



**HPFT**

## Medical Treatment for Mental Disorder under the MHA Policy

Mental Health Act 1983 as amended by the  
Mental Health Act 2007

HPFT Policy

Version	5
Executive Lead	Executive Director Quality & Safety
Lead Author	MHA Operational Manager
Approved Date	06/06/2017
Approved By	Mental Health Act Quality & Policy Group
Ratified Date	06/06/2017
Ratified By	Mental Health Act Quality & Policy Group
Issue Date	28/07/2017
Expiry Date	28/02/2020
Target Audience	This Policy must be understood by anyone: <ul style="list-style-type: none"><li>• Prescribing or administrating treatment for a mental disorder and seeking consent to treatment</li><li>• Working with those subject to the provisions of the MHA, both detained and “community” patients.</li></ul>

<b>Title of document</b>	MHA Medical Treatment for Mental Disorder		
<b>Document Type</b>	Policy		
<b>Ratifying Committee</b>	Policy Panel		
<b>Version</b>	<b>Issue Date</b>	<b>Review Date</b>	<b>Lead Author</b>
5	28/07/2017	28/07/2020	MHA Operational Manager
<b>Staff need to know about this policy because (complete in 50 words)</b>	All staff must be aware of which legal authority they are using to give treatment for a mental disorder; there must be valid authority to treat all patients detained under the MHA. Any treatment given without legal authority is an assault on that patient.		
<b>Staff are encouraged to read the whole policy but I (the Author) have chosen three key messages from the document to share:</b>	<p>Anyone administering medication for a mental disorder must ensure that there is a legal authority to do so.</p> <p>All patients admitted to an in-patient unit, whether informal or detained, should be assessed for their capacity to consent to treatment.</p> <p>Where there are any doubts to the legal authority to treat a patient for their mental disorder staff should guidance as soon as possible.</p>		
<b>Summary of significant changes from previous version are:</b>	<p>T2 &amp; CTO12 form added as attachments which CQC guidance on completion, (BNF codes no longer required).</p> <p>The “capacity assessment” on PARIS is the preferred method of recording a patient’s capacity to consent to treatment.</p>		

## Contents Page

Part:		Page:
<b>Part 1</b>	<b>Preliminary Issues:</b>	
	1. Introduction	4
	2. Summary	4
	3. Objectives	4
	4. Scope	4
	5. Definitions	4
	6. Duties and Responsibilities	5
<b>Part 2</b>	<b>What needs to be done and who by:</b>	
	7. Capacity to Consent to Treatment	6
	8. Capacity to Consent: People Aged 16 or Over	6
	9. Competence to Consent to Treatment: Children under 16	6
	10. Treatment without Consent – General Points	6
	11. Interface between Part 4 and Part 4A of the Mental Health Act and Section 28 of the Mental Capacity Act 2005	7
	12. Treatments subject to Special Rules and Procedures	7
	13. HPFT Procedures for ensuring lawful medical treatment under Mental Health Act 1983	11
	14. Training	15
	15. Process for Monitoring Compliance with this document	16
	16. Embedding a culture of equality and respect	16
<b>Part 3</b>	<b>Document Control &amp; Standards Information</b>	
	17. Version Control	19
	18. Relevant Standards	19
	19. Associated Documents	19
	20. Supporting References	19
	21. Consultation	19
<b>Part 4</b>	<b>Appendices</b>	
	<b>Appendix 1</b> - Statement of Guiding principles – MHA Code of Practice	20
	<b>Appendix 2</b> - Exceptions to the normal rules on treatment and consent	21
	<b>Appendix 3</b> - Statement of Capacity and Consent to Treatment	22
	<b>Appendix 4</b> - Communication of SOAD's decision by RC	23
	<b>Appendix 5</b> - Statutory Consultee's Record of Consultation with SOAD	25
	<b>Appendix 6</b> - T2 Form	26
	<b>Appendix 7</b> - CTO12 Form	27

## **1. Introduction**

1.1. This document relates specifically to patients who are detained under the Mental Health Act 1983 as amended by the Mental Health Act 2007 (the MHA) and the treatment of their mental disorder and sets out the procedure to followed by the staff of Hertfordshire Partnership NHS Foundation Trust (the Trust).

## **2. Summary**

2.1 The MHA provides the legal framework for treatment of mental disorder and by following this policy staff members will act in accordance with the MHA, therefore ensure that the rights of patients are not compromised.

2.2 This policy should be read in conjunction with the Hertfordshire Partnership University NHS Foundation Trust Consent to Examination, Care and Treatment including Electro-Convulsive Therapy (ECT).

## **3. Objectives**

The purpose of this document is to ensure that all Trust staff are aware of what is required of them when treating a patient under the MHA for their mental disorder. In addition it outlines the procedure that should be followed by staff to ensure that statutory requirements in respect of the MHA are adhered to as well as following the Guiding Principles as specified in the MHA Code of Practice, see Appendix 1.

## **4. Scope**

- Staff prescribing or administering treatment for a mental disorder and seeking consent to treatment
- Staff working with those subject to the provisions of the MHA, both detained and “community” patients.

## **5. Definitions**

### **MEDICAL TREATMENT UNDER THE MHA:**

- The Act defines medical treatment for mental disorder as medical treatment which is for the purpose of alleviating or preventing a deterioration of a mental disorder or one or more of its symptoms or manifestations.
- In the Act, “medical treatment” includes nursing, psychological intervention and specialist mental health habilitation, rehabilitation and care.
- This includes treatment of physical health problems only to the extent that such treatment is part of, or ancillary to, treatment for mental disorder (e.g. treating wounds self-inflicted as a result of mental disorder). Otherwise, the Act does not regulate medical treatment for physical health problems.

### **CONSENT:**

- 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 to consent does not consent to 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.
- 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.
- 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.

## **6. Duties and Responsibilities**

As the issue of consent to treatment is of fundamental importance everyone involved in the medical treatment of mental disorder should be familiar with the provisions of Part 4 and Part 4A of the Mental Health Act.

The Trust is ensuring through this document that all staff are aware of their role in relation to treatment of mental disorders under the MHA.

It is the responsibility of the organisation's operational management to ensure policy distribution, implementation and compliance throughout the organisation.

It is the responsibility of individual staff working with patients to ensure that they are treating patients within the scope of the MHA.

The Chief Executive is ultimately responsible for ensuring that the Trust meets its responsibilities with regard to the delivery of services. The lead Director for this policy is the Executive Director, Quality & Safety.

The Mental Health Act Quality and Policy Group meeting agree this policy and any changes that need to be added as legislation changes.

## 7. CAPACITY TO CONSENT TO TREATMENT:

7.1. The Act frequently requires healthcare professionals to determine:

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

7.2. Everyone is assumed to have capacity unless it is established that they lack capacity. People are not to be treated as unable to make a decision unless all practicable steps to help them do so have been taken without success. People are not to be treated as unable to make a decision merely because they make an unwise decision.

## 8. CAPACITY TO CONSENT: PEOPLE AGED 16 OR OVER:

8.1 For people aged 16 or over, capacity to consent is defined by the Mental Capacity Act 2005 (MCA). The principles of the MCA state that:

- People must be assumed to have capacity unless it is established that they lack capacity.
- People are not to be treated as unable to make a decision unless all practicable steps to help them do so have been taken without success; and
- People are not to be treated as unable to make a decision merely because they make an unwise decision.

## 9. COMPETENCE TO CONSENT TO TREATMENT: CHILDREN UNDER 16

9.1 The MCA does not apply to medical treatment for children under 16. Children who have sufficient understanding and intelligence to enable them fully to understand what is involved in a proposed treatment are considered to be competent (or “Gillick competent”) to consent to it. The common law deals with cases where children are not capable of consenting; please refer any queries to your local MHA office.

## 10. TREATMENT WITHOUT CONSENT – GENERAL POINTS:

10.1 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 records, as should the treating clinician’s assessment of the patient’s capacity to consent.

10.2 An initial assessment of capacity to consent to treatment must be done within the first 7 days of admission under section to all units, this includes transfers from one unit to another.

**There is a dedicated capacity to consent to treatment care documents on PARIS, this should be used as a preference for recording capacity to enable accurate monitoring of compliance.**

- 10.3 Clinicians authorising or administering treatment without consent under the Mental Health Act are performing a function of a public nature and are therefore subject to the provisions of the Human Rights Act 1998. It is unlawful for them to act in a way that is incompatible with the patients' rights as set out in the European Convention of Human Rights. Adherence to the requirements of the Mental Health Act and good clinical practice should ensure that there is no incompatibility with Human Rights legislation. If clinicians have concerns about a treatment plan then they should seek legal advice from the Trust.

## **11. INTERFACE BETWEEN PART 4 AND PART 4A OF THE MHA AND SECTION 28 OF THE MENTAL CAPACITY ACT 2005:**

- 11.1 Decisions about medical treatment (non-mental disorder treatment) for people aged 16 or over that lack capacity to consent to treatment are governed by the Mental Capacity Act even though they may be detained under the Mental Health Act. There are however several exceptions that apply only to medical treatment for mental disorder. The MHA Code of Practice provides a useful table that explains this. See appendix 2.

## **12. TREATMENTS SUBJECT TO SPECIAL RULES AND PROCEDURES:**

### **12.1 Treatments requiring consent and a second opinion under Section 57**

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

Where section 57 applies, these treatments can be given **only if all three of the following requirements are met:**

- the patient consents to the treatment;
- a Second Opinion Appointed Doctor (SOAD) (and two other people appointed by the Commission) certify that the patient has the capacity to consent and has done so; and
- the SOAD also certifies that it is appropriate for the treatment to be given to the patient.

Before asking the Commission to implement the process of issuing a certificate, referring professionals should personally satisfy themselves that the patient is capable of giving valid consent and is willing to consent. The restrictions and procedures imposed by section 57 should be explained to the patient, and it should be made clear to the patient that their willingness to receive the treatment does not necessarily mean that the treatment will be given.

### **12.2 Treatments requiring consent or a second opinion under Section 58**

Section 58 applies to the administration of medication for mental disorder, this applies only to patients detained under the MHA. It only applies once three months have passed from the day on which any form of medication for mental disorder was first administered to the patient during the patient's current period of detention under the Act ("the three-month period").

The patient's current period of detention continues even if the section under which the patient is detained changes. It also includes any time that the patient has spent on a Community Treatment Order.

Medication administered as part of electro-convulsive therapy (ECT) is covered by Section 58A.

Patients cannot be given medication to which section 58 applies unless:

- the Approved Clinician in charge of the treatment, or a SOAD, certifies that the patient has the capacity to consent and has done so; **or**
- a SOAD certifies that the treatment is appropriate and either that:
  - the patient does not have the capacity to consent; or
  - the patient has the capacity to consent but has refused to do so.

MHA Managers are required to ensure that systems are in place to remind both the clinician in charge of the medication and the patient at **least four weeks before the expiry of the three-month period** of when consent is required. The Mental Health Act departments are responsible for ensuring that this happens within the Trust.

### **12.3 Electro-convulsive therapy (ECT) under Section 58A (Please refer to HPFT ECT policy)**

Section 58A applies to ECT and to medication administered as part of ECT. It applies to detained patients and to **all** patients aged under 18.

The key differences from Section 58 are that:

- patients who have the capacity to consent may not be given treatment under Section 58A unless they do in fact consent;
- no patient aged under 18 can be given treatment under Section 58A unless a SOAD has certified that the treatment is appropriate; and
- there is no initial three-month period during which a certificate is not needed (even for the medication administered as part of the ECT).

A patient who has capacity to consent may not be given treatment under section 58A unless the clinician in charge, or a SOAD, has certified that the patient has the capacity to consent and has done so. If the patient is under 18, only a SOAD may give the certificate, and the SOAD must also certify that the treatment is appropriate.

A patient who lacks the capacity to consent may not be given treatment under section 58A unless a SOAD certifies that the patient lacks capacity to consent and that:

- the treatment is appropriate;
- no valid and applicable advance decision has been made by the patient under the Mental Capacity Act 2005 (MCA) refusing the treatment;
- no suitably authorised attorney or deputy objects to the treatment on the patient's behalf; and
- the treatment would not conflict with a decision of the Court of Protection which prevents the treatment being given.

In all cases, SOADs should indicate on the certificate the maximum number of administrations of ECT which it approves.

For children and young people under 18, a SOAD certificate by itself is not sufficient to authorise the treatment, unless they are detained. Clinicians must also have the patient's own consent or some other legal authority, just as they would if Section 58A did not exist. (Please refer to Chapter 36 of the Code of Practice – Children and young people under the age of 18.)

Patients of all ages who are to be treated with ECT should be given written information before their treatment starts which helps them to understand and remember, both during and after the course of ECT, the advice given about its nature, purpose and likely effects.

#### **12.4. Treatment of CTO Patients not recalled to hospital under Part 4A**

The treatment of CTO patients, who have not been recalled to hospital, (including patients who are in hospital on a voluntary basis not having been recalled), is dealt with under Part 4A of the Act. The Code refers to them for convenience as Part 4A patients and provides detailed guidance on their treatment in Chapters 23 and 24. HPFT policy on CTO also covers these issues and the procedures that apply.

There are different rules for Part 4A patients who have capacity to consent to specified treatments and for those that do not. Anyone that has capacity can only be given treatment in the community that they consent to. Even in an emergency, they can only be treated by recalling them to hospital. However, recall will not be appropriate unless the patient meets the criteria for recall.

The Part 4A rules recognise and incorporate aspects of the Mental Capacity Act 2005 (MCA) including Advance Decisions and persons appointed to make surrogate decisions such as an attorney under a Lasting Power of Attorney (personal welfare) or a court appointed deputy. It should be noted that the MCA may not generally be used to give CTO patients any treatment for mental disorder other than where an attorney, deputy or Court of Protection order provides consent. It may still be appropriate to rely on the MCA for the provision of treatments for physical problems for a CTO patient.

A Part 4A certificate is needed for:

- Treatments which would require a certificate under Section 58 if the patient were detained – i.e. medication after an initial three- month period; and
- ECT and any other types of treatment to which Section 58A applies (“Section 58A type treatment”)

However, a certificate is not required for Section 58 type treatment during the first month following a patient's discharge from detention onto CTO (even if the 3 month period in Section 58 has already expired or expires during that first month). Once this period has passed the treatment must be approved by a SOAD using form CTO11 or if the patient has the capacity to consent to treatment and is consenting the Responsible Clinician should complete a CTO12.

#### **CTO patients recalled to hospital – exceptions to the need for certificates under Sections 58 or 58A**

In general, CTO patients recalled to hospital are subject to Section 58 and 58A in the same way as other detained patients. There are however three exceptions as follows:

- A certificate under Section 58 is not needed for medication if less than one month has passed since the patient was discharged from hospital and became an CTO patient.
- A certificate is not needed under either Section 58 or 58A if the treatment in question is already explicitly authorised for administration on recall on the patients Part 4A certificate (CTO11), and
- Treatment that was already being given on the basis of a Part 4A certificate may be continued, even though it is not authorised for administration on recall, if the approved clinician in charge of the treatment considers that discontinuing it would cause the patient serious suffering.

As a result, Second Opinion Appointed Doctors (SOAD) giving Part 4A certificates need to consider what (if any) treatments to approve should the patient be recalled to hospital. They must also decide whether to impose any conditions on that approval. Unless they specify otherwise, the certificate will authorise the treatment even if the patient has capacity to refuse it (unless it is a Section 58A type treatment).

The potential advantage of authorising treatments to be given on recall to hospital is that it will enable such treatments to be given quickly without the need to obtain a new certificate. However, SOADs should do so only where they believe they have sufficient information on which properly to make such a judgement.

The exceptions to the requirement to have a certificate under Section 58 or 58A set out above continue to apply if the patient's CTO is revoked, but only while steps are taken to comply with Section 58 (where relevant). Responsible Clinicians should ensure that steps are put in hand to obtain a new SOAD certificate under Section 58 or 58A, if one is needed, as soon as they revoke the CTO.

It is not good practice on recall, to rely on a certificate that was issued while a patient was detained prior to going onto CTO even if it remains technically valid. A new certificate should be obtained.

#### **12.5. Urgent cases where certificates are not required (Section 62, 64B, 64C and 64E)**

Sections 57, 58 and 58A do not apply in urgent cases where treatment is immediately necessary (Section 62). Similarly, a Part 4A certificate is not required in urgent cases where the treatment is immediately necessary (Sections 64B, 64C and 64E).

This applies only if the treatment in question is immediately necessary to:

- save the patient's life;
- prevent a serious deterioration of the patient's condition, (and the treatment does not have unfavourable physical or psychological consequences which cannot be reversed);

- alleviate serious suffering by the patient, (and the treatment does not have unfavourable physical or psychological consequences which cannot be reversed and does not entail a 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 a significant physical hazard).

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

### **13. HPFT PROCEDURES FOR ENSURING LAWFUL MEDICAL TREATMENT UNDER MHA 1983:**

In all cases, a copy of the relevant form authorising treatment should be attached to the medication chart and a copy must be on the EPR. **If there is no valid authority attached to eligible medication charts, nursing staff should not administer medication. They should immediately bring the matter to the attention of the Team Leader and notify the MHA office.**

Staff administering treatment authorised under any of the regimes listed below have a continuing responsibility to satisfy themselves that it is still an appropriate treatment given the circumstances prevailing at the time when they are preparing to administer it.

#### **13.1. Part 4 Detained Patients – Section 58/59 and ECT (58A)**

3 weeks prior to the end of the three-month period the Mental Health Act (MHA) office will send notification of the consent due date to the Responsible Clinician (RC) and the ward.

The ward staff will record the due date in the ward diary to ensure that consent is discussed in ward round well before it falls due and in good time to request a SOAD if necessary.

#### **13.2. The Consenting Patient**

The RC must first assess the patient's capacity to consent to the proposed treatment. S/he must then give information to the patient as detailed in the paragraphs relating to "Consent" above.

If the patient still consents to the treatment following receipt of this information the Statement of Capacity & Consent Form (Appendix 3) and Form T2 should be completed and the original forms sent to the MHA office.

The T2 form should clearly indicate:

- All proposed drugs including any PRN medication;
- The drugs should be listed by class ensuring that the number of drugs authorised in each class is indicated;
- The class of drug as described in the British National Formulary;
- All dosages within BNF limits (if the dosage is above BNF limits a SOAD should be requested);

- The route of administration for each drug or class of drug proposed.

On receipt of the Form T2, the MHA office will scrutinise it and request any necessary amendments. MHA office staff will scan it to the EPR and advise the ward that it is available to be printed off. In those locations where there is no EPR, the MHA office will forward two copies of the form to the ward.

A new Form T2 should be completed for consenting patients with capacity on the following occasions:

- after 3 months of continuous detention;
- when there is a change of medication;
- when there is a change of permanent RC;
- when there is a renewal of detention;
- when the patient reinstates consent after withdrawing it;
- when the patient regains capacity to consent after a period of incapacity

### **13.3. Patient refusing to consent or who lacks the capacity to consent**

If the patient is not consenting to the treatment proposed or is incapable of giving consent, the MHA office should be contacted by the treating team to request a SOAD as soon as this becomes known. It is important to note that it takes anywhere between five working days and two weeks for a SOAD to attend and no medication can be given to the patient without SOAD approval or a Section 62 emergency treatment certificate signed by the RC once the due date for consent has passed.

The SOAD will contact the ward to arrange a suitable time to visit. Copies of all the statutory documents will be made available to the SOAD.

The SOAD will need to consult the following statutory consultees:

- a qualified nurse who has been professionally involved with the patient's care.
- A member of staff who has direct knowledge of the patient in his/her professional capacity and is neither a nurse nor a doctor, (for example a social worker, occupational therapist, psychologist or psychotherapist).

The ward should ensure that one person from the second group will be available to speak to the SOAD, by telephone if necessary, on the day of the visit.

The SOAD, if in agreement with the proposed plan of treatment, will complete a Form T3. This should be forwarded by the ward to the MHA office.

The MHA office will scrutinise it and request any necessary amendments. MHA office staff will scan it to the EPR and advise the ward that it is available to be printed off. In those locations where there is no EPR, the MHA office will forward two copies of the form to the ward.

The RC will complete the Communication of SOAD's Decision by RC form ("the Wooder Form" Appendix 4) which should then be returned to the MHA office to be scanned to the EPR. The ward will be advised to print off a copy for filing in the

patient's notes together with Form T3. In those locations where there is no EPR, the MHA office will forward a copy to the ward.

The MHA office will send a copy of the Statutory Consultee's Record of Consultation (Appendix 5) to both consultees for completion. It should be returned to the MHA office for scanning to the EPR. The ward will be advised to print off a copy.

A new Form T3 should be completed for an incapable or refusing patient on the following occasions:

- after 3 months of continuous detention;
- when there is a change of medication;
- when there is a renewal of detention;
- when the patient withdraws consent;
- when the patient loses capacity to consent ;
- when a SOAD-specified time limit for any treatment expires;
- when a capacitated patient was certified by a SOAD as refusing treatment, but has now lost capacity

#### **13.4. Electro-convulsive therapy (ECT) under Section 58A**

##### **A. The consenting patient**

The RC must first be sure that the patient has the capacity to consent to ECT. If the patient is over the age of 18, the RC will complete a Form T4 and a Statement of Capacity & Consent Form (Appendix 3) and send the original forms to the MHA office where they will be scanned to the EPR; the ward will then be notified that they are available to be printed off. In those locations where there is no EPR, the MHA office will forward copies to the ward in the usual way.

##### **B. The patient who lacks capacity**

A patient without the capacity to consent can not be given ECT without a SOAD certificate stating that the following conditions apply:

- the treatment is appropriate;
- there is no valid advance decision refusing ECT;
- Page 14
- there is no suitably authorised attorney or deputy who objects to the treatment on the patient's behalf;
- the treatment would not conflict with a decision of the Court of Protection which prevents the treatment being given.

The procedure is as explained in paragraph 13.5, except, of course, that the form in this case will be Form T6.

## C. Persons under the age of 18

**Detained patients** under the age of 18: a SOAD must complete Form T6 certifying that the patient has capacity to consent and has done so AND that the treatment is appropriate. The RC does not have legal authority to authorise ECT for a patient in this age-group.

**Informal patients** under the age of 18 must have capacity and consent to the treatment. The RC and patient must therefore complete a Certificate of Capacity and Consent. In addition to this, a SOAD must complete Form T5.

### 13.5 Part 4A CTO patients – Section 58 and 58A

#### A. Treatment for Community Treatment Order patients: Procedure

Contrary to the name of the order, Community Treatment Order, (CTO), a patient subject to a CTO), cannot be forced to have treatment in the community.

The MHA does not give any authority to treat for a patient in the community for Mental Disorder unless the treatment is of urgent necessity.

Within one month of the effective date of the CTO there should either be a CTO11 or CTO12 in place. Although neither of these certificates gives authority to give treatment to a patient in the community they confirm that the treatment is appropriate.

For those lacking capacity or not consenting the treatment a CTO11 should be completed by a Second Opinion Appointed Doctor, (SOAD). The CTO11 can include authorisation by the SOAD for treatment on recall, if this section of the CTO11 is completed it means that there is no requirement to complete any further documentation to authorise treatment if a patient is recalled.

For those with capacity and consenting a CTO12 should be completed by the Responsible Clinician.

The original CTO11 or CTO12 should be sent to the Mental Health Act office where it will be scanned to the EPR. In locations where there is no EPR, a copy should be placed in the patient's notes.

The MHA office will, upon receipt of the individual CTO, request either the completion of a SOAD request form or a CTO12 from the RC.

The SOAD request form should include:

- the proposed location of the interview between patient and SOAD;
- the names and contact details of the two proposed consultees professionally concerned with the patient;
- the name and contact details of the RC.

The request for the SOAD is made via the internet by the MHA office, a copy of the request will be scanned to the EPR or placed in the patient's notes.

## B. Procedure on Recall

When a patient has been recalled, if one month or more has passed since the patient's discharge onto a CTO, it will be necessary to obtain either the patient's consent to treat them if they have the capacity to do so, (unless the treatment in question is already explicitly authorised on the patient's CTO11, (Part 4A certificate) for administration on recall) otherwise treatment can only be given if it is of urgent necessity.

## C. Procedure on Revocation

If the treatment is that specified on Form CTO11, the medication may lawfully be administered until a new Form T2/T3 can be completed.

If the patient has capacity and consents, the RC, the ward and the MHA office will follow the procedure specified above for consenting patients.

If the patient lacks capacity or refuses consent, the RC, the ward and the MHA office will follow the procedure specified in paragraph 13.3 for those patients that lack capacity or refuse to consent.

## 14. Training and Awareness

Course	For	Renewal Period	Delivery Mode
Mental Health Act Overview	All staff dealing directly with patients subject to the Mental Health Act.	Every 3 years	Taught class
		On-line training	E-learning

## 15. Process for monitoring compliance with this document

Key process for which compliance or effectiveness is being monitored	Monitoring method (i.e. audit, report, on-going committee review, survey etc.)	Job title and department of person responsible for leading the monitoring	Frequency of the monitoring activity	Monitoring Committee responsible for receiving the monitoring report/audit results etc.	Committee responsible for ensuring that action plans are completed
Nursing staff to ensure that patients are treated for Mental Disorder in accordance with MHA	Compliance check against statutory requirements of MHA	Team Leaders	Monthly	Mental Health Act Quality and Policy Group	QRMC
RC's to ensure adherence to requirement to assess capacity within	Audit of 7 day capacity assessment	MHA Operational Manager	Quarterly	Mental Health Act Quality and Policy Group	QRMC
RCs and clinical team to ensure completion of statutory forms within required time scales	Audit of statutory forms	MHA Quality Manager		Mental Health Act Quality and Policy Group	QRMC

## 16. Embedding a culture of equality and respect

The Trust promotes fairness and respect in relation to the treatment, care and support of service users, carers and staff.

Respect means ensuring that the particular needs of 'protected groups' are upheld at all times and individually assessed on entry to the service. This includes the needs of people based on their age, disability, ethnicity, gender, gender reassignment status, relationship status, religion or belief, sexual orientation and in some instances, pregnancy and maternity.

Working in this way builds a culture where service users can flourish and be fully involved in their care and where staff and carers receive appropriate support. Where discrimination, inappropriate behaviour or some other barrier occurs, the Trust expects the full cooperation of staff in addressing and recording these issues through appropriate Trust processes.

Access to and provision of services must therefore take full account of needs relating to all protected groups listed above and care and support for service users, carers and staff should be planned that takes into account individual needs. Where staff need further information regarding these groups, they should speak to their manager or a member of the Trust Inclusion & Engagement team.

Where service users and carers experience barriers to accessing services, the Trust is required to take appropriate remedial action.

<p><b>Service user, carer and/or staff access needs</b> (including disability)</p>	<p>This should specifically address how the needs of people with disabilities and differing communication needs are given appropriate adjustments within the service/process/workplace to facilitate better access. Consider issues such as interpreters, location of services, access to physical and sensory impairment etc taking into account how the service/process would cope with any demands.</p> <p>For staffing it should access to the workplace as well as issues such as reasonable adjustments.</p> <p>This should also reflect how potential for inequality is minimised.</p>
<p><b>Involvement</b></p>	<p>This should specify the opportunities that are made available within the service/process for service users and carers to be involved in making contributions to the Trust and development of services.</p> <p>This should also reflect how potential for inequality is minimised.</p>
<p><b>Relationships &amp; Sexual Orientation</b></p>	<p>How is the service/process taking account of the needs of people in different relationships as well as those in none? This should address issues around sexual orientation (and any barriers for people around their orientation) as well as any relevant issues re: nearest relatives and family carers.</p> <p>For staff this may also include an awareness of the needs of LGB staff in workforce and an understanding of how an open workplace culture improves the experience for staff working in the Trust.</p> <p>This should also reflect how potential for inequality is minimised.</p>
<p><b>Culture &amp; Ethnicity</b></p>	<p>What is specifically in place to ensure that ethnic minority service users will receive a cultural appropriate experience from the service/process? This should include issues of language, diet, hygiene and personal care etc.</p> <p>This should also reflect how potential for inequality is minimised.</p>
<p><b>Spirituality</b></p>	<p>How are issues of spirituality assured for the service user or carer where necessary? This should focus around the HOPE model for:</p> <p><b>H</b> – Sources of Hope  <b>O</b> – Needs re: organised religion  <b>P</b> – Personal belief structure (including non-faith)  <b>E</b> – Effects on care of practicing spiritual beliefs. (positive and negative)</p> <p>This could include how chaplains and spiritual care visitors are used in the service/process (where applicable)</p> <p>This should also reflect how potential for inequality is minimised.</p>
<p><b>Age</b></p>	<p>Does the service/process take account of the needs of different age groups? There should be specific references that identify how any</p>

	<p>particular groups are favoured for targeted support.</p> <p>This should also reflect how potential for inequality is minimised.</p>
<b>Gender &amp; Gender Reassignment</b>	<p>This should specifically look at how the service/process provides equal treatment for men and women or – where justified – one group is favoured (e.g. single sex accommodation). All services/processes should include detail on how the needs of transgender service users and carers are acknowledged and what support is offered. As well as links to documentation supporting staff in relation to gender.</p> <p>This should also reflect how potential for inequality is minimised.</p>
<b>Advancing equality of opportunity</b>	<p>General information on how the service/process will develop in a way that incorporates equality of opportunity through continual feedback and evaluation of the service/process.</p>

**17. Version Control**

<b>Version</b>	<b>Date of Issue</b>	<b>Author</b>	<b>Status</b>	<b>Comment</b>
1	October 08	Directorate Manager (Mental Health Legislation)	Superseded	
2	October 08	Directorate Manager (Mental Health Legislation)	Superseded	Added
3	September 09	Directorate Manager (Mental Health Legislation)	Superseded	Updated to take account of DH Reference guide on consent. Service user and carer comments added
4	5 <sup>th</sup> December 13	Directorate Manager (Mental Health Legislation)	Superseded	Updated – put into new Trust format
5	June 2017	MHA Operational Manager	Current	Full review, change to new Trust template

**18. Relevant Standards**

**a) Mental Health Act 1983 as amended by MHA 2007**

**b) Equality and RESPECT:** The Trust operates a policy of fairness and RESPECT in relation to the treatment and care of service users and carers; and support for staff.

**c) Procedural document Management System 2017**

**19. Associated Documents**

General Consent to Treatment Policy

Consent to Examination, Care and Treatment including ECT Guidance and Procedure

Mental Capacity Act Policy

MCA Advance Decisions to Refuse Treatment and Advance Statements Policy

Community Treatment Order Policy

**20. Supporting References**

Mental Health Act Manual , Richard Jones

The Mental Health Act Code of Practice 2015

Dept of Health Reference Guide to consent for examination or Treatment

**21. Consultation**

Medical Director	MHA Operational Manager
Directorate Manager MHA Legislation	MHA Quality Managers

**Statement Of Guiding Principles – MHA Code Of Practice****Purpose principle**

Decisions under the Act must be taken with a view to minimising the undesirable effects of mental disorder, by maximising the safety and wellbeing (mental and physical) of patients, promoting their recovery and protecting other people from harm.

**Least restriction principle**

People taking action without a patient's consent must attempt to keep to a minimum the restrictions they impose on the patient's liberty, having regard to the purpose for which the restrictions are imposed.

**Respect principle**

People taking decisions under the Act must recognise and respect the diverse needs, values and circumstances of each patient, including their race, religion, culture, gender, age, sexual orientation and any disability. They must consider the patient's views, wishes and feelings (whether expressed at the time or in advance), so far as they are reasonably ascertainable, and follow those wishes wherever practicable and consistent with the purpose of the decision. There must be no unlawful discrimination.

**Participation principle**

Patients must be given the opportunity to be involved, as far as is practicable in the circumstances, in planning, developing and reviewing their own treatment and care to help ensure that it is delivered in a way that is as appropriate and effective for them as possible.

The involvement of carers, family members and other people who have an interest in the patient's welfare should be encouraged (unless there are particular reasons to the contrary) and their views taken seriously.

**Effectiveness, efficiency and equity principle**

People taking decisions under the Act must seek to use the resources available to them and to patients in the most effective, efficient and equitable way, to meet the needs of patients and achieve the purpose for which the decision was taken.

**Using the principles**

All decisions must, of course, be lawful and informed by good professional practice. Lawfulness necessarily includes compliance with the Human Rights Act 1998.

The principles inform decisions, they do not determine them. Although all the principles must inform every decision made under the Act, the weight given to each principle in reaching a particular decision will depend on the context.

That is not to say that in making a decision any of the principles should be disregarded. It is rather that the principles as a whole need to be balanced in different ways according to the particular circumstances of each individual decision.

**Medical treatment of patients subject to the Mental Health Act –  
exceptions to the normal rules on treatment and consent in the Mental Capacity Act  
2005**

<b>Situation</b>	<b>Exceptions to the normal rules in the MCA</b>
Section 57 treatment (neurosurgery for mental disorder etc)	The MCA may not be used to give anyone treatment to which section 57 applies
Section 58A treatment (ECT and related medication)	The MCA may not be used to give detained patients ECT or any other treatment to which section 58A applies.
Treatment for detained patients	The MCA may not be used to give detained patients any other medical treatment for mental disorder. Treatment must be given in accordance with Part 4 of the Mental Health Act instead.
Treatment for CTO patients 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 Mental Health 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. 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 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 patients behalf; or • consent to or refuse any other treatment on behalf of detained patients. 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, also refuse treatment on behalf of those patients



## STATEMENT OF CAPACITY AND CONSENT TO TREATMENT

Patients Name: ..... Date of Birth: .....

Section: ..... Unit/Ward: .....

**Responsible Clinician:** Dr .....

I have assessed the above named patient and am satisfied that, at this time:

he/she has the capacity and is consenting\*/has capacity and is refusing\*/does not have the capacity\* to consent to treatment (Code of Practice 16.13)

I have/have not\* explained to him/her the nature of the proposed treatment plan, likely effects and possible risks of that treatment, including the likelihood of its success and any alternatives to it. (Code of Practice 15.15).

- Information has been given in a language/way that he/she can understand
- He/She is able to retain this information
- Has used this information as part of their decision making process
- Has communicated their decision to me.

Signature:..... Date:.....

*\*delete the phrase which does not apply*

### Patient:

Dr. .... has explained my proposed treatment plan and has given me all the information stated above. I have consented to that treatment plan at this time.

I understand that I have the right to withdraw my consent at any time and that

Dr. .... would then have to obtain a second opinion in order to continue with the proposed treatment

Signature:..... Date:.....

***N.B. ONE COPY TO BE KEPT WITH A COPY T2/T4 ATTACHED TO THE MEDICATION CHART. THE ORIGINAL TO BE SENT TO THE MENTAL HEALTH ACT ADMINISTRATOR FOR INCLUSION, WITH THE T2/T4 FORM, ON THE ELECTRONIC PATIENT RECORD (CARENOTES).***

**HERTFORDSHIRE PARTNERSHIP NHS UNIVERSITY FOUNDATION TRUST  
COMMUNICATION OF SOAD's DECISION BY RC  
(RC's AND THE EFFECT OF R (ON THE APPLICATION OF WOODER) V DR FEGGETTER AND  
THE MENTAL HEALTH ACT COMMISSION**

<b>NAME OF RC:</b>	<b>NAME OF PATIENT:</b>
<b>RC to complete either A, B or C</b>	

**A.** I confirm that I have communicated the results of the SOAD visit for the purposes of a Second Opinion under Section 58/58A of the Mental Health Act 1983. **I have** explained the reasons for the decision supplied by the SOAD and **have** given a copy of the written reason to the above name patient.

**Signed:** ..... **(RC) Date:** .....

**B.** I confirm that **I have** communicated the results of the SOAD visit for the purposes of a Second Opinion under Section 58/58A of the Mental Health Act 1983. However, **I have not** explained the reasons for the decision supplied by the SOAD **nor** provided a copy of the written reasons to the above patient(due to) the following reasons:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Signed:** ..... **(RC) Date:** .....

**C.** The decision **could not** be communicated because the patient lacks the capacity to understand. This is expected to be a long term condition.

**Signed** ..... **(RC) Date:** .....

Once completed please return to the MHA Office

## **HERTFORDSHIRE PARTNERSHIP NHS UNIVERSITY FOUNDATION TRUST**

### **RC'S AND THE EFFECT OF R (ON THE APPLICATION OF WOODER) V DR FEGGETTER AND THE MENTAL HEALTH ACT COMMISSION**

The guidance issued for Responsible Clinicians by the Care Quality Commission following the above case states:

“RCs should make a record of their actions in relation to providing patients with the reasons supplied by SOADs.” The Court determined that there was a duty to disclose SOADs’ reasons to patients, although there would be an exemption from the general duty in line with current data protection legislation.

This form must be completed by the RC each time the SOADs reasons are communicated or not as the case may be.

#### **Procedure:**

1. All requests for a SOAD will be made through your MHA Office.
2. The Mental Health Act Administrator will ensure that the Ward Manager is reminded of the procedure and a copy of the SOAD Report Form is available on the ward should the SOAD want to use this.
3. The SOAD should complete the SOAD Report Form or make a separate note of his reasons appropriately on another piece of paper.
4. The SOAD Report Form will be given to the MHA Office by the SOAD. The RC will make his/her decision with regard to communication of the reasons for the decision.
5. The RC will then complete either A, B or C of this Form and return it to the Mental Health Act Office.
6. The Mental Health Act Administrator will then ensure this form is returned to the case notes and filed with the Section papers.

#### **NB.**

##### **For RC’s completing Part A of this form**

When completing Part A please remember to give a copy of the SOAD Report Form/CTO11 form to the patient.

##### **For RC’s completing Part B of this form**

Please state the reasons for withholding this information. An example would be because disclosure of this information would be likely to cause serious harm to the physical or mental health of the patient or any other person.

##### **For RC’s completing Part C of this form**

This section should only be completed when the patient lacks the capacity to understand.



**Form T2** Regulation 27(2)

**Section 58(3)(a)—certificate of consent to treatment**

*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 the phrase which does not apply)* certify that

*(PRINT full name and address of patient)*

(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.)

**\*All drugs must have the route & maximum dosage specified, also if regular or PRN. The maximum no. of simultaneous medications in each category must be stated. Please see examples below.**

*(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

/ /

**\* Examples**

*One oral antidepressant drug within BNF advisory maximum dose limits.*

*Olanzapine, oral antipsychotic, maximum 15mg daily.*

*Clonazepam 1mg orally as required, maximum 4mg daily, for adjunct management of agitation.*

*Quetiapine, oral antipsychotic, within BNF advisory maximum dose limits.*

**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)**

I [PRINT full name and address]

am the approved clinician in charge of the treatment of

[PRINT full name and address of the 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]

*\*All drugs must have the route & maximum dosage specified, also if regular or PRN. The **maximum no. of simultaneous medications in each category** must be stated. Please see examples below.*

**Signed**

**Date**

/ /

*\* Examples*

*One oral antidepressant drug within BNF advisory maximum dose limits.*

*Olanzapine, oral antipsychotic, maximum 15mg daily.*

*Clonazepam 1mg orally as required, maximum 4mg daily, for adjunct management of agitation.*

*Quetiapine, oral antipsychotic, within BNF advisory maximum dose limits.*

	<i>we are...</i>	<i>you feel...</i>
<b>Our Values</b>	<b>Welcoming</b>	✔ Valued as an individual
	<b>Kind</b>	✔ Cared for
	<b>Positive</b>	✔ Supported and included
	<b>Respectful</b>	✔ Listened to and heard
	<b>Professional</b>	✔ Safe and confident

Our  values  
 Welcoming Kind Positive Respectful Professional