

Consent to Treatment Policy

Version number :	5.6
Consultation Groups	Mental Health Law department Mental Health Law Monitoring Group
Approved by (Sponsor Group)	Mental Health Law Monitoring Group
Ratified by:	Quality Committee
Date ratified:	23 rd March 2022
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Implementation Date :	March 2022
Last Review Date	March 2022
Next Review date:	March 2025

Services	Applicable
Trust-wide	Yes
Mental Health and LD	
Community Health Services	

Version Control Summary

Version	Date	Author	Status	Comment
5.3	20 th January 2016	Johanna Turner	Final	Reference to Mental Capacity Act Policy added Amendments to comply with new Code of Practice
5.4	8 th January 2018	Johanna Turner	Final	Change of terminology from supervised community treatment to community treatment orders Replaced reference to paper forms with templates to reflect use of electronic recording systems
5.5	8 th April 2021	Yetunde Asiru-Balogun		Added - T2; T3 certificates are no longer attached to Medication chart following the implementation of JAC – they are now kept in a box in medication room. Added - expired certificates must be removed from prescription chart on JAC
5.6	21 st March 2022	Guy Davis	Final	References to sending documents via electronic means, added throughout.

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Executive Summary

- The policy sets out the law and associated guidance in respect of consent to treatment in general.
- The two main legislative mechanisms are the Mental Health Act 1983 and the Mental Capacity Act 2005. Although both of these Acts of Parliament could apply to those under the age of 18 years, the Children Act 1989 and the Family Law Reform Act 1969 are also key pieces of legislation when it comes to the treatment of children.
- The policy covers each legal perspective in situations involving adults and children, but each case will have its own unique characteristics.

This policy should be read in conjunction with the policies on Community Treatment Order, Electro Convulsive Therapy, Advance Decision to Refuse Medical Treatment, Deprivation of Liberty, Safeguarding Adults, Covert Administration of Medicines, Mental Capacity Act Policy and Care Programme Approach

Key Principles of Consent

- 1.1 There is no statute in English Law which sets out the general principles of consent. However, case law has established that touching someone without their valid consent may constitute an offence of battery.¹
- 1.2 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 alternatives to it. Permission given under unfair or undue pressure is not consent.²
- 1.3 A person who lacks capacity to consent does not consent to treatment, even if they cooperate with the treatment or actively seek it.³
- 1.4 A record should be kept of information provided to patients. On rare occasions, there may be a reason, (which would be in the patients best interest – see paragraph 5.9 below) for not disclosing certain information.⁴ A professional who chooses not to disclose information must be prepared to justify this and fully document the reasons why in the patients notes.

¹ Department of Health 2009 *Reference Guide to consent for examination or treatment 2nd Ed.* Para 2 page 5
www.dh.gov.uk/consent

² Department of Health 2015 *Code of Practice* The Stationary Office Para 24.34

³ Department of Health 2015 *Code of Practice* The Stationary Office Para 24.35

⁴ Department of Health 2015 *Code of Practice* The Stationary Office Para 24.38

- 1.5 Patients should be told their consent to treatment can be withdrawn at any time. If an adult with capacity makes a voluntary and appropriately informed decision to refuse or withdraw consent to treatment (whether contemporaneously or in advance), this decision must be respected, except in certain circumstances as defined by the Mental Health Act 1983. This is the case even when this may result in the death of the person⁵ (issues regarding young people under the age of 18 are covered in section 6 below). If the patient withdraws consent, they must be given a clear explanation of the likely consequences of not having treatment and, where relevant, an explanation of the circumstances in which treatment may be given without their consent under the Mental Health Act 1983. A record of this discussion must be documented in the patient's notes.
- 1.6 If a voluntary (i.e. informal) patient refuses treatment such as medication, this wish must be respected if they are capable of making this decision. The only authority for treating a voluntary patient is either their valid consent or the Mental Capacity Act, but only if the patient lacks capacity to make this decision and treatment would be in their best interest (see section 5 below).
- 1.7 It is the responsibility of the professional in charge of the particular treatment to establish the valid authority to treat, and for the professional administering the treatment to be satisfied that such authority exists.
- 1.8 The Mental Health Act Code of Practice (2015) states that 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 and 'the patient's consent, refusal to consent or lack of capacity should be recorded in the case notes'⁶. To comply with this statutory guidance, the trust has developed a 'record of assessment of capacity and consent to treatment' template which must be completed for all patients on admission, for relevant patients at 3 months, when there is a change of Approved Clinician in charge of medication for mental disorder, when a patient becomes subject to a community treatment order and when there is a significant change in mental state. The template is available within the

⁵ Department of Health 2009 *Reference Guide to consent for examination or treatment 2nd Ed.* Para 44 page 19 www.dh.gov.uk/consent

⁶ Department of Health 2015 *Code of Practice* The Stationary Office Para 24.41

'Mental Capacity Act and Mental Health Act' folder in the patient's electronic record on RiO.

Consent to Treatment and the Mental Health Act 1983

Introduction

The Mental Health Act 1983 permits some medical treatment for mental disorder to be given without consent, however, wherever practicable, the patients consent should still be sought before the treatment is given.

2.0 Key Principles of Consent and the Mental Health Act 1983

- 2.1 Neither the existence of mental disorder nor the fact of detention under the Mental Health Act should give rise to an assumption of incapacity. The person's capacity must be assessed in relation to the particular decision they are being asked to make.
- 2.2 Consent or refusal to consent to treatment should be recorded in the patient's electronic records, as should an assessment as to the patient's capacity to consent (see 5.2 below).
- 2.3 If a patient withdraws consent, the clinician in charge of the treatment should review the treatment and consider whether to provide alternative treatment, give no further treatment or proceed with treatment in the absence of consent under the Mental Health Act (where appropriate).
- 2.4 The responsibility for ensuring that a treatment plan is in place lies with the Responsible Clinician. Treatment plans are essential for patients who are being given treatment for mental disorder under the Mental Health Act 1983. The treatment plan should form part of the care plan under the Care Programme Approach, be recorded in the patients electronic records and should include immediate and long term goals and treatment methods. The plan should be reviewed regularly and in conjunction with the patient and with carers where appropriate.

3.0 Part IV of the Mental Health Act 1983

- 3.1 Part IV of the Mental Health Act 1983 relates to treatment for mental disorder for those patients liable to be detained in hospital.
- 3.2 Part IV of the Act covers those patients liable to be detained under the following: sections 2, 3, 36, 37 (or 37/41), 38, 44, 45A, 47, 47/49, 48, 48/49 and Community Treatment Order patients who have been recalled to Hospital (section 17E).
- 3.3 Patients not covered by Part IV of the Act are those patients detained under sections 4, 5(2), 5(4), 35, 135(1), 136, conditionally discharged restricted patients and Community Treatment Order patients who have not been recalled to Hospital. Patients detained in a place of safety under Part III of the Act (i.e. section 37(4)) are also not subject to Part IV.
- 3.4 Medical treatment is defined in section 145(1) of the Mental Health Act 1983 as including 'nursing, psychological intervention and specialist mental health habilitation, rehabilitation and care'.
- 3.5 Section 145(4) makes it clear that medical treatment for mental disorder means treatment 'for the purpose of alleviating or preventing a worsening of a patient's mental disorder or one or more of its symptoms or manifestations'. The Mental Health Act Code of Practice (2015) states that 'it should never be assumed that any disorders or patients are inherently or inevitably untreatable'.⁷
- 3.6 Medical treatment must be appropriate, taking into account the nature and degree of the person's mental disorder and all their particular circumstances; the treatment must also be available. This 'applies to those liable to be detained under sections 3, 36, 37 (or 37/41), 44, 45A, 47, 47/49, 48, 48/49 and those patients on a Community Treatment Order. It also applies to those patients who were originally detained under the Criminal Procedure (Insanity) Act 1964 prior to the amendment of that Act on 31st March 2005.
- 3.7 Part IV applies to all forms of treatment for mental disorder however, certain types of treatment are subject to special rules – see below. All certificates authorising treatment must be sent to the MHL office via electronic means. Mental Health Law office who will upload this to the patient's electronic record. Certificates which are no longer valid must be marked as expired and uploaded to electronic records. Compliance with this

⁷ Department of Health 2015 *Code of Practice* The Stationary Office Para 23.6

requirement of the code at 25.86 will be reviewed via audit by the mental health law department on a regular basis.

- 3.8 Section 57 of the Act relates to those treatments that require both the consent of the patient and a second opinion from a Second Opinion Appointed Doctor (otherwise known as a SOAD and provided for by the Care Quality Commission).
- 3.9 Treatments covered by section 57 currently cover neurosurgery for mental disorder and surgical implantation of hormones to reduce male sex drive.
- 3.10 Section 57 is applicable to both informal and detained patients and certificates authorising section 57 type treatments must be authorised using form T1. A T1 certificate will become invalid if the patient no longer consents or no longer has the capacity to consent to the treatment.
- 3.11 Section 58 of the Act relates to those treatments requiring consent of the patient or a second opinion from a Second Opinion Appointed Doctor.
- 3.12 Treatment currently covered by section 58 is medication for mental disorder after three months of medication for mental disorder first being administered during an unbroken period of compulsion under the sections set out in 3.2 above.
- 3.13 A period is not unbroken because a patient moves from a section 2 to a section 3. Nor is a period unbroken if a person becomes a Community Treatment Order patient and then is recalled back to Hospital and has their Order revoked.
- 3.14 If, after 3 months of administration of medication, a patient has capacity and consents to the treatment, a form T2 is completed by either the approved clinician in charge of the treatment or a Second Opinion Appointed Doctor.
- 3.15 If the patient withdraws consent or loses capacity to give consent, the T2 is no longer valid and cannot be relied upon as authority to treat.
- 3.16 If the patient refuses to consent to the treatment after 3 months of administration, or does not have the capacity to consent, or withdraws consent or loses capacity, a form T3 must be signed by a Second Opinion Appointed Doctor if he/she believes it is appropriate for the treatment to be given (see also s62).

- 3.17 As to if the patient has or lacks capacity to make the decision to accept medication, this must be documented on the appropriate trust template (see paragraph 1.8) as to how this assessment was reached.
- 3.18 A copy of the appropriate treatment certificate must be uploaded to the patients' electronic records since the implementation of JAC electronic medication portal – appropriate treatment certificates are now kept in a box in the medication room where person administering medication is able to check.
- 3.19 All certificates must set out the forms of treatment to which they apply. All drugs should be listed (including “as required” drugs), either by their name or their class as described by the British National Formulary (EBNF). If the drugs are described by class, the certificate should state how many of each drug within the class is authorised and whether any are particularly excluded (e.g. Clozapine). Maximum dosage and route must also be set out.
- 3.20 If, once section 58 is applicable, medication is prescribed that is not covered on the certificate then it should not be given until a fresh certificate is authorised or unless section 62 applies (see paragraph 3.33 below).
- 3.21 It is the responsibility of the administering professional to check the medication authorised on the certificate against the prescription chart each time the medication is given, satisfy themselves that the certificate remains applicable and raise any issues of incompatibility immediately with the Responsible Clinician.
- 3.22 Treatment certificates may be time limited; however, if no specified time period for validity of the certificate is recorded on the form, it is important that the clinician in charge of the treatment reviews it at regular intervals.
- 3.23 A T2 certificate will need to be changed if the approved clinician who issued the certificate stops being the approved clinician in charge of the treatment. A T3 certificate will need to be updated if the certificate was given on the basis that the patient had capacity to consent and was refusing and either the patient is now consenting or the patient has lost capacity. The T3 certificate will also need to be changed if the patient did not have the capacity to consent and has regained capacity.

- 3.24 **Section 58A** – this section also covers treatment requiring consent or a second opinion but the current relevant treatment in section 58A is Electro Convulsive Therapy (ECT) together with medication administered as part of ECT.
- 3.25 Section 58A cannot be used if the detained patient has capacity to consent to treatment and has not done so; a Second Opinion Appointed Doctor cannot authorise ECT in the face of a capable refusal unless it is an emergency (see 3.33-4 below). In other words, section 58A can only be given with either the patient's valid consent or with a Second Opinion Appointed Doctor's certificate when the patient lacks capacity, and it does not conflict with a valid advance decision to refuse the treatment, or conflict with a decision made by a lasting power of attorney or a deputy from the Court of Protection or a decision from the Court of Protection (see section 5).
- 3.26 See section 6 below regarding the rules relating to section 58A in respect of patients under the age of 18.
- 3.29 Certificates by Approved Clinicians or Second Opinion Appointed Doctors confirming that the patient has given valid consent are made using form T4.
- 3.30 A certificate by a Second Opinion Appointed Doctor stating that the treatment is appropriate in the case of a patient who does not have the capacity to give consent is made using form T6. A copy of any T4 or T6 certificate must be uploaded in the patient's electronic records and an additional copy kept in the clinical area where local protocol demands.
- 3.31 A T4 certificate must be changed, if the Approved Clinician who issued the certificate stops being the Approved Clinician in charge of the treatment, or if any time limit expires.
- 3.32 A T4 or T6 certificate issued by a Second Opinion Appointed Doctor will become invalid if any time limit expires, if the patient was consenting and is no longer consenting or has lost the capacity to consent; if the patient lacked capacity to consent and has now regained capacity or if it is discovered that the incapacitated patient has made an advanced decision to refuse treatment which would conflict with the treatment, or an attorney, deputy or the Court of Protection makes a decision that treatment should not be given (see paragraph 5).
- 3.33 **Section 62** – this section relates to Urgent Treatment. Sections 57 and 58 will not apply if the treatment:

- Is immediately necessary to save a patient's life; or
 - Which (not being irreversible) is immediately necessary to prevent a serious deterioration of his condition; or
 - Which (not being irreversible or hazardous) is immediately necessary to alleviate serious suffering by the patient; or
 - Which (not being irreversible or hazardous) is immediately necessary and represents the minimum interference necessary to prevent the patient from behaving violently or being a danger to himself or others
- 3.34 For Electro Convulsive Therapy (or medication administered as part of Electro Convulsive Therapy), only the first two categories apply.
- 3.35 If section 62 is to be used as authority to treat, the treatment can continue for as long as it remains immediately necessary; if it is no longer immediately necessary, the normal requirement for a certificate will apply.
- 3.36 If section 62 is used as authority to treat, the Approved Clinician in charge of the treatment should complete the relevant section 62 form – see appendix 2. A copy of this form must be kept in the clinical room whilst it is be relied on for authority to treat the patient. A copy must also be uploaded to the electronic records. The Mental Health Law department will monitor the use of section 62 forms as part of the departmental audit process and report outcomes to the Trust Directorate Management Teams.
- 3.37 **Section 63** – this section relates to other treatments that do not require the patients consent. Specifically this covers all medical treatment for mental disorder (see definition at 3.4) which is not covered by sections 57, 58 or 58A; providing it is given under the direction of the Approved Clinician in charge of the treatment.
- 3.38 **Obtaining Second Opinion Appointed Doctor Certificates for Section 57/58/58A type treatments** – Once the need for a Second Opinion Appointed Doctor has been identified, the Approved Clinician in charge of the treatment should complete a second opinion request form, available online at the Care Quality Commission website⁸; a copy of this should be emailed to the local Mental Health Law office.
- 3.39 The Mental Health Law office will monitor the completion of the process and where there are problems, liaise with the Responsible Clinician and CQC.

⁸ <https://webdataforms.cqc.org.uk/Checkbox/SOAD.aspx>

- 3.40 When the Second Opinion Appointed Doctor carries out the assessment, s/he will expect to discuss the treatment plan with two statutory consultees who have been professionally concerned with the patient's medical treatment. One must be a nurse and one must be neither a nurse nor a doctor (it could be an occupational therapist, social worker, psychologist, pharmacist etc.)
- 3.41 It is for the Second Opinion Appointed Doctor to be satisfied about the validity of the particular person's profession and/or opinion. The name and designation of the two statutory consultees must be recorded on the request form.
- 3.42 The Second Opinion Appointed Doctor will also expect to see the clinical records, and interview the patient.
- 3.43 It is a legal requirement⁹ that the reasons as to why the patient should have the treatment be communicated to him/her. It is the responsibility of the clinician in charge of the treatment to communicate the results of the visit to the patient and this must be documented either within the electronic progress notes or an explanation given as to why if it has not been done and when the position will be reviewed.
- 3.44 **Section 61 & 64H – Review of Treatment** where treatment is being given in accordance with a Second Opinion Appointed Doctor's certificate, it is a requirement for the Approved Clinician in charge of the treatment (usually the RC) to complete a review of treatment and document it on the form and send to the CQC in these situations detailed below:
- Non-restricted patient - T3 certificate – when the renewal form is furnished (not the time of expiry);
 - Restricted patient – T3 certificate – 6 months after the date of the order (not the admission date), then each time that the RC is required to send a report to the Secretary of State for Justice which is a minimum of every 12 months;
 - CTO patient – CTO extension is furnished and during the preceding period the patient had been recalled to hospital **AND** was treated under the authority of the CTO11 because the SOAD had authorised treatment on recall **AND** the patient lacked capacity or refused that treatment at the time;
 - At any other time as required by the CQC.

⁹ R (on the application of Wooder) v Dr Feggetter and the MHAC [2002] EWCA Civ 554

3.45 The role of the Mental Health Law Office

The Mental Health Law Office department in each locality has electronic and other systems for alerting Responsible Clinicians when certificates for consent are due. Reminders are sent via email to the Approved Clinician in charge of the treatment together with the relevant clinical team at least 4 weeks and then 2 weeks prior to the need for a certificate (for section 58 type treatments). However, this does not preclude the clinical team from also ensuring systems are in place for recording when a certificate may be due and when it will expire. This is vitally important because if a patient is treated under section 57/58/58A without a valid certificate of authority, apart from the distress this may cause, it will potentially be deemed unlawful and the Trust will be at risk of a legal claim that could result in both reputational and financial loss.

4.0 Part 4A of the Mental Health Act 1983

- 4.1 Part 4A of the Act applies to those patients' subject to Community Treatment Orders (CTO) who have not been recalled to hospital and it also brings in aspects of the Mental Capacity Act 2005 (MCA) (see section 5 below).
- 4.2 The requirements of Part 4A of the Act are firstly, that the person giving the treatment must have the authority to do so, and secondly, if the treatment in question is either medication (section 58 type treatment) or Electro Convulsive Therapy (section 58A type treatment), then a certificate requirement must also be met.
- 4.3 There are different rules for Part 4A patients who have capacity to consent to specified treatments and 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 set out in section 17E.
- 4.4 The Part 4A rules recognise and incorporate aspects of the MCA including advance decisions and persons appointed to make surrogate decisions such as a donee of a lasting power of attorney or a court appointed deputy. It should be noted in these cases that the MCA may not generally be used to give CTO patients any treatment for mental disorder other than where a donee, deputy or Court of Protection order provides consent.

- 4.5 It may still be appropriate to rely on the MCA for the provision of treatments for physical problems for a CTO patient (see section 5).
- 4.6 The MCA does not normally apply to a child under the age of sixteen, so decisions about capacity in relation to medical treatment are made by determining whether a child is 'Gillick competent'¹⁰ in accordance with a landmark ruling of the House of Lords¹¹.
- 4.7 Part 4A patients over the age of sixteen who lack capacity, may be given specified treatments on the authority of an attorney¹² or court appointed deputy or by order of the Court of Protection.
- 4.8 If over sixteen, treatment cannot be given where a deputy (or a lasting power of attorney donee if over eighteen) refuses on the patient's behalf (see also section 5).
- 4.9 If the patient is over eighteen, treatment cannot be authorised if it would contravene a valid and applicable advance decision made under the MCA (see also 5.2).¹³
- 4.10 If physical force needs to be used to administer treatment to a patient of any age who lacks capacity or competence, it can only be given in an emergency following the conditions set out in section 64G of the Act, which reflect the similar scheme in the MCA¹⁴. This is that the relevant professional believes that the patient lacks capacity, the treatment is immediately necessary (see below) and that any force used is a proportionate response to the likelihood of harm being suffered. The alternative mechanism is via recall to hospital.
- 4.11 In an emergency, treatment for Part 4A patients who have not been recalled and who lack capacity, can be given by anyone (it need not be an Approved Clinician or the Responsible Clinician) but only if the treatment is immediately necessary to:
- a) Save the patient's life;

¹⁰ A Gillick competent child is a child who has sufficient understanding and intelligence to enable them to understand fully what is involved in a proposed intervention and will have the competence to consent to that intervention (see MHA code Para's 36.38-36.50). if the child is Gillick competent and able to give voluntary consent after receiving appropriate information, that consent will be valid and additional consent by a person with parental responsibility will not be required.

¹¹ *Gillick v West Norfolk and Wisbech Area Health Authority* [1985] 3 All ER 402 (HL)

¹² Young people aged 16 and 17 do not have the power, under the Mental Capacity Act to make a lasting power of attorney nor make valid and applicable advanced decisions to refuse treatment.

¹³ See 24.54r of *The Code*

¹⁴ See conditions set out in section 6 *Mental Capacity Act 2005*

- b) Prevent a serious deterioration of the patient's condition, and the treatment does not have unfavourable physical or psychological consequences which cannot be reversed;
- c) 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
- d) Prevent the patient 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.

For Electro Convulsive Therapy (or medication administered as part of Electro Convulsive Therapy), only the first two categories apply.

- 4.12 In an emergency where treatment is immediately necessary as above, it may be given even if it goes against an advance decision or a decision made by a person authorised on the patient's behalf under the MCA. These are the only exceptional circumstances in which force can be used to treat an objecting CTO patient, who doesn't have capacity, without first recalling them to hospital.
- 4.13 In non-emergency situations (excluding Electro Convulsive Therapy for which reference should be made to paragraphs 25.19 - 25.25 of the Code of Practice and to the Trust's Electro Convulsive Therapy Policy) a patient may lack capacity and object to treatment but, where physical force is not required, he or she can be treated with medication for mental disorder in the community
- 4.14 For the first month, no certificate is required, however, during this time, an assessment of capacity to consent must be made by the Approved Clinician in charge of the treatment which should be documented on the trusts 'record of capacity and consent template. After the first month, a Second Opinion Appointed Doctor must certify that such treatment is appropriate on a Part 4A certificate (form CTO11) for a person who is judged to be lacking capacity. If a person has capacity and is consenting to treatment in the community, the Approved Clinician in charge of that treatment should complete form CTO12 certifying the patient has capacity and is consenting. If a person is judged to have capacity but is refusing treatment in the community, the Second Opinion Appointed Doctor will visit to consider certifying on form CTO11 that certain treatment proposed for the patient whilst in the community is appropriate even though such

certification provides no authority to give it if the patient is refusing; and/or certain treatment would be appropriate (and could be given without consent) if the patient was recalled to hospital.

- 4.15 The Second Opinion Appointed Doctor will consider what (if any) treatments to approve in the event that the patient is recalled to hospital and to specify any conditions that will apply.
- 4.16 A copy of form CTO11 or CTO12 or Section 64(g) should be kept in the patient's electronic records and on the community prescription chart/ file where relevant; a copy must also be sent to the Mental Health Law office via electronic means.
- 4.17 The arrangements surrounding the Second Opinion Appointed Doctor's examination will be complicated by the fact that the patient is in the community so an appropriate person should be asked to confirm arrangements with the Second Opinion Appointed Doctor and coordinate the process. This will usually be the care coordinator.
- 4.18 Other than in exceptional circumstances, Second Opinion Appointed Doctor examinations will be arranged in a hospital or clinical setting. If the Responsible Clinician agrees that it is necessary to visit a community treatment order patient in a hostel or home, the Second Opinion Appointed Doctor will always be accompanied by an appropriate member of the care team, who will act as one of the statutory consultees. At least one statutory consultee shall not be a Doctor and neither of the statutory consultee's can be either the Responsible Clinician or the Approved Clinician in charge of the treatment in question – see Code of Practice at 25.54.
- 4.19 When a patient on a CTO is recalled, they will become subject to the provisions of those sections of the Act governing treatment for detained patients.¹⁵ If treatment does not include psychotropic medication or Electro Convulsive Therapy and a patient with capacity consents to it, it may be given under the direction of the Responsible Clinician.
- 4.20 If a Second Opinion Appointed Doctor has approved any treatment (on form CTO11) in the event of the patient's recall to hospital, such treatment may be given as approved subject to any conditions that may have been specified. Unless the Second Opinion Appointed Doctor has indicated otherwise, the certificate will authorise treatment (other than Electro Convulsive Therapy) whether the patient has or does not have capacity to refuse it.

¹⁵ Sections 57, 58, 58A and 63, *The Act*

4.21 On recall and revocation, treatment that was already being given as described on form CTO11 (but not authorised for administration on recall), may continue to be given if the Approved Clinician in charge of the treatment considers that stopping it would cause the patient serious suffering but steps must be taken at the earliest opportunity to obtain a new certificate to authorise treatment (there is no new “three month rule” for section 58 type treatment if the CTO is revoked). This can include previously authorised Electro Convulsive Therapy treatment. For those patients who continue to have capacity and to consent to treatment on recall, the CTO12 will provide authority to continue with that treatment. In the event that a patient loses capacity or is not consenting then consideration will need to be given to whether the criteria for the use of section 62 is applicable. Responsible clinicians must record details of why it was necessary to continue treatment without a certificate and how long it took to obtain a new certificate. As above, the Mental Health Law Office will monitor the use of incidences of treatment on recall pending the certificate requirement as part of the departmental audit process and report outcomes to the Trust Quality committee.

4.22 It is not good practice on recall or after revocation, to rely on a certificate that was issued while a patient was detained prior to going onto supervised community treatment even if it remains technically valid. A new certificate should be obtained.¹⁶

4.23 **Section 64H – Review of Part 4A treatment**

Where treatment is being given in accordance with a Second Opinion Appointed Doctor’s Part 4A certificate, the Approved Clinician in charge of that treatment is required to provide a written report on that treatment and the relevant patient’s condition at any time if requested by the Care Quality Commission.

5.0 **Consent and the Mental Capacity Act 2005**

5.1 The MCA 2005 came into force in October 2007 and regulates care and treatment for those people who lack capacity (where the Mental Health Act 1983 does not apply). It generally applies to people over the age of 18 but some parts apply to young people aged between 16 and 18.

5.2 The MCA 2005 essentially codified common law rights of autonomy and bodily integrity. It allows for others to make decisions on behalf of the person without capacity (lasting power of attorney, deputies appointed by the Court of Protection etc.) and

¹⁶ *The Code*, para. 25.36

allows for people to make decisions in advance as to which treatments they do not want in the event that they lose capacity ('advance decision to refuse medical treatment').

- 5.3 The MCA 2005 also provides protection for those carers/professionals caring for people who lack capacity provided the care that is carried out is in their best interest (section 5) and if restraint is used, then that restraint is a proportionate response to the likelihood and seriousness of harm which might occur if the person was not restrained (section 6).
- 5.4 A person must always be presumed to have capacity unless it can be established otherwise. A person cannot be treated as lacking capacity if they make a decision that seems unwise or irrational, unless it can be established that capacity is lacking (see 5.5 below).
- 5.5 **Test for Capacity** – the MCA 2005 defines someone who lacks capacity as a person who is unable to make a decision for themselves because of an impairment or disturbance in the functioning of the mind or brain. It does not matter if this is a permanent or temporary disturbance.
- 5.6 An assessment of capacity is based on the person's ability to make a specific decision at the time it needs to be made, not their ability to make decisions in general. A person may have the capacity to make one decision but not another.
- 5.7 A person is deemed to be lacking capacity if the person cannot do one or more of the following:
- Understand the information that is given to them relevant to the decision that they are being asked to make;
 - Retain that information for long enough to make the decision;
 - use or weigh up the information as part of the decision making process;
 - Communicate the decision - every effort must be made to assist the person to communicate in whatever mode they can.

And the above is a consequence of an impairment or disturbance of the mind or brain. If the person is assessed to lack capacity to make a specific decision, this must be documented in the patient's records as to how this assessment was reached and by whom. There is no statutory form required to be completed when using the MCA 2005.

Advance decisions to refuse Medical Treatment¹⁷

- 5.8 Under the MCA 2005, all persons over the age of 18, whether in receipt of health services or not, can make a legally binding advance decision to refuse treatment, if, at that point, they have capacity to do so. This would be a decision to refuse particular treatment in anticipation that at some point in the future the person may lose the capacity to refuse the treatment.
- 5.9 Advance decisions to refuse treatment may be given verbally or in writing (in the case of life sustaining treatment, they must be made in writing). If it is valid and applicable, the advance decision to refuse treatment has the same effect as a contemporaneous decision to refuse treatment, and must be followed.
- 5.10 A person's treatment decision can be overridden in some limited circumstances. For example when a patient is detained under the Mental Health Act 1983, the contents of any advance decision relating to a refusal of treatment for mental disorder may be overridden by virtue of the provisions in Part IV of the Act in most cases. Additionally, an advance decision must be valid and application to take effect in the relevant circumstances.
- 5.11 Note that there is an important legal distinction between a written statement expressing treatment preferences, which a health care professional must take into account when making a best interest decision on behalf of an incapacitated patient (sometimes known as an advance statement or directive), and a valid and applicable advance decision to refuse treatment which healthcare professionals must follow.

Lasting Power of Attorney & Court Appointed Deputies¹⁸

- 5.12 The Mental Capacity Act allows a person with capacity to appoint someone to make their health and welfare decisions at any point in the future when they lose capacity. This is known as a lasting power of attorney and dependent on what powers have been

¹⁷ See chapter 9 of Mental Capacity Act Code of Practice for more information on Advance decisions
<http://elcmhtintranet/uploads/National%20Guidelines/Mental%20Capacity%20Act/Mental%20Capacity%20Act%20Code%20Full.pdf>

¹⁸ See chapter 7 of Mental Capacity Act Code of Practice for more information on the role of the LPA's & deputies
<http://elcmhtintranet/uploads/National%20Guidelines/Mental%20Capacity%20Act/Mental%20Capacity%20Act%20Code%20Full.pdf>

granted and when, the donee of a personal welfare lasting of power of attorney can make healthcare decisions which would be as valid as if the person had made the decision themselves.

- 5.13 Deputies are those people appointed by the Court of Protection to make decisions on behalf of the incapacitated person. The powers of a court appointed deputy may be limited in scope so it is important to ascertain what decision making powers this person has.
- 5.14 With the exception of Electro Convulsive Therapy (see 3.32 above), donees and deputies may not give or refuse consent to treatment on a patient's behalf if that treatment is covered by Part IV of the Mental Health Act (although they could with an incapacitated Community Treatment Order patient under Part 4A of the Mental Health Act – see section 4.5). Nor may they take a decision which will conflict with decisions that a Guardian (for a person under a Mental Health Act Guardianship Order) has a lawful right to make.
- 5.15 Being subject to the Mental Health Act 1983 does not mean a person cannot make a lasting power of attorney if they have capacity to do so. The donee of a lasting power of attorney and court appointed deputies may also have the power to apply to the First Tier Tribunal (mental health) for the patients discharge from detention, guardianship or a community treatment order – see the code at 7.7.
- 5.16 The rights of the nearest relative under the Mental Health Act are not affected because the person also has a court appointed deputy or a lasting power of attorney. The donee of a lasting power of attorney or deputy may not exercise the rights of the nearest relative (unless of course, they are also themselves the nearest relative).
- 5.17 If there are any doubts as to the rights of a donee of a lasting power of attorney or a court appointed deputy, it is advisable to seek help from the local Mental Health Law office (details of each locality office can be found at appendix 1).

Court of protection¹⁹

- 5.18 The MCA 2005 established the Court of Protection which deals with decision-making for adults lacking capacity. It deals with serious decisions affecting personal welfare matters, including healthcare which were previously dealt with in the High court. It has the same rights, powers, privileges and authorities as the High Court.

Treatment for Physical Disorder and the Mental Capacity Act

- 5.19 Except in certain circumstances governed by the Mental Health Act 1983 (see 5.20 below), if an adult with the capacity to make the decision refuses treatment for a physical disorder, practitioners must comply with the person's decision. If a refusal is ignored, they will be treating the person unlawfully.
- 5.20 The exception, governed by the Mental Health Act 1983, is if the physical treatment is part of or ancillary to treatment for mental disorder (e.g. treating wounds self-inflicted as a result of mental disorder; feeding by naso-gastric tube of a patient with anorexia nervosa²⁰). In these cases, the ancillary treatment may be given under the authority of section 63 of the Mental Health Act 1983.
- 5.21 For a person who lacks capacity, treatment for physical disorder may be given under the authority of the MCA if it is in the person's best interest and would not conflict with an advance decision to refuse medical treatment or a decision by a donee of a lasting power of attorney or a Court of Protection or a deputy decision. The MCA applies to persons detained under the Mental Health Act 1983 in relation to physical disorders, just as it does to informal patients²¹.
- 5.22 **Best Interests and protection from liability** – section 5 of the MCA 2005 states that as long as acts or decisions are made in the best interests of the person who lacks capacity, the decision maker or carer will be protected from liability. The Act does not give a definition as to what "best interests" means as it encompasses a wide range of decisions and care acts but section 4 sets out a checklist and states that the care giver/ decision maker must take into account all the relevant circumstances when coming to a decision as to whether the care/ decision is in the person's best interest. This will

¹⁹ See chapter 8 of Mental Capacity Act Code of Practice for more information on the role of the Court of Protection

²⁰ B v Croydon District Health Authority [1995] 1 ALL ER 683 (CA)

²¹ See chapter 13 of Mental Health Act Code of Practice for more information on the relationship between the MCA and the MHA

include finding out if possible, the person's views before they lost capacity and taking into account their current preferences and wishes.

- 5.23 Section 6 of the MCA 2005 explains that carers can carry out personal care, healthcare and treatment of incapacitated patients if it is in their best interests, and that this may even extend to the restraint of a person.
- 5.24 However, any action in respect of restraint on a person who lacks capacity will only be lawful if the person taking the action believes the restraint is necessary to prevent harm to the person who lacks capacity and the amount or the type of restraint and the length of time of restraint must be a proportionate response to the likelihood and seriousness of the harm. In other words, if restraint is necessary to prevent harm to the person who lacks capacity, it must be the minimum force for the shortest time possible.
- 5.25 **Deprivation of Liberty** – on 1st April 2009, Deprivation of Liberty Safeguards (DoLS) came into effect. This means that if an incapacitated person will be cared for in a manner which amounts to a deprivation of their liberty, authorisation for this must be obtained from a “supervisory body” (i.e. the local authority) or, if the deprivation falls outside of the scope of the safeguards then authority must be obtained from the Court of Protection. This does not apply to persons detained in Hospital under the Mental Health Act 1983.
- 5.26 Having an authorisation to deprive someone of their liberty does NOT automatically also allow the treatment of that person. Treatment that is proposed following a deprivation of liberty authorisation may only be given with the persons consent (if they have the capacity to make this decision) or in accordance with the MCA 2005.

6.0 Children and young people

- 6.1 The legal position relating to treatment and children and young people varies from adults with regards to certain sections of the Mental Health Act 1983. Other legislation which may be applicable includes the Children Acts 1989 and 2004; the MCA 2005 and the Family Law Reform Act 1969. In this policy, children refers to those under the age of 16 and young people refers to those aged 16 and 17.
- 6.2 When taking decisions about children and young people, it is important to establish whether they have the capacity or competence to consent to the treatment and whether they are actually consenting. As the rules relating to treatment of young people and

children can often appear quite confusing, it is always preferable to seek advice from the local Mental Health Law office if unsure of legal authority to treat.

- 6.3 **Treatment for mental disorder and the informal child or young person** Treatment can be given to an informal child or young person if they have the competence or capacity to consent and they are consenting to it. If the child or young person is informal and they lack capacity, then a person with parental responsibility may give consent on their behalf if it falls within the scope of parental responsibility²².
- 6.4 The Mental Health Act Code of Practice advises that parental consent should not be relied on for authority to treat if the child or young person has capacity and is not consenting.
- 6.5 If the young person of 16 or 17 lacks capacity then it may be possible to treat them in accordance with the MCA 2005 (however, this cannot be relied on to authorise treatment if the treatment would result in the person being deprived of their liberty; also the MCA will only apply if section 2(1) is fulfilled – that is that the person lacks capacity because of an impairment or a disturbance in the functioning of the mind or brain. If they are unable to make a decision for some other reason, for example because they are overwhelmed by the implications of the decision, the Act will not apply to them).
- 6.6 For children or young people who are informal patients but for whom electro-convulsive therapy is prescribed, please see below.
- 6.7 **Treatment (medication) for mental disorder and the child or young person detained under the Mental Health Act 1983.** If a child or young person meets the criteria for detention and is subsequently detained on a section to which Part IV of the Mental Health Act applies, then treatment rules are similar to adults with the exception of section 58A.
- 6.8 **Treatment (electro-convulsive therapy) for mental disorder and the child/ or young person – detained or informal.** Section 58A provides that all people under the age of 18, whether detained or not can only be given electro-convulsive therapy if they have consented to it and a Second Opinion Appointed Doctor has certified (Form

²² This term is used by the Mental Health Act Code of Practice to describe types of decisions that someone with parental responsibility can make in relation to a child/ young person's care and treatment. There are no clear rules as to what may fall under the scope, however, professionals must consider 2 key questions (1) is it a decision that a parent should reasonably be expected to make (2) are there any factors that might undermine the validity of parental consent. For more guidance. Please see chapter 19 of the MHA Code of practice, together with sections 2 and 3 of the Children Act 1989.

T5) that the patient is capable of understanding the nature, purpose and likely effects and it is appropriate that the treatment be given.

- 6.9 When a person under 18 is not capable of consenting, a Second Opinion Appointed Doctor certifies (Form T6) that the patient is not capable of understanding the nature, purpose and likely effects of ECT but it is appropriate that the treatment is given and it would not conflict with a decision made by a deputy appointed by the Court of Protection (for 16 & 17 year olds only) or a decision by the Court of Protection preventing the treatment being given (advance decisions to refuse treatment and lasting power of attorneys do not apply to those under the age of 18).
- 6.10 If the child/young person is under the age of 18 and not detained, a Second Opinion Appointed Doctor certificate in itself does not authorise the treatment; there must be legal authority from either the person via their valid consent, or via the MCA (for 16 & 17 year olds) or via a court authorisation (even with Court authorisation, a SOAD certificate must also be obtained unless the treatment is immediately necessary – see below). The Mental Health Act Code of Practice advises at 19.85 that careful consideration should be given as to whether to rely on parental consent.
- 6.11 **ECT in an emergency for the child/ young person detained under the Mental Health Act** Section 58A does not apply if the electro convulsive therapy treatment is immediately necessary to save a patient's life or prevent a serious deterioration in their condition. The requirement to first obtain a second opinion appointed doctors certificate does not apply and the person can be treated without their consent as long as the criteria for section 62 (a & b only – see 4.11 above) apply.
- 6.12 **Independent Mental Health Advocates** – all children and young people to whom ECT applies should have access to an Independent Mental Health Advocate, whether or not they are detained under the Act. It is the responsibility of the doctor or approved clinician to take whatever practicable steps necessary to ensure the child or young person understands what help is available from the Independent Mental Health Advocacy service and how to access it. This information must be given to the child or young person both verbally and in writing.
- 6.13 **Treatment for mental disorder and the child or young person subject to compulsion in accordance with Part 4A of the Mental Health Act (Community Treatment Order (CTO))** Both young persons and children are subject to the same requirements as adults for certificates by a Second Opinion Appointed Doctor or the

Approved Clinician in charge of the treatment if they are subject to medication or electro-convulsive therapy in the community.

- 6.14 Young persons of 16 or 17 who are CTO patients are considered to be adult community patients and rules relating to adult community patients apply as per paragraph 4 above (but note that young persons of 16 and 17 cannot make advance decisions to refuse treatment, nor can they make a lasting power of attorney).
- 6.15 For children under the age of 16 who are CTO patients, practitioners must assess whether they are “Gillick competent” (see footnote to para 4.6 above). If the child is deemed competent and consents to treatment in the community, the treatment can be given. If the child is competent and does not consent to treatment in the community, the treatment cannot be given.
- 6.16 If the child is not “Gillick competent” treatment can be given if there is no reason to believe that the child objects or, if the child objects, force is not required. Treatment can be given in an emergency in the community for a child who is not Gillick competent as long as any use of force is a proportionate response to the likelihood of the person suffering harm and to the seriousness of that harm (section 64G – see 4.10-4.11 above).
- 6.17 **Treatment for physical disorders** just as with adults, the Mental Health Act 1983 does not authorise treatment of children or young persons for physical disorder unless the physical treatment is part of or ancillary to treatment for mental disorder. Authority to treat must be found either through the capable young person or the competent child’s consent. If the child or young person has capacity and refuses to give consent, and it could be within the scope of parental responsibility to consent on their behalf, then the matter must be referred to the Mental Health Law office for advice as to whether it is lawful for the treatment to go ahead on the basis of parental consent in the face of a capable child or young person’s refusal.
- 6.18 Under section 3 of the Children Act 1989 a person with parental responsibility is generally able to consent on behalf of a child or young person receiving care or treatment. However, if a 16 or 17 year old lacks capacity and the MCA 2005 applies, they could be treated whether or not the person with parental responsibility consents²³

²³ See chapter 12 (Para 12.11-12.22) of Mental Capacity Act Code of Practice for more information on the Act and children and young people

in these circumstances it is prudent to seek advice from the local Mental Health Law office before proceeding.

- 6.19 It is prudent to refer any disagreements (regarding capacity or best interests and treatment issues of the child/ young person) between a family and the clinical team to the Mental Health Law office to seek clarification in the first instance on the legal position of the Trust. It may be deemed advisable following this consultation to seek a declaration from the Court to resolve the matter.

7.0 Other issues regarding consent

- 7.1 **Consent to visual and audio recordings** – consent should ideally be obtained for any visual or audio recordings where possible (i.e. the person has capacity to consent). The purpose and any possible future use must be clearly explained before consent is sought. If the use is for diagnostic or clinical purposes, the clinical team must be aware that this recording constitutes medical records and should be treated as any other form of medical record, the Data Protection Act 1998 and common law duties of confidentiality apply. Please refer to the Trust audio/ visual recording policy.
- 7.2 **Covert medication** - Covert administration of medicines is the giving of medication disguised in food or fluids. It is only likely to be necessary or appropriate when patients actively refuse medication and are judged not to have the capacity to understand the consequences of their refusal. Covert medication should generally not be given to a mentally capable detained patient without their consent²⁴. It may only be given to a mentally incapable patient who is detained under the Mental Health Act 1983 if they fall under Part IV of the Act (i.e. if sections 58 or 63 apply) and it is treatment for mental disorder. If a mentally incapable patient does not fall under Part IV of the Mental Health Act, covert medication may be given under the MCA if it is deemed that it is in the best interests of the patient (see Section 5). If a mentally capable patient is not detained or subject to Part IV of the Mental Health Act, any refusal of consent for medication (in whatever form) must be respected and not overridden. All action in relation to the giving of covert medication must comply with the Trusts Covert Administration of Medication Policy, and further advice can be sought from the Mental Health Law office.

²⁴ Mental Health Act Commission “*Rights and Recovery*” 12th Biennial report 2005-2007 Para 6.45 page 208
http://www.cqc.org.uk/_db/_documents/pdf%2012th%20biennial%20report.pdf

Mental Health Law Contacts

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Record of Urgent Treatment - Section 62
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Full Name		Section	
RiO No		Ward	

Urgent treatment is to be given to the above named patient:

- a) Which is immediately necessary to save the patient's life or:

- b) Which (not being irreversible) is immediately necessary to prevent a serious deterioration in his/her condition or:

- c) Which (not being irreversible or hazardous), is immediately necessary to alleviate serious suffering by the patient or:

- d) Which (not being irreversible or hazardous) is immediately necessary and represents the minimum interference necessary to prevent the patient from behaving violently or being a danger to him/herself or others.

Delete the statutory criterion that does not apply.

NOTE THAT IN THE CASE OF ECT, ONLY a) OR b) CAN APPLY (S58A)

Details of treatment (what is the proposed treatment and why is it immediately necessary to give the treatment?):

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Steps taken to obtain a Second Opinion Approved Doctor in compliance with Section 58(3) (b) OR
Section 58A (4) or 58A (5)

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OR

Exceptional reasons for not doing so:

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Signed		Date	
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Approved Clinician in Charge of the Treatment

OR

Where the Approved Clinician is unable to sign this form the following should be completed:

Authority obtained from			
	(BLOCK CAPS)		
On Date:		Time:	
			am/pm

(Explain how authority was obtained)

.....
.....
.....

Name of person completing this form..... (BLOCK CAPS)

Signature of person completing this form.....

Date:

WHEN FULLY COMPLETED, THE ORIGINAL MUST BE SENT VIA ELECTRONIC MEANS TO THE MENTAL
HEALTH LAW ADMINISTRATION OFFICE AND A COPY KEPT IN THE MEDICATION ROOM FOR
REFERENCE AGAINST THE ELECTRONIC PRESCRIPTION



Urgent treatment under section 64 Of the Mental Health Act 1983

Name of Patient: _____

Section: **17A - Community Treatment Order**

I am

I confirm that I am the Approved Clinician responsible for the above named patient and that the following treatment:

(Delete option that does not apply)

1. is emergency treatment which is authorised under Section 64G as the patient lacks the capacity to consent to it;

(PLEASE TICK)

AND

a) is immediately necessary to save the patient's life { } or

- b) which (not being irreversible) is immediately necessary to prevent a serious deterioration in their condition { } or
- c) which (not being irreversible or hazardous) is immediately necessary to alleviate serious suffering by the patient { } or
- d) which (not being irreversible or hazardous) is immediately necessary and represents the minimum interference necessary to prevent the patient from behaving violently or being a danger to themselves or others { }

(Note: If treatment plan involves ECT only a) and b) of the above options apply)

I confirm full details of this course of treatment under S64 is recorded in the case notes.

Signed _____

Date _____

WHEN FULLY COMPLETED, THE ORIGINAL MUST BE SENT VIA ELECTRONIC MEANS TO THE MENTAL HEALTH LAW ADMINISTRATION OFFICE AND A COPY ATTACHED TO THE COMMUNITY PRESCRIPTION CHART WHERE RELEVANT