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Originator

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Designation: Mental Health Law Scrutiny Group

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Where policy deemed relevant to equality-

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Review

Review Date: October 2018

Responsibility of: Mental Health Law Manager

Designation: On behalf of the Mental Health Law Scrutiny Group

This policy is to be disseminated to all relevant staff.

This policy must be posted on the Intranet.

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GUIDING PRINCIPLES

All Pennine Care NHS Foundation Trust Mental Health Act related policies are developed in accordance with the guiding principles as identified by Sections 118(2A), 118(2B) and 118(2C).

It is essential that all those undertaking the functions under the Mental Health Act 1983 (MHA) understand the five sets of overarching principles which should always be considered when making decisions in relation to care, support or treatment provided under the Act.

The five overarching principles are:

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

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

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

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

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

Staff must apply all the principles to all decisions. All decisions must be lawful and informed by good professional practice. Lawfulness necessarily includes compliance with the Human Rights Act 1998 (HRA) and Equality Act 2010. All five sets of principles are of equal importance, and should inform any decision made under the Act. The weight given to each principle in reaching a particular decision will need to be balanced in different ways according to the circumstances and nature of each particular decision.

Any decision to depart from the directions of the policy and the Code of Practice must be justified and documented accordingly in the patient's case notes. Staff should be aware that there is a statutory duty for these reasons to be cogent and appropriate in individual circumstances.

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POLICY ON TREATMENT OF PATIENTS
SUBJECT TO THE MENTAL HEALTH ACT PART 4 AND PART 4A

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1. Introduction

1.1 Part 4 and Part 4A of the Mental Health Act (hereafter referred to as "The Act") governs the provision of treatment to patients subject to the Act providing specific powers and safeguards for the treatment of patients for their mental disorder.

1.2 The aim of this policy is to provide guidance to staff involved in the treatment of patients subject to the Act, in order to ensure the Trust complies with the Act's provisions and that the legal authority to give treatment is in place.

1.3 This policy also aims to provide guidance for staff dealing with patients or treatments not covered by Part 4 and Part 4A of the MHA.

2. Responsibilities

2.1 Hospital Managers
The "Hospital Managers" are responsible for ensuring compliance with the provisions of the Act. This includes ensuring statutory documentation is completed and available and that adequate arrangements are made for "Second Opinion Appointed Doctor" (SOAD) visits.

2.2 Responsible Clinician
The patient's Responsible Clinician/Approved Clinician must ensure there is compliance with the Act's provisions relating to the treatment of patients for whom they are responsible.

2.3 Nursing Staff
Nurses administering medication to patients must ensure they have legal authority to do so. (PLEASE REFER TO THE INFORMATION NOTE FOR NURSES ADMINISTRATING MEDICATION FOR MENTAL DISORDER UNDER THE MENTAL HEALTH ACT (APPENDIX I).

2.4 Mental Health Law Administrators
MHL Administrators are responsible for maintaining records of consent to treatment information, issuing reminders regarding consent to treatment dates and providing advice to staff regarding consent to treatment issues. They are also responsible for providing training, involvement in audits and issuing guidance on consent to treatment, as required by the borough or division.

2.5 Mental Health Law Manager
Responsible for monitoring compliance with the Act, including consent to treatment issues through the MHL Administrators, Care Quality Commission visits and incident reporting. On behalf of the Medical Director, the Mental Health Law Manager is also required to agree Trust-wide training, guidance, information sharing, audits and policy changes, as necessary.

3. Scope

3.1 This policy applies to patients subject to the Act, either in the community, or in-patients.

3.2 All staff involved in the treatment of these patients are covered by this policy and should be aware of, and follow, the guidance within this policy.

4. Monitoring

4.1 The application of this policy will be monitored by the Mental Health Law Scrutiny Group which is chaired by the Medical Director or nominated deputy.

4.2 Locally the policy will be monitored by the Mental Health Law Forums.

5. Definitions[1]

5.1 Detained Patient
This refers to any patient who is subject to an application under the Mental Health Act. See 6.1 for a list of sections this would apply to.

5.2 Community Treatment Order (CTO)
The legal authority for the discharge of a patient from detention in hospital, subject to the possibility of recall to hospital for further medical treatment if necessary.

5.3 Community Patients
This is a patient who is currently subject to a Community Treatment Order as set out within Section 17A of the Mental Health Act.

5.4 Responsible Clinician
The approved clinician with overall responsibility for a patient's case. Certain decisions (such as renewing detention or placing a patient on a CTO) can only be taken by the Responsible Clinician. Within Pennine Care currently all Responsible Clinicians are Consultant Psychiatrists although the Mental Health Act allows other professions to carry out this role.

5.5 Approved Clinician
A mental health professional approved by the Secretary of State to act as an approved clinician for the purposes of the Act. Some decisions under the Act can only be taken by people who are approved clinicians. All Responsible Clinicians must be Approved Clinicians. The MHA allows Trusts to assign other professionals as Responsible Clinicians and then that patient would need a medical practitioner to act as the approved clinician to authorise treatment. This is not currently the practice in Pennine Care because all Responsible Clinicians are Consultant Psychiatrists.

5.6 Second Opinion Appointed Doctor (SOAD)
An independent doctor appointed by the Care Quality Commission who gives a second opinion on whether certain types of medical treatment for mental disorder should be given without the patient's consent.

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[1] Where possible definitions have been taken from the Code of Practice, 2015.

5.7 SOAD Certificate
A certificate issued by a second opinion appointed doctor (SOAD) approving particular forms of medical treatment for a patient.

5.8 Medical Treatment
In the MHA, this covers a wide range of services. As well as the kind of care and treatment given by doctors, it also includes nursing, psychological therapies, and specialist mental health habilitation, rehabilitation and care.

5.9 Appropriate Medical Treatment
Medical treatment for mental disorder which is appropriate taking into account the nature and degree of the person's mental disorder and all other circumstances of their case.

5.10 Advance Decision to refuse treatment
A decision under the Mental Capacity Act, to refuse specified treatment made in advance by a person who has capacity to do so. This decision will then apply at a future time when that person lacks capacity to consent to, or refuse the specified treatment.

5.11 Consent
Agreeing to allow someone else to do something to or for you. Particularly consent to treatment. Valid consent requires that the person has the capacity to make the decision (or the competence to consent, if a child), and they are given the information they need to make the decision, and that they are not under any duress or inappropriate pressure.

5.12 Part 4 – The part of the Act which deals with the medical treatment for mental disorder of detained patients (including community patients who have been recalled to hospital). In particular, it sets out when they can and cannot be treated for their mental disorder without their consent.

5.13 Part 4A – The part of the Act which deals with the medical treatment for mental disorder of community patients when they have not been recalled to hospital.

6. Part 4 - Consent to Treatment

6.1 Patients covered by Part 4 are those who are subject to the following sections of the Act:

- Section 2
- Section 3
- Section 37
- Section 37/41
- Section 38
- Section 36
- Section 17A patients who have been recalled.
- Section 47
- Section 48
- Section 47/49
- Section 48/49

This includes patients who have been granted leave using Section 17.

6.2 Patients not covered by Part 4 are:

- Patients detained on short term holding powers (Section 4, 5(2), 5(4), 35, 37(4), 135, 136)
- Patients on Guardianship (Section 7)
- Patients who have been conditionally discharged from a hospital order but
- are still subject to a restriction order (Sections 41 or 49)
- Informal patients. These patients may only be treated either with their capiticious consent or in accordance with the Mental Capacity Act.

6.3 The exception to paragraphs 6.1 and 6.2 above is treatment provided under Section 57 - which applies to all patients either detained or informal. In practice this relates to Neurosurgery for mental disorder and is used so infrequently that individual guidance should be sought through the MH Law Manager before proceeding.

6.4 Three Month Rule

6.4.1 If a patient is detained under a section included in the list provided in 6.1, then for the first three months they may be given medication for mental disorder under the authority of their Responsible Clinician without the need for consent or the authorisation of a SOAD. However the Code of Practice states that the patient's consent should still be sought before any medication is administered, wherever practicable. The patient's consent, refusal to consent, or a lack of capacity to give consent should be recorded by the Responsible Clinicians on the Trust Capacity and Consent to Treatment Record (Appendix C).

6.4.2 If a person has capacity to consent, but such consent is not forthcoming or is withdrawn during this period, the clinician in charge of the treatment must consider carefully whether to proceed in the absence of consent, to give alternative treatment or stop treatment.

6.4.3 Clinicians authorising or administering treatment without consent under the Act are performing a function of a public nature and must therefore comply with the Human Rights Act (HRA) 1998, which gives effect in the UK to certain rights and freedoms guaranteed under the European Convention on Human Rights (ECHR).

6.4.4 In particular, the following should be noted:

- Compulsory administration of treatment which would otherwise require consent is invariably an infringement of article 8 of the ECHR (respect for family and private life). However, it may be justified where it is in accordance with law (in this case the procedures in the Act) and where it is proportionate to a legitimate aim (in this case, the reduction of the risk posed by a person's mental disorder and the improvement of their health)

- Compulsory treatment is capable of being inhuman treatment (or in extreme cases even torture) contrary to article 3 of the ECHR, if its effect on the person concerned reaches a sufficient level of severity. But the European Court of Human Rights has said that a measure which is convincingly shown to be of medical necessity from the point of view of established principles of medicine cannot in principle be regarded as inhuman and degrading.

6.4.5 Scrupulous adherence to the requirements of the legislation and good clinical practice should ensure that there is no such incompatibility. If clinicians have concerns about a potential breach of a person's human rights they should seek senior clinical and, if necessary, legal advice.

6.4.6 Good recording of capacity and consent to treatment reviews can provide a useful tool for risk assessment, especially in terms of future treatment compliance, as this allows consideration to be based upon patients past attitudes and concerns rather than simple legal facts about the authority to treat. The Capacity and Consent to Treatment Record should be completed on assessment following admission, at the three month point, renewal, change of RC, CTO or withdrawal of consent and change in mental state and on a review of treatment of restricted patients.

6.4.7 The 3 month rule does not apply to ECT (see ECT Policy CL81).

Expiration of the Three Month Period

6.4.8 The Mental Health Law office will notify the Responsible Clinician, patient and ward staff, one month before the expiration of the three month period. This notification will include details of the requirement to comply with the provisions of Section 58 if treatment is to continue. The MHL Office will also telephone the ward one week before, and on the day of expiry, to remind nursing staff they cannot continue with treatment if the necessary documentation is not in place. Ward staff should document in the diary the expiry date and the requirement for the Responsible Clinician to review the treatment during a ward round prior to the ending of the 3-month period.

6.4.9 For patients whose detention has changed from Section 2 to Section 3, without a break, the 3 month period is calculated from the start date of Section 2.

6.5 Procedure for a Consenting Patient's Treatment

6.5.1 Prior to the three-month period ending, the Responsible Clinician must personally seek the patient's consent, and make a record of that discussion. The Responsible Clinician should record that decision in the Capacity and Consent to Treatment Record (Appendix C).

6.5.2 If the patient can and does give their informed capacitous consent[2] to continue the proposed treatment, the Responsible Clinician must complete a T2 form - 'Certificate of Consent to Treatment' and must include on this form:

[2] Consent is the voluntary and continuing permission of a patient to be given a particular treatment, based on a sufficient knowledge of the purpose, nature, likely effects and risks of that treatment, including the likelihood of its success and any alternatives to it. Permission given under any unfair or undue pressure is not consent. By definition, a person who lacks capacity is unable to consent or refuse treatment, even if they co-operate with the treatment or actively seek it. It is the duty of everyone seeking consent to use reasonable care and skill, not only in giving information prior to seeking consent, but also in meeting the continuing obligation to provide the patient with sufficient information about the proposed treatment and alternatives to it. In every case, sufficient information should be given to the patient to ensure that they understand in broad terms the nature, likely effects and all significant possible adverse outcomes of that treatment, including the likelihood of its success and any alternatives to it. A record should be kept of information provided to patients. Patients should be told that their consent to treatment can be withdrawn at any time. Where patients withdraw their consent (or are considering withdrawing it), they should be given a clear explanation of the likely consequences of not receiving the treatment and (where relevant) the circumstances in which the

- All drugs proposed (including PRN medication) either by name or by ensuring that the number of drugs authorised in each class is indicated using BNF categories. If drugs are specified by class, the certificate must clearly state the number of drugs authorised in each class, and whether any drugs within the class are excluded.
- Maximum dosage, and route of administration must be clearly indicated for each drug or category of drugs proposed.

6.5.3 The original form should then be submitted to the MHL Administrator who will provide the ward with two copies, one for the patient's notes and the other to be attached to the in-patient medicine chart.

6.5.4 Local procedures should be developed to check there are valid treatment forms in place for all qualifying patients and this should be agreed via the Mental Health Law Forums.

6.5.5 Mental Health Law offices will also write to the wards on a regular basis providing details of the status of treatment forms for detained patients.

6.6 Procedure for patients who are not consenting, or lack capacity, to give consent

6.6.1 Consent must be voluntary and based on sufficient understanding of the treatment. If a patient refuses consent or is unable to give valid consent, then the Responsible Clinician must request a 'Second Opinion Appointed Doctor Visit' to continue treatment.

6.6.2 The Responsible Clinicians must complete a request for a SOAD using the online form on the CQC website. A copy of this form should be sent to the MHL Office. SOADs can be requested at any time prior to the expiry of the three months and to avoid delay, this should be completed as soon as it is identified that a SOAD will be needed.

6.7 Process following a SOAD Request

6.7.1 Once the Responsible Clinician has submitted the online form and sent a copy of the form to the MHL Office the MHL Office will return a copy of the form to the ward to be kept in the patient's notes.

6.7.2 Approved clinicians should ensure that SOADs are informed if the hospital know that the patient has an attorney or deputy who is authorised under the Mental Capacity Act to make decisions on the patient’s behalf about medical treatment. Details of any relevant advance decisions, or advance statements of views, wishes or feelings should already be recorded in the patient’s notes. If they are not, they should be drawn to the SOAD’s attention.

6.7.3 Ward staff should prepare for the visit by:

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treatment may be given without their consent under the Act. A record should be kept of the information provided to patients.

- Identifying the two professionals involved in the patient's care for the SOAD to consult with.

- Arrange for these professionals to be available when the date of the visit is known.

- Remind both professionals of the need to document their consultation in the ward clinical notes.

- Ensure the treatment plan and detention papers are available for the SOAD.

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

- The proposed treatment and the patient's ability to consent to it;
- Their understanding of the past and present views and wishes of the patient;
- Other treatment options and the way in which the decision on the treatment proposal was arrived at;
- The patient's progress and the views of the patient's carers; and
- Where relevant, the implications of imposing treatment on a patient who does not want it and the reasons why the patient is refusing treatment.

If the SOAD wishes to speak to a consultee face to face then it is the responsibility of the Hospital Managers to ensure arrangements for this are made. Please notify the MHL Office if you have been asked to meet face- to-face with a SOAD.

6.7.5 If the SOAD visits and agrees that the treatment is appropriate and completes a Form T3 then this should be submitted to the MHL Administrator who will provide the ward with two copies, one for the patient's notes and the other to be attached to the in-patient medicine chart.

6.7.6It is also a legal requirement for the SOAD to provide a written explanation of the reasons for their decision. The SOAD will complete a form documenting the nature of and reasons for their decision and the MHL Office will send a copy of this to the Responsible Clinician asking them to explain the reasons to the patient and document this within the notes. This must be done within one month of the SOAD's visit.

6.8 Reviews of Treatment

6.8.1 Authority for treatment should be reviewed regularly and in the following situations:

- If the Responsible Clinician wishes to change the medication beyond that specified on Form T2 they must discuss this with the patient and then either complete a new Form T2 if consenting or request a SOAD visit if the patient does not consent or is incapable of consenting.

- It is good practice to review the treatment being provided on Form T2 each time a section is renewed. The MHL Office will ask the Responsible Clinician to do this within one month following renewal.

- If a Form T3 is in place, the Responsible Clinician must complete a Section 61 Review of Treatment Form which will be sent to them by the MHL Office. Again this should be completed and returned to the MHL Office within one month of the date that it is sent to the Responsible Clinician.

- A Section 61 Review of Treatment Form is required when a section is restored under Section 21B (following a period of AWOL over 28 days).

- As requested by a SOAD e.g. they may have time limited the authority for treatment or specified the requirement for periodic reports on the Form T3

- For patients on Restriction Orders authority to treat should be reviewed annually. This usually coincides with the date that a report should be provided to the Ministry of Justice. For the MHL Offices this would correlate to the original start date of the warrant.

- If there is a change in Responsible Clinician a Form T2 provides authority to treat and only ends if the patients consent is withdrawn, the patient becomes mentally incapable of consenting to treatment, the patient, or the treatment specified in the form changes. However, the Trust policy is that whenever there is a permanent change of Responsible Clinician, a new Form T2 should be completed. In other circumstances, where the Responsible Clinician is unavailable for long periods of time over one month, the covering Responsible Clinician is asked to review the treatment forms.

- Following Transfer under Section 19 of the Act.

- If the patients capacity changes i.e. if a T3 has been issued due to lack of capacity but the patient regains capacity they should be asked if they consent to the treatment and should they decline a fresh SOAD needs to request to continue treatment. In the interim Section 62 may be considered if the treatment meets the criteria (paragraph 6.9 of policy).

- At the point of review of consent to treatment, a Capacity and Consent to Treatment Record Form (Appendix C) must also be completed.

6.8.2 Following a review of treatment if a new form T2 or T3 is completed then old forms must be crossed through to mark that they are no longer valid and then filed in the clinical notes. Although crossed through the contents of the form must remain legible.

6.9 Section 62 – Urgent Treatment

6.9.1 Section 62 provides that treatment can be given in response to an urgent situation in the absence of the forms required by Section 58 above. If it is proposed to continue with the treatment after the urgent situation has passed, the usual procedures set out above apply.

6.9.2 To be lawful any medication given using section 62 must:

- Be *immediately* necessary to save the person's life OR
- (not being irreversible) prevent a serious deterioration in their condition OR
- Alleviate serious suffering OR
- Represent the minimum interference necessary to prevent the patient from behaving violently or being a danger to themselves or others.

If the treatment is ECT (or medication administered as part of ECT) only the first two categories above apply. For further advice see Trust ECT Policy (CL81).

6.9.3 Treatment under section 62 is not limited by time or a set number of interventions. If it is still not possible to treat under Section 58 e.g. in circumstances when the RC is awaiting a SOAD visit, the treatment can continue under Section 62 provided that the conditions above still apply. If the patient's condition means it is no longer *immediately* necessary, the normal requirements for certificates apply.

6.9.4 The treatment must be documented on the Section 62 Form (Appendix D) which should then be submitted to the MHL Office who will return two copies, one for patient's notes and the other for the In-Patient Medicines chart.

6.9.5 The use of Section 62 across the Trust will be monitored on at least an annual basis[3].

6.10 Section 58A – Electro-Convulsive Therapy

6.10.1 The ECT policy provides detailed information on this aspect of treatment but staff should be aware that:

- Patients who have the capacity to consent may not be given ECT unless they consent to it
- ECT is not subject to the three-month rule
- Before any course of ECT the patient must give valid consent and have a Form T4 completed by RC OR have a Form T6 completed by a SOAD
- A SOAD can only authorise ECT if the patient lacks capacity and not if they have capacity but are refusing
- No patient under 18 can be given ECT unless a SOAD has assessed them and completed a T5

[3] Code of Practice, Para 25.42

- ECT may not be given where there is an applicable advance decision, a Lasting Power of Attorney or deputy who objects to the ECT or a decision by the Court of Protection conflicting with the giving of ECT
- Any form completed for ECT must specify the upper limit of ECT to be given and the method (bi-lateral or uni-lateral)
- In some circumstances the MCA authorises the provision of ECT to a compliant, incapacitated INFORMAL patient (See ECT Policy for further details).

7. Part 4A – Treatment of Patients on Community Treatment Orders

7.1 Not Recalled to Hospital

7.1.1 A different set of treatment rules apply to patients on CTOs who have not been recalled to hospital by their Responsible Clinician. The rules differ depending on whether or not the patient has the capacity to consent or refuse the treatment in question. Such patients can only be given treatment if they consent or, if they lack the capacity to consent, do not actively object.

7.1.2 Refusal to consent to treatment in itself does not automatically justify a recall to hospital and fuller consideration of the patient's presentation, risk to self/others and circumstances is required when considering whether a recall to hospital is warranted.

7.1.3 Consent is the voluntary and continuing permission of a patient to be given a particular treatment, based on a sufficient knowledge of the purpose, nature, likely effects and risks of that treatment, including the likelihood of its success and any alternatives to it.

7.1.4 Permission given under any unfair or undue pressure is not consent.

7.1.5 By definition, a person who lacks capacity is unable to consent or refuse treatment, even if they co-operate with the treatment or actively seek it.

7.1.6 It is the duty of everyone seeking consent to use reasonable care and skill, not only in giving information prior to seeking consent, but also in meeting the continuing obligation to provide the patient with sufficient information about the proposed treatment and alternatives to it.

7.1.7 The information which should be given should be related to the particular patient, the particular treatment and relevant clinical knowledge and practice. In every case, sufficient information should be given to the patient to ensure that they understand in broad terms the nature, likely effects and all significant possible adverse outcomes of that treatment, including the likelihood of its success and any alternatives to it.

7.1.8 A record should be kept of information provided to patients. Patients should be told that their consent to treatment can be withdrawn at any time. Where patients withdraw their consent (or are considering withdrawing it), they should be given a clear explanation of the likely consequences of not receiving the treatment and (where relevant) the circumstances in which the treatment may be given without their consent under the Act (i.e. following recall to hospital). A record should be kept of the information provided to patients.

7.2 CTO patients who have capacity to consent to treatment

7.2.1 After one month of the patient being discharged on to a CTO, treatment can only continue if authorised by a part 4A certificate. Where a patient is considered to have capacity and to be consenting to their proposed treatment plan (or, if they are under 16, is competent to consent) then the Responsible Clinician can complete a CTO12 form. Exceptions would be where the 3 month rule under section 58 still applies and the RC would complete the CTO12 at the end of the period. The RC must also evidence the patient's capacity to consent to the treatment on the Trust Capacity to Consent to Treatment record (Appendix C). The person giving the treatment (i.e. the RC or someone acting under the direction of the RC) must ensure there is always the authority to treat as well as the relevant certificate to treat (i.e. patient's capacity to consent to the proposed treatment to the prescribed medication authorised on the CTO12 (Appendix G) certificate continues to apply and are relevant at the time of administering treatment).

7.2.2 When a CTO patient with capacity refuses to consent to a particular treatment it is good practice for the staff involved to ascertain whether the patient is also making an advance decision to refuse that treatment in future if they lose capacity. If the patient confirms they would not want that treatment at any point this should be clearly documented in the patients' notes/care plan and the MHL Office should be notified[4].

7.2.3 Remember the patients refusal to consent to treatment at a particular time in itself does not automatically justify a recall to hospital and fuller consideration of the patient's presentation, risk to self/others and circumstances is required when considering whether a recall to hospital is warranted.

7.3 CTO patients who lack capacity or competence to give consent

7.3.1 If a patient lacks capacity to consent to treatment within the first month of being discharged onto a CTO then the Responsible Clinician will be required to take immediate steps to complete a SOAD request so that the certificate requirements are in place one month from the patient being discharged onto a CTO unless of course s58 is still applicable for the time being. The SOAD will need to certify that treatment is appropriate on form CTO11. The Responsible Clinician should discuss this with the patient prior to the patient leaving the hospital or within the first month of the patient being discharged onto a CTO and discuss any a suitable places for the patient to be seen by the SOAD. This may be at an outpatient clinic or somewhere the patient visits regularly. Arrangements must also be made for the SOAD to have access to the patient's notes in the agreed location.

7.3.2 As well as the certificate requirement one month from the patient being discharged on to a CTO if a CTO patient lacks capacity, treatment could be given to them in the community under the direction of the RC unless:

- The treatment – for a patient 18 or over – was contrary to a valid and applicable advance decision by the patient.

[4] Advance decisions for non-life saving treatment can be taken verbally. The MHL Office will be aware of the procedure to be followed so it is only necessary for the clinician to document the details in the patient notes/care plan and discuss with the patient. Ensuring their capacity is recorded clearly in the notes.. PLEASE ALSO REFER TO CHAPTER 9 AND CHAPTER 24 OF THE 2015 MHA CODE OF PRACTICE FOR FURTHER INFORMATION REGARDING ADVANCE DECISIONS REFUSING TREATMENT FOR MENTAL DISORDER OR CONTACT YOUR LOCACL MENTAL HEALTH LAW OFFICE.

- The treatment for a patient 16 or over – was contrary to someone authorised under the MCA to refuse the treatment (i.e. attorney, deputy, or court of protection).
- Force was needed to administer the medication and the patient was objecting to the treatment (this applies to patients of any age).

7.4 Treatment of non-recalled CTO patients – emergency treatment (section 64G)

7.4.1 In an emergency, treatment can also be given to part 4A patients who lack capacity to consent to or refuse a treatment (and who have not been recalled to hospital) by anyone, whether or not they are acting under the direction of an approved clinician.

7.4.2 It is an emergency only if the treatment is immediately necessary to:

- save the patient's life
- prevent a serious deterioration of the patient's condition and the treatment does not have unfavourable physical or psychological consequences which cannot be reversed
- alleviate serious suffering by the patient and the treatment does not have unfavourable physical or psychological consequences which cannot be reversed and does not entail significant physical hazard, or
- prevent patients behaving violently or being a danger to themselves or others and the treatment represents the minimum interference necessary for that purpose, does not have unfavourable physical or psychological consequences which cannot be reversed and does not entail significant physical hazard.

7.4.3 If the treatment is ECT (or medication administered as part of ECT), only the first two categories above apply.

7.4.4 In addition, force may be used (whether or not the patient objects), provided that:

- the treatment is necessary to prevent harm to the patient, and
- the force used is proportionate to the likelihood of the patient suffering harm and to the seriousness of that harm.

7.4.5 These are the only circumstances in which force may be used to treat patients on CTOs who object, without recalling them to hospital. This exception is for situations where the patient's interests would be better served by being given urgently needed treatment by force outside hospital rather than being recalled to hospital. This might, for example, be where the situation is so urgent that recall is not realistic, or where taking patients to hospital would exacerbate their condition, damage their recovery or cause them unnecessary anxiety or suffering. Situations like this should be exceptional.

7.5 ECT Treatment and CTO patients

7.5.1 For CTO patients who are aged 18 years or over, Form CTO12 can be used to certify the patient's informed and capacitated consent to ECT treatment in the rare circumstances where this might be considered.

7.6 Recalled Patients

7.6.1 If the patient is recalled they are subject to s.58 and 58A treatment rules under the MHA (see Appendix j) in the same way as other detained patients. However there are 3 exceptions to this:

- A certificate under section 58 is not needed for medications if less than one month has passed since the patient was discharged from hospital and became a CTO patient.
- A certificate is not needed if the treatment is explicitly authorised for administration on recall on the patients Part 4A certificate. This will be documented on form CTO11.
- Treatment that was already being given in the community on the basis of a Part 4A certificate may be continued even if not authorised specifically for administration on recall if the Responsible Clinician considers discontinuing it would cause the patient serious suffering. But it may only be continued pending compliance with s.58 or 58A. In other words, it applies only for the time it takes to obtain the certificate that would normally be required, or for a SOAD to decide that it is not appropriate to issue such a certificate. The Responsible Clinician must however in the meantime complete form 62A where the criteria for s62A is met.

7.6.2 During recall if the patient has capacity and is consenting to the proposed treatment, treatment can be authorised by the Responsible Clinician completing a T2 form.

7.7 SOAD Visit not completed within One Month

7.7.1 Where a SOAD visit has not been completed within the first month of CTO as required by the Act the following must be completed:

- The MHL Office must notify the Responsible Clinician and continue to contact the CQC office on at least a weekly basis to try to ensure the visit takes place. Each contact must be recorded in the MHL Register.

- The Responsible Clinician must review the treatment plan and the patient's capacity and consent to the medications they are taking in the community to ensure they can continue using the criteria set out in Sections 64A-G.

7.7.2 The certificate requirement [i.e. the need for CTO11 or CTO12] does not apply if the treatment is "immediately necessary" and the patient has capacity to consent to it and does consent to it. This also applies to incapacitated patients where a donee or deputy has consented to the treatment on that patient's behalf.

7.7.3 Because of the 'immediately necessary' requirement, this provision should only be used until the SOAD visit is complete - it does not dispense with the need for a SOAD visit.

7.7.4 The CQC has taken the opinion that these 'emergency ' provisions can extend to be used to ensure that a patient's medication levels does not drop below the therapeutic dose – i.e. it is not necessary to wait for a relapse to show before authorising treatment under these powers .

7.7.5 Responsible Clinicians must complete the Trust Section 64 form as well as the Trust capacity to consent to treatment record and must also record clearly when authorising treatment under this provision that the reason that it has been necessary to use these powers is because the SOAD visit has yet to take place.

7.7.6 The use of these section provisions will be closely monitored by the Mental Health Law Scrutiny Group using the Mental Health Law Registers. MHL Office will prompt the completion of this form if it is unlikely that the SOAD will visit within a month of the patient being discharged onto a CTO.

7.7.8 Treatment may be given to a CTO patient aged 18 or over who lacks capacity to consent or refuse treatment, if someone who has a Lasting Power of Attorney or a Court of Protection appointed deputy with authority to make health and welfare decisions, consents on the patient's behalf. Similarly, it may be given in the case of those aged 16 and over if a deputy with authority to make health and welfare decisions, consents on the patient's behalf.

8. Interface between Parts 4 and 4A of the MHA and the Mental Capacity Act (MCA)

8.1 Subject to paragraph 8.2 below, the MCA applies to decisions about medical treatment made on behalf of people aged 16 or above who lack capacity to consent or refuse such treatment. Provided that the clinician reasonably believes that the patient lacks capacity to consent or refuse the treatment and reasonably believes that it is in the patient's best interests then legal authority is provided by Section 5 of the MCA.

8.2 The normal rules on treatment and consent in the MCA apply to patients subject to the MHA in the same way as to anyone else. However, there are exceptions in relation to medical treatment for mental disorder:

Situation	Exceptions to the normal rules in the MCA
Section 57 treatment (neurosurgery for mental disorder etc)	The MCA may not be used to give anyone treatment to which section 57 applies (see chapter 25 for guidance on section 57).
Section 58 treatment (medication after an initial three month period, except ECT-related medication)	The MCA may not be used to give anyone treatment to which section 58 applies (see chapter 25 for guidance on section 58).
Section 58A treatment (ECT and related medication)	The MCA may not be used to give detained patients (as defined in paragraphs 24.10 – 24.11) ECT and any other treatment to which section 58A applies.
Treatment regulated by part 4 of the Act for detained patients	The MCA may not be used to give detained patients (as defined in this chapter) any other medical treatment for mental disorder. Treatment regulated by part 4 of the Act at the time of the proposed treatment must be given in accordance with part 4 of the Act instead (see paragraphs 24.10 – 24.13).
Treatment for patients on CTOs who have not been recalled to hospital (part 4A patients)	The MCA may not generally be used to give these CTO patients any medical treatment for mental disorder, but attorneys, deputies and the Court of Protection may consent to such treatment on behalf of these CTO patients.
Advance decisions to refuse treatment (as defined in the MCA)	Where the Act allows treatment to be given against the wishes of a patient who has capacity to consent, it also allows treatment to be given despite the existence of a valid and applicable advance decision made under the MCA (see chapter 9). But note that, except in emergencies: • treatment to which section 58A applies cannot be given contrary to a valid and applicable advance decision, and • treatment cannot be given to CTO patients who have not been recalled to hospital (part 4A patients) contrary to a valid and applicable advance decision.
Patients who have attorneys or court-appointed deputies under the MCA with authority to take decisions on their behalf about their medical treatment	Attorneys and deputies (acting within the scope of their authority under the MCA) may not: • consent to treatment to which section 57 or 58 applies on behalf of any patient • consent to treatment to which section 58A applies – but note that (except in emergencies) they may refuse it on a patient's behalf, or • consent to or refuse any other treatment on behalf of detained patients (as defined in paragraphs 24.10 – 24.11). But note that attorneys and deputies may: • consent to treatment on behalf of CTO patients who have not been recalled to hospital (part 4A patients), even if treatment is to be given forcibly, and • except in emergencies, refuse treatment on behalf of those patients.

8.3 Please refer to the Trust's Policy CL2 for further guidance on the application of the MCA generally.

9. Information for Patients

9.1 When staff are seeking consent from patients they must ensure they take all reasonable steps to provide information to patients. This is a continuing obligation throughout the patient's detention and treatment and should be revisited regularly with patients.

9.2 The information which must be given should be related to the particular patient, the particular treatment and relevant clinical knowledge and practice. In every case, sufficient information must be given to the patient to ensure that they understand in broad terms the nature, likely effects and all significant possible adverse outcomes of that treatment, including the likelihood of its success and any alternatives to it. A record should be kept of information provided to patients and the dates that the information was provided.

9.3 Patients should be invited to ask questions and professionals should answer fully, frankly and truthfully. There may sometimes be a compelling reason, in the patient's interests, for not disclosing certain information. A professional who chooses not to disclose information must be prepared to justify the decision. If the professional requires advice on whether the reason for withholding information is valid, they should contact the MHL Manager.

9.4 Patients should be told that their consent to treatment can be withdrawn at any time. Where patients withdraw their consent (or are considering withdrawing it), they should be given a clear explanation of the likely consequences of not receiving the treatment and (where relevant) the circumstances in which the treatment may be given without their consent under the Mental Health Act. A record should be kept of the information provided to patients and the date that the discussions took place.

9.5 Information may need to be provided in other formats for patients i.e. where English is not their first language. Ward staff and the MHL Office must ensure this is done following the Trust's translation procedure.

9.6 Patients subject to the MHA have a statutory right to access the Independent Mental Health Advocacy service and they may be referred to this service if they have any issues relating to their treatment. Ward staff and the MHL Office should ensure patients are provided with information on this service.

10. Treatment plans

10.1 Treatment plans are essential for patients being treated for mental disorder under the MHA. A patient's Responsible Clinician is responsible for ensuring that a treatment plan is in place for that patient. A treatment plan should include a description of the immediate and long-term goals for the patient and should give a clear indication of the treatments proposed and the methods of treatment.

10.2 The treatment plan should form part of a coherent care plan under the Care Programme Approach and be recorded in the patient's notes.

Psychological therapies should be considered as a routine treatment option at all stages, including the initial formulation of a treatment plan and each subsequent review of that plan. Any programme of psychological intervention should form part of the agreed treatment plan and be recorded in the patient's notes as such.

10.3 Wherever possible, the whole treatment plan should be discussed with the patient. Patients should be encouraged and assisted to make use of advocacy support available to them, if they want it. This includes, but need not be restricted to, independent mental health advocacy services under the Act. Where patients cannot (or do not wish to) participate in discussion about their treatment plan, any views they have expressed previously should be taken into consideration

10.4 Subject to the normal considerations of patient confidentiality, the treatment plan should also be discussed with their carers, with a view to enabling them to contribute to it and express agreement or disagreement.

10.5 Discussion with carers is particularly important where carers will themselves be providing care to the patient while the plan is in force. Plans should not be based on any assumptions about the willingness or ability of carers to support patients, unless those assumptions have been discussed and agreed with the carers. Carers have an important role to play in maintaining the patient's contact with home and community life and providing emotional support when the patient is detained. In some cases carers' willingness and ability to contribute to the provision of care may be dependent on additional support and they should be reminded of possible sources of such support and their entitlement to a carer's assessment by the local authority.

10.6 Treatment plans should be regularly reviewed and the results of reviews recorded in the patient's notes.

11. Treatment of Children and Young People

11.1 The medical treatment of children and young people is not covered within this policy. If you have a specific issue please contact your local MHL Office or refer to Chapter 19 of the revised 2015 Code of Practice to the MHA.

12. Monitoring Arrangements

12.1 The Mental Health Law Scrutiny Group will consider any issues relating to the application of this policy and will monitor the use of this policy through the Local Mental Health Law Forums and local incident reporting processes and procedures as and when this is considered appropriate.

12.2 The processes and principles of this policy where applicable will be included in clinical audits where this is also considered appropriate.

13. Equality Statement

13.1 Assessments of consent status and decisions to use compulsory treatment should not be affected by ethnicity, age, gender, sexual orientation or disability. The Mental Health Law Scrutiny Group will strive to ensure this is the case and address any reports of potential impact immediately. When assessing capacity or explaining treatment to patients, interpreters or translation services may be sought through the normal process.

14. Training

14.1 Training packages developed by the Mental Health Law team will address the key points within this policy. Specific training modules will also be developed in response to need either Trustwide or locally within the boroughs.

14.2 Ward and Team Managers will be required to ask staff involved in the administration of medication to familiarise themselves with this policy and Chapters 23 to 25 of the Code of Practice (2015).

14.3 In addition to this Ward Manager must distribute the Guidance on ‘Nurses and the Administration of Medication for Mental Disorder’ on at least an annual basis. This guidance must also be available on wards.

15. Other Policies

CL14 Policy for Rapid Tranquilisation
CL15 Medicines Policy
CL81 ECT Policy
CL2 Consent to Examination or Treatment Policy

16. Resources

Mental Health Act 1983 (as amended)
Mental Capacity Act 2005
Code of Practice, Mental Health Act, 2015
Reference Guide, Mental Health Act, 2015
Code of Practice, Mental Capacity Act, 2007

Form T2 *Regulation 27(2)* **Mental Health Act 1983**
Section 58(3)(a)—certificate of consent to treatment

I	

[PRINT full name and address – no initials]

the approved clinician in charge of the treatment described below/a registered medical practitioner appointed for the purposes of Part 4 of the Act (a SOAD)
<delete the phrase which does not apply>

certify that	

[PRINT full name and address of patient – no initials]

(a) is capable of understanding the nature, purpose and likely effects of: [Give description of treatment or plan of treatment. Indicate clearly if the certificate is only to apply to any or all of the treatment for a specific period.]

[If you need to continue on a separate sheet please indicate here [ ] and attach that sheet to this form.]

AND

(b) has consented to that treatment.

Signed:	
Date:	

Form T4 *Regulation 27(3)(b)* **Mental Health Act 1983**

Section 58A (3)—certificate of consent to treatment (patients at least 18 years old)

ECT

THIS FORM IS NOT TO BE USED FOR PATIENTS UNDER 18 YEARS OF AGE

I	

[PRINT full name and address]

the approved clinician in charge of the treatment described below/a registered medical practitioner appointed for the purposes of Part 4 of the Act (a SOAD)
<delete as appropriate>

certify that	

[PRINT full name and address of patient]

who has attained the age of 18 years

(a) is capable of understanding the nature, purpose and likely effects of: [Give description of treatment or plan of treatment. Indicate clearly if the certificate is only to apply to any or all of the treatment for a specific period.]

[If you need to continue on a separate sheet please indicate here [ ] and attach that sheet to this form]

AND

(b) has consented to that treatment.

Signed:	
Date:	

mental health law

Pennine Care NHS
NHS Foundation Trust

Capacity and Consent to Treatment Record

Mental Health Act: To be completed for patients detained for assessment (s.2) or treatment (s.3,37,37/41, 47), on admission, at 3 month review of treatment, when there's a permanent change in Responsible Clinician or significant change in mental state, or change/withdrawal of consent. To be completed by Responsible Clinician.

Patient Name:				**NHS Number:**	
Responsible Clinician:		**Ward:**		**Date of Section**	
				Assessment	

Capacity	
As the Responsible Clinician for the above named patient I completed an assessment of their capacity to provide informed consent to their treatment plan. Although working on an assumption of capacity the Mental Health Act requires me to complete an assessment and formally document this.	
Outcome:	**Tick**
1. I found the patient to have capacity to make that decision (go to Q.3)	☐
2. As a result of an impairment in or disturbance in the functioning of their mind or brain, the patient did not have capacity because they are unable to;	

understand information about the decision to be made	☐	retain that information	☐
use or weigh that information as part of the decision making process;	☐	unable to communicate their decision (by talking, using sign language or any other means)	☐

The first three should be applied together. If a person cannot do any of these three things, they will be treated as unable to make the decision. The fourth only applies in situations where people cannot communicate their decision in any way.

3. My decision is founded upon the following factors and discussion with the patient / others:

4. As part of my assessment I discussed the proposed treatment with the patient and asked for their views regarding the treatment and their options. Their views are: **(Please comment even if patient does not have capacity)**

5. The patient **did not / could not** consent to the treatment after being given information on the purpose, nature, likely effects and risks of that treatment, including the likelihood of its success and any alternatives to it as well as their right to refuse or withdraw consent at any time.	☐
6. The patient **did** consent and they have an adequate knowledge of the purpose, nature, likely effects and risks of that treatment, including the likelihood of its success and any alternatives to it. They were invited to ask questions and I explained they may withdraw their consent at any time.	☐

Purpose of Completing Form						
a) On assessment following admission	☐	b) At 3 month point /renewal of detention inc. CTO / change of RC / withdrawal of consent / change in mental state /Review at ASR / CTO at 1 month point / Recall and or Revocation				☐
If you selected b) then confirm:	Form T2 / CTO12 Completed	☐	SOAD Visit Arranged / Section 61 Completed	☐	Section 62/62A Completed	☐

Signed:		**Date:**	

Once completed original to be given to MHL Office

Capacity and Consent to Treatment Process

Code of Practice 24.41 and 24.42
"Although the Mental Health Act permits some medical treatment for mental disorder to be given without consent, the patient's consent should still be sought before treatment is given, wherever practicable. The patient's consent or refusal should be recorded in their notes, as should the treating clinician's assessment of the patient's capacity to consent. The patient's consent, refusal to consent, or a lack of capacity to give consent should be recorded in the case notes. If a person has capacity to consent, but such consent is not forthcoming or is withdrawn during this period, the clinician in charge of the treatment must consider carefully whether to proceed in the absence of consent, to give alternative treatment or stop treatment. Clinicians authorising or administering treatment without consent under the Act are performing a function of a public nature and must therefore comply with the Human Rights Act (HRA) 1998, which gives effect in the UK to certain rights and freedoms guaranteed under the European Convention on Human Rights (ECHR)".

Code of Practice 25.17
"Where approved clinicians certify the treatment of a patient who consents, they should not rely on the certificate as the only record of their reasons for believing that the patient has consented to the treatment. A record of their discussion with the patient, and of the steps taken to confirm that the patient has the capacity to consent, should be made in the patient's notes as normal."

The Mental Health Act requires the Responsible Clinician's to determine regularly;

- whether a patient has the capacity to consent to or to refuse a particular form of medical treatment, and if so,
- whether the patient does, in fact, consent

Process

1. The Responsible Clinician (RC) must complete a Capacity and Consent to Treatment form:
   - By the first ward round following detention under the Mental Health Act (maximum of 7 days from admission)
   - After the first 3 months of detention
   - Following renewal of detention
   - At the time of completing the Annual Statutory Report for the MOJ
   - At the time the patient is discharged on to CTO
   - Following extension of CTO
   - Following recall /revocation of CTO
   - When there is a permanent change of Responsible Clinician.
   - At times when there is a significant change in mental state or consent is withdrawn

2. In addition to completing this form, the RC must document in the healthcare record the date the assessment and form were completed. This will ensure that the form can be easily located by the Care Quality Commission, MHL Office's and clinical staff for inspection.

3. The completed form must be given to the Mental Health Law office who will return copies for the ward.

4. If the Responsible Clinician has indicated that a SOAD is required, the appropriate SOAD request form must be completed online, with a copy sent to the MHL Office.

NB: Although the requirement to complete a formal review using this form is defined above, all staff remain responsible for assessing capacity on an ongoing basis and recording this in the patient's healthcare records. Other Capacity Assessment forms are available for decisions outside of the Mental Health Act i.e. housing, medical treatment. Contact local MHL Office for copies of these.

This process and the completion of the form are evidence of the Trust's compliance with the Mental Health Act, Mental Capacity Act, Registration requirements and the local policies on consent to treatment and examination and the treatment for detained patients. If you have any questions or concerns relating to this process you must speak with your local MHL office.

URGENT TREATMENT; Section 62

Authorisation to prescribe and administer sections 57, 58 and 58A treatments without consent and/or second opinion

I (*PRINT full name and address)*

am the approved clinician in charge of the treatment of:

(*PRINT full name and address of patient)*

Compliant with Section 62 of the Mental Health Act 1983 I certify that the treatment(s)

Is/are:

(a) immediately necessary to save a patient's life;

(b) a treatment which is not irreversible and is immediately necessary to prevent a serious deterioration of the patient's condition;

(c) a treatment which is not irreversible or hazardous but is immediately necessary to alleviate serious suffering by the patient;

(d) treatment which is not irreversible or hazardous, is immediately necessary, and represents minimum interference necessary, to prevent the patient from behaving violently or being a danger to themselves or others.

<Delete the <u>three</u> phrases that do not apply>

ECT Statement:

I confirm that ECT is the treatment, or one of the treatments identified as being *urgent* within the meaning of section 62, and that it is authorised **only** by virtue of satisfying either (a) or (b) above **[*i.e.: if neither (a) nor (b) ECT cannot be given as urgent treatment]***

PTO

I confirm that the identified treatment(s) will only be administered under this section for as long as they continue to remain ***urgent*** within the meaning of section 62 of the Act, its key principles (s.118 (2)), and paras. 25.37 to 25.41 of the Act's Code of Practice.

The patient is:

(a) Capable and refusing the proposed treatment
(b) Incapable and refusing the proposed treatment
(c) Incapable and compliant with the proposed treatment

<Delete the two phrases that do not apply>

The treatment is **immediately necessary** because:

Date Treatment Commenced under s.62			
Approved Clinician Print Name			
Sign You must take immediate steps to complete a SOAD request (Code 25.81)		**Date**	

MH Law Office Completion **Date form received by MHL Office:**					
Date SOAD request sent		**Diary**	Y / N	**Initials of MHL Office**	
Date chased		**Register**	Y / N	**Date Treatment Ceased**	

Copies:

MHL Office ☐ Patient Notes ☐ Medicine Chart ☐

Pennine Care NHS
NHS Foundation Trust

URGENT TREATMENT; Section 62A

For Patient recalled/revoked from Section 17A

Authorisation to prescribe and administer sections 57, 58 and 58A treatments without consent and/or second opinion

I (*PRINT full name and address)*

am the approved clinician in charge of the treatment of:

(*PRINT full name and address of patient)*

Compliant with Section 62A of the Mental Health Act 1983 I certify that the treatment(s)

Is/are:

(e) immediately necessary to save a patient's life;

(f) a treatment which is not irreversible and is immediately necessary to prevent a serious deterioration of the patient's condition;

(g) a treatment which is not irreversible or hazardous but is immediately necessary to alleviate serious suffering by the patient;

(h) treatment which is not irreversible or hazardous, is immediately necessary, and represents minimum interference necessary, to prevent the patient from behaving violently or being a danger to themselves or others.

<Delete the three phrases that do not apply>

ECT Statement:
I confirm that ECT is the treatment, or one of the treatments identified as being *urgent* within the meaning of section 62A, and that it is authorised **only** by virtue of satisfying either (a) or (b) above **[*i.e.: if neither (a) nor (b) ECT cannot be given as urgent treatment*]**

PTO

I confirm that the identified treatment(s) will only be administered under this section for as long as they continue to remain ***urgent*** within the meaning of section 62A of the Act, its key principles (s.118 (2)), and paras. 25.37 to 25.41 of the Act's Code of Practice.

The patient is:

(d) Capable and refusing the proposed treatment
(e) Incapable and refusing the proposed treatment
(f) Incapable and compliant with the proposed treatment

<Delete the two phrases that do not apply>

The treatment is **immediately necessary** because:

Date Treatment Commenced under s.62A			
Approved Clinician Print Name			
Sign You must take immediate steps to complete a SOAD request (Code 25.81)		**Date**	
Date of Recall/Revocation			

MH Law Office Completion **Date form received by MHL Office:**					
Date SOAD request sent		**Diary**	Y / N	**Initials of MHL Office**	
Date chased		**Register**	Y / N	**Date Treatment Ceased**	

Copies:

MHL Office ☐ Patient Notes ☐ Medicine Chart ☐

URGENT TREATMENT; Section 64

Authorisation to prescribe and administer sections 57, 58 and 58A treatments without second opinion to CTO patients who *have not* been recalled or revoked

I (*PRINT full name and address)*

am the approved clinician in charge of the treatment of:

(*PRINT full name and address of patient)*

Compliant with Section 64 of the Mental Health Act 1983 I certify that the treatment(s)

Is/are:

(i) immediately necessary to save a patients life;

(j) a treatment which is not irreversible and is immediately necessary to prevent a serious deterioration of the patients condition;

(k) a treatment which is not irreversible or hazardous but is immediately necessary to alleviate serious suffering by the patient;

(l) treatment which is not irreversible or hazardous, is immediately necessary, and represents minimum interference necessary, to prevent the patient from behaving violently or being a danger to themselves or others.

<Delete the three phrases that do not apply>

ECT Statement:
I confirm that ECT is the treatment, or one of the treatments identified as being *urgent* within the meaning of section 64G, and that it is authorised **only** by virtue of satisfying either (a) or (b) above **[*i.e.: if neither (a) nor (b) ECT cannot be given as urgent treatment*]**

PTO

I confirm that the identified treatment(s) will only be administered under this section for as long as they continue to remain ***urgent*** within the meaning of section 64G of the Act, its key principles (s.118 (2)), and paras. 24.24 to 24.25 of the Act's Code of Practice.

The patient is:

(g) Incapable and not objecting to the proposed treatment (Section 64D)
(h) Incapable and refusing (Section 64G)

<Delete the <u>one</u> phrase that does not apply>

If (a) or (b)
I confirm that the treatment does not conflict with any applicable and valid advance decision or a decision of any donee or deputy or the Court of Protection.

And

Where force is necessary in order to give the treatment

i) the treatment needs to be given in order to prevent harm to the patient, and
ii) the use of such force is a proportionate response to the likelihood of the patient suffering from harm, and to the seriousness of that harm.

The treatment is **immediately necessary** because:

Date Treatment Commenced under s.64			
Approved Clinician Print Name			
Sign You must take immediate steps to complete a SOAD request (Code 25.81)		**Date**	

MH Law Office Completion **Date form received by MHL Office:**					
Date SOAD request sent		**Diary**	Y / N	**Initials of MHL Office**	
Date chased		**Register**	Y / N	**Date Treatment Ceased**	

Copies:

MHL Office ☐ Patient Notes ☐ Medicine Chart ☐

Form CTO12 Regulation 28(1A) **Mental Health Act 1983**

Section 64C (4A) — Certificate that community patient has capacity to consent (or if under 16 is competent to consent) to treatment and has done so (Part 4A consent certificate)

(To be completed on behalf of the responsible hospital)

(PRINT full name and address)

I	

am the approved clinician in charge of the treatment of

(PRINT full name and address of patient)

who is subject to a community treatment order.

I certify that this patient has the capacity / is competent to consent (*delete the one that is not appropriate)*

and has consented to the following treatment.

The treatment is:
(Give description of treatment or plan of treatment)

Signed:	
Date:	

Section 61 Review of Treatment form

(previously Form MHAC1)

Please enclose a copy of the current statutory certificate authorising treatment with this form

Restricted

This form must be completed by the approved clinician in charge of the treatment and forwarded to the Care Quality Commission when a patient is being treated under Section 58(3)(b), 58A (4) or (5) or 62A (in accordance with a Part 4A certificate) on the occasions referred to in Section 61.

The form does not relate to Section 57(2) treatments (neurosurgery for mental disorder); you should complete a separate form for this specific treatment, which is available from our Mental Health Operations team (contact details at the back).

Please fill in all sections of this form

I examined: (Full name of patient in **capital letters**)	
Name of provider: (NHS trust or service provider responsible for patient)	
Name of hospital: (N/A for SCT)	

Ward: (N/A for SCT)	

Contact name and telephone: (Please provide a name and number to contact if CQC requires further information regarding this form)	Name: Telephone:

Patient's date of birth: (dd/mm/yyyy)	

Gender:	**Male:** ☐	**Female:** ☐

Date of examination: (dd/mm/yyyy)	

Date patient was first detained in this period of detention or date of SCT: (dd/mm/yyyy)	

Current section:	

Date statutory certificate was last given by a registered medical practitioner appointed for the purposes of Part IV of the Act: (dd/mm/yyyy)	(Please provide a copy of the statutory certificate with this form)
Date statutory certificate expires if applicable: (dd/mm/yyyy)	

Please indicate whether certificate is for ECT or medication:	Please tick one box: **Medication:** ☐ **ECT:** ☐

Describe the treatment given:		
a) Please state present medication by drug name, route and dosage		
Drug name:	**Route:**	**Dosage:**
b) Number of ECTs given:		

Please describe the progress made:

Please delete a) or b) below as appropriate:

a) **I intend to continue the treatment as authorised.**

b) **The patient is now consenting to the treatment and I have completed a statutory form to indicate this, a copy of which is enclosed with this report. Completion of this form is taken to cancel any previous SOAD certificate. (Not applicable for SCT patients.)**

Signature of approved clinician in charge of treatment		**Date:**
Name of approved clinician in charge of treatment	(Please use capital letters)	

Mental Health Act 1983 – Review of Treatment, Section 61

Notes to help you complete form

1. Sections 58 and 58A relate to treatment requiring consent or a second opinion.
2. Section 61 provides for reports to be given in relation to treatments given under Section 57, 58, 58A or 62A. This form does not relate to Section 57 treatments. You should complete a separate form for these treatments.
3. This form is issued by the Care Quality Commission (CQC) and notifies:
   a. Health authorities
   b. NHS trusts, and
   c. Mental health nursing homes, registered to take detained patients

   of the arrangements for reports to be given by the approved clinician in charge of a patient's treatment under Section 61 of the Mental Health Act 1983. Please ensure that you provide a copy of the current statutory certificate with the completed form.
4. Section 61 provides that where a patient is given treatment in accordance with Section 57(2) or Section 58(3)(b), 58A (4) or (5) or 62A (i.e. where a treatment plan has been authorised by a doctor appointed by CQC), the approved clinician in charge of the patient's treatment must give CQC a report on the treatment and the patient's condition:
   a. on the next and subsequent occasions that the authority for the patient's detention is renewed under Section 20(3), 20A(4) or 21B(2);
   b. at any other time if so required by CQC, and
   c. in the case of patients subject to a restriction order, at the end of the first six months, if treatment began during this period, and subsequently on each occasion that the responsible clinician is statutorily required to report to the Secretary of State.
5. **Unless the treatment was initially authorised on Form T3, T5 and T6, a report is not required when the treatment has been given after the approved clinician has certified on Form T2 that the patient is capable of understanding the nature, purpose and likely effects of the treatment and has consented to it.**
6. When a report has been given to CQC, as required by Section 61, permission to continue treatment as authorised may be assumed to be given unless CQC gives notice of the withdrawal of the statutory form in use at the time. If such notice is given, a further certificate will be required before treatment may be continued, except for urgent treatment given under the provisions of Section 62 or 64.
7. Please issue a copy of this document to the patient on completion.
8. Guidance on reviews of treatment can be found in paragraphs 24.72 to 24.76 of the Code of Practice.
9. Please send your completed forms to:

   CQC Mental Health Act, Citygate, Gallowgate, Newcastle upon Tyne, NE1 4PA

   Tel: 03000 616161 (press option 1 when prompted), **Fax: 0115 873 6251.**

Information Note for Nurses Administrating Medication for Mental Disorder under the Mental Health Act

If the rights and interests of patients are to be protected, it is essential that nurses, and other mental health practitioners, understand the consent to treatment provisions of the Mental Health Act 1983 ('MHA 1983'), and in particular, of section 58. Any nurse who administers medicine for mental disorder to a patient detained under the Mental Health Act must be satisfied that there is legal authority for him/her to do so.

Three Month Rule
In the first three months of a patient's detention a doctor may prescribe and a nurse may administer medication for mental disorder, even if the patient refuses consent or is incapable of giving it except for ECT. This does not apply to patients on short term detentions or s.35.

After three months, medicine for mental disorder may be administered to a patient either with his/her capable consent or, if s/he withholds such consent or is incapable of giving it, if the giving of the medicine is authorised by a second opinion appointed doctor ('SOAD'). A patient's capable consent to the administration of medicine should be recorded by the Approved Clinician authorising the consent on statutory Form T2. In the absence of such consent, authorisation by a SOAD should be recorded on statutory Form T3.

Type	Capacity		No Capacity
	Consenting	Refusing	
Medication	Form T2 (AC Completes)	Form T3 (SOAD)	Form T3 (SOAD)
ECT	Form T4 (AC Completes)	**Can't treat**	Form T6 (SOAD)
Medical	Treat	**Can't Treat**	MCA

Nurses Role and Responsibilities
Where a nurse administers prescribed medication to a patient who is detained under MHA 1983 and subject to the provisions of section 58, s/he should ensure that s/he is legally entitled to do so and that all legal requirements have been met.

After the end of the three-month period, the Form T2 or Form T3 will represent the legal authority to continue administering medication to a detained patient who is subject to section 58. A copy of any current Form T2 or Form T3 should be kept with the In-patients medicine chart, and nurses should refer to it when they administer to the patient any medicine for mental disorder. In the case of a patient who has been detained and receiving medicine for at least three months, it will be unlawful to administer medicine for mental disorder to him/her unless it is covered by a Form T2 or a Form T3. The only exception to this rule is in the case of urgent treatment, where MHA 1983, section 62 may apply. Where, although it is required, a Form T2 or a Form T3 has not been completed, the administration of medicine for mental disorder to a patient may constitute an assault, and therefore a civil wrong and/or a criminal offence

As a **minimum** nursing staff **must** check In-patients medicine chart for the date of entry of a prescription for the medicine, for its dose, and for the route of administration, check the date of the first administration, to ensure that the three-month period has not been exceeded, where a patient has consented to medication beyond the three-month period, ensure that a Form T2 is in place and is correctly completed, where a second opinion has been obtained, ensure that the Form T3 is in place and is correctly completed.

mental health law

Community Treatment Order
Part 4A Rules

Community Treatment Order

Community

Capacity

- **CAN'T TREAT IF PATIENT DOES NOT CONSENT**
- Can treat without certificate in first month of CTO if patient is consenting to the proposed treatment
- If patient consenting, RC to complete CTO12 to authorise ongoing treatment in community
- ECT – CTO12 only if patient consents

Lacks Capacity

- Can treat without SOAD certificate in first month as long as patient does not actively object then SOAD certificate (CTO11) needed after one month

OR

- The RC wishes to give treatment that DOESN'T conflict with an Advance Decision and an Attorney / Deputy / Court of Protection can agree to it
- If force is necessary treatment can only be provided if the patient doesn't object
- ECT – SOAD certificate always needed to authorise treatment
- If the treatment is an emergency under S64(G) this overrides advance decision but only if immediately necessary to save life or prevent serious deterioration

Recalled

- If less than one month since discharge on to CTO then no certificate is needed
- If CTO11 in place authorising treatment on recall this may be used
- If CTO11 doesn't specify treatment on recall but RC believes stopping treatment on CTO11 would cause suffering then can continue until T3 is completed, form 62A required.
- RC can complete T2 if patient capable and consenting

Revoked

- Patients original section commences again BUT
- Three month rule does not so will depend on how long they have been detained
- New T2 or T3 will need to be completed
- Section 62 may be considered while waiting for new T3
- T2 or 62A completed on recall can continue to be used if no changes to treatment plan or capacity