has the advantage also of being much shorter and more accessible.

The effect of the amendment is to require a SOAD to examine a community patient in the same circumstances as a detained patient, that is at a time when the patient is no longer consenting to the treatment or has lost capacity to consent. We consider that a second opinion is an essential safeguard at that time.

## **Explanation of the SOAD system**

This section gives a detailed explanation of the existing system in order to explain the changes. For a detained in-patient who has already been on medication for a period of 3 months since being under the Act s 58 provides for two situations:

- (1) Patient has capacity to consent to the medication and is consenting, as confirmed by RC: The RC specifies the medication on a statutory form<sup>2</sup>.

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(1) <sup>2</sup> (Note: Should the patient lose capacity or decide to refuse to take the treatment at some future time, a Second Opinion Appointed Doctor (SOAD) is required, see below, if the medication is to continue. There are provisions to ensure necessary medication can be given whilst awaiting the SOAD).

- (2) Patient lacks capacity to consent to medication or retains capacity but refuses medication: RC must request a SOAD.

### The role of the SOAD

The SOAD reads the patient's medical records, examines the patient, interviews a nurse and another professional, neither a doctor nor nurse, who is involved with the patient's care, discusses the case with the RC, and then authorises what medication may be given. (including such detail as to whether or not it may be given by injection or only by mouth – assuming an injectable form of the medication is made), details being given on the statutory certificate issued by the SOAD.

The SOAD will assess the patient's mental state, decide if the patient retains capacity, listen to the patient's objections (if any) to any of the medication, take note of the patient's past history and response to medication, including adverse effects, note the patient's physical health, explore, particularly with the other professionals, if there are other, non-medication, interventions which might be more appropriate or a reasonable alternative.

### The Bill and CTOs

All patients on a CTO (after the relevant time, 3 or 4 months) will see a SOAD. The SOAD will undertake the same assessments, examinations and interviews as described above but because the patient is agreeing to the treatment, it is self-evident that the SOAD cannot explore why the patient is refusing and whether this is reasonable. The SOAD will issue a certificate authorising both the medication which can only be given with the patient's capacitous consent and that which can be given should the patient lose capacity or refuse the medication at some time in the future.

The SOAD will have to issue the certificate despite having no knowledge of, nor being able to assess, why the patient has become incapacitous or, whilst retaining capacity, has decided to refuse medication s/he was previously accepting

This is a higher safeguard, in one respect. All patients, including those who are capacitous and consenting will have their medication authorised by a SOAD. However this gain is at the expense of a serious loss. That is the right of the patient who becomes incapacitous or who changes his/her mind, perhaps for very good reasons, and decides no longer to consent to treatment, not to have the medication given without a current assessment by a second opinion doctor.

### The Alliance's concerns

Patients sent on a CTO will be agreeing to their treatment, otherwise a CTO would not be appropriate. **The SOAD certificate authorises treatment for some future time (perhaps many months later) when the mental state of the patient has changed, in that the patient has now become incapacitous or has decided to refuse the treatment, and the patient's physical health may also have changed (perhaps as a result of the medication).** The certificate issued by the SOAD will authorise treatment which was appropriate at the time it was issued. However, as described, circumstances must have changed. At this point there is no safeguard for the patient. It would be very poor medical practice for a doctor (the SOAD) to state that a particular medication is

appropriate, and may be given without the patient's consent (indeed forcibly injected against the patient's capacitous wish), without examining the patient at the time. The responsible clinician (or whoever is the doctor or other prescriber such as a nurse involved in actually giving the treatment to the recalled patient) will of course have a duty of care and will not endanger the health or life of a patient. Lord Patel stated in the House of Lords debates at Report stage

“But if the only safeguard against the SOAD's authorisation being used recklessly in another context to that which it was given is the professional judgment of the treating doctor, then we have negated the point of the SOAD role. I believe that it is important that we preserve the role of the SOAD to considering what treatments should be given on the basis of the actual presentation of the patient at the time of their examination, and so preserve the protection that SOADs offer to patients”

As the Chairman of the Mental Health Act Commission, which is responsible for the administration of second opinions Lord Patel also said

“One of the MHAC's roles is to appoint and train SOADS, and this of course means that the MHAC must provide advice on second opinion procedure. The MHAC would be likely to advise SOADS to be extremely cautious indeed when considering whether or not to authorise treatments to be given in unforeseeable situations at some unidentified point in the future. Indeed, even putting the issue that way makes me wonder whether the discretion that the Bill allows SOADS in this respect will actually be taken up by this body of responsible psychiatrists. I have to say that I hope that it would not”

Another ethical issue arises from the Bill. A SOAD who is certifying that a community patient consents to the treatment that he or she is receiving would also seem to be enabled to certify what treatments would be imposed upon that patient if he or she withdraws consent and is recalled to hospital. At the very least, it would appear to breach the principle underlying true consent that is set out in the current Mental Health Act Code of Practice, which states at paragraph 15.13 that “permission given under any unfair or undue pressure is not ‘consent’”.

## The Alliance amendment

The amendment gives CTO patients exactly the same rights and safeguards as those detained in hospital. Patients who are capacitous and consenting would have their treatment authorised by the Responsible Clinician.

Patients who lack capacity, or refuse treatment, would have the safeguard of the requirement for a SOAD authorisation based on an examination and assessments **at the time the decision needed to be made**, not based on information which may be many months out of date. Safeguards for necessary and emergency treatments are included (by amending section 62) to ensure no patient would suffer as a result of having to wait for the SOAD assessment (up to 5 days is the current MHAC standard).

The Alliance amendment does not replicate the added protection of a SOAD for all CTO patients at 3 months, provided by the government proposal. We would welcome such an amendment if:

- It was additional to, rather than instead of, a SOAD examination and authorisation at the time it is needed i.e. at the time that the patient's consenting status changes.
- It applied to ALL detained/compelled patients at 3 months, not just CTO patients. It is illogical to have the added protection for patients in the community but not those detained in hospital because:
  - In-patients are more seriously ill than those on a CTO,
  - They are more likely to succumb to inappropriate pressure because they want their freedom.
- We had presumed the government would reject such a proposal on the grounds of cost given their refusal to reduce the time until a SOAD is required from the current 3 months.

**For further discussion on the importance of the SOAD under the Mental Health Act please refer to the briefing that accompanies the amendment on the 3 month rule.**