

Consent to Treatment Policy

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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.
6.0	15 th April, 2025	David Markovitch	Final	5.18-19 added when new certificates are required 5.46 recording of outcome of SOAD visit discussion

				6.15 treatment certificate requirements for treatment under Part 4A Removed duplications with MCA policy Added 2 x Appendices Updated Monitoring
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Executive Summary:

The policy sets out the law and associated guidance in respect of Consent to Treatment in general.

1.0 Introduction:

1.1 The two main legislative mechanisms in relation to Consent to Treatment 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.

1.2 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.

1.3 The policy covers each legal perspective in situations involving adults and children, but each case will have its own unique characteristics.

2.0 Purpose:

2.1 The purpose of the policy is to provide guidance to clinical members of staff who have to comply with legislation in respect of Consent to Treatment in general.

3.0 Duties and Responsibilities:

Key Principles of Consent

3.1 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.

3.2 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.

3.3 A person who lacks capacity to consent does not consent to treatment, even if they cooperate with the treatment or actively seek it.

3.4 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 7.3 below) for not disclosing certain information. A professional who chooses not to disclose information must be prepared to justify this and fully document the reasons why in the patients notes.

3.5 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 person (issues regarding young people under the age of 18 are covered in section 12 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.

- 3.6 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.
- 3.7 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.
- 3.8 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'.
- 3.9 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. The template is available within the 'Mental Capacity Act and Mental Health Act' folder in the patient's electronic record on RiO.
- 3.10 This is completed for relevant patients at the following points:
 - Admission
 - At three months
 - When a T2 is done
 - When a patient becomes subject to a Community Treatment Order (CTO)
 - When there is a change of AC in charge medication

4.0 **Key Principles of Consent to Treatment and the Mental Health Act 1983**

- 4.1 The Mental Health Act 1983 permits some medical treatment for mental disorder to be given without consent, however, wherever practicable, the patient's consent must still be sought before the treatment is given.
- 4.2 Neither the existence of mental disorder nor the fact of detention under the Mental Health Act should give rise to an assumption of incapacity in relation to treatment of that disorder. The person's capacity must be assessed in relation to the particular decision they are being asked to make, at the point it is being made.
- 4.3 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 3.9 above).
- 4.4 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

- Proceed with treatment in the absence of consent under the Mental Health Act (where appropriate).
- 4.5 The responsibility for ensuring that a treatment plan is in place lies with the Approved Clinician in charge of the patient's treatment. Treatment plans are essential for patients who are being given treatment for mental disorder under the Mental Health Act 1983.
- 4.6 The treatment plan should form part of the care plan under the Community Mental Health Framework, be recorded in the patients' electronic records and should include short, medium and long term goals along with treatment methods. The plan should be reviewed regularly and in conjunction with the patient and carers where appropriate.
- 5.0 Part 4 of the Mental Health Act 1983 - Inpatients**
- 5.1 Part IV of the Mental Health Act 1983 relates to treatment for mental disorder for those patients liable to be detained in hospital.
- 5.2 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).
- 5.3 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).
- 5.4 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'.
- 5.5 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'.¹
- 5.6 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.
- 5.7 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. The Mental Health Law office will upload this to the patient's electronic record.

¹ Department of Health 2015 *Code of Practice* The Stationary Office Para 23.6

- 5.8 **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).
- 5.9 Treatments covered by section 57 currently cover neurosurgery for mental disorder and surgical implantation of hormones to reduce male sex drive.
- 5.10 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.
- 5.11 **Section 58** of the Act relates to those treatments requiring consent of the patient or a second opinion from a SOAD.
- 5.12 Treatment currently covered by section 58 is medication for mental disorder after three months of medication or for CTO recall (immediately) for mental disorder first being administered during an unbroken period of compulsion under the sections set out in 5.2 above.
- 5.13 A period is not broken because a patient moves from a section 2 to a section 3. Nor is a period broken if an in-patient becomes a Community Treatment Order patient and then is recalled back to Hospital and has their Order revoked, although their legal status for treatment would have changed requiring a new certificate with immediate effect.
- 5.14 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. The Trust default for providing this certificate is via eMHA.
- 5.15 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.
- 5.16 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 may be issued by a Second Opinion Appointed Doctor if s/he believes it is appropriate for the treatment to be given (see also s62 – Para 5.24).
- 5.17 As to if the patient has, or lacks capacity to make the decision to consent to treatment, this must be documented on the appropriate trust template (see paragraph 3.9).
- 5.18 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 5.18-5.19 above).
- 5.19 **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
- 5.20 For Electro Convulsive Therapy (or medication administered as part of Electro Convulsive Therapy), only the first two categories apply.
- 5.21 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.
- 5.22 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 1.
- 5.23 A copy of the appropriate treatment certificate under IV of the Act must be uploaded to the patients' electronic records (RIO) by the Mental Health Law Department. Since the implementation of JAC electronic medication portal – appropriate treatment certificates are now kept in a box in the medication room which the person administering medication must check.
- 5.24 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 Approved Clinician in charge of treatment or out of hours on call Consultant.
- 5.25 All certificates must set out the forms of treatment to which they apply. All drugs must 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 – see Code of Practice, 25.18.

Example: If the patient is consenting to the following medication:

Chlopromazine (tablets)
Haloperidol (depot)
Procyclidine (oral)

The Care Quality Commission would expect the description of treatment on Form T2/Section 62 to read thus:

Antipsychotic drug (oral) eBNF 4.2.1. excluding Clozapine
Antipsychotic depot injection eBNF 4.2.2.
Antimuscarinic drug (oral) eBNF 4.9.2.

One drug in each category
All dosage within eBNF limits

- 5.26 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.

- 5.27 **Section 61** – Where treatment is being given in accordance with a SOAD’s certificate, the Approved Clinician in charge of the treatment must complete a review of treatment and document it on the S61 form and send to locality MHA office to pass onto 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 forcibly treated **AND** the patient lacked capacity to consent to treatment or refused that treatment at the time;
 - At any other time as required by the CQC.
- 5.28 **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.
- 5.29 Section 58A cannot be used if the detained patient has capacity to consent to treatment and has not done so; a SOAD cannot authorise ECT in the face of a capable refusal unless it is an emergency (see 5.24 above). In other words, section 58A can only be invoked with either the patient’s valid consent or with a SOAD’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 8).
- 5.30 See paragraph 12 below regarding the rules relating to section 58A in respect of patients under the age of 18.
- 5.31 Certificates by Approved Clinicians or Second Opinion Appointed Doctors confirming that the patient has given valid consent to Section 58A treatment are made using form T4.
- 5.32 A certificate by a SOAD 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.
- 5.33 A new T4 certificate must be issued, if:
- the Approved Clinician who issued the certificate stops being the Approved Clinician in charge of the treatment, or
 - if any time limit expires.
- 5.34 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 8).

- 5.35 **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 7.2) 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.
- 5.36 **Obtaining Second Opinion Appointed Doctor (SOAD) Certificates for Section 57/58/58A type treatments** – Once the need for a SOAD 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 website²; a copy of this should be emailed to the local Mental Health Law office for tracking purposes.
- 5.37 The Mental Health Law office will monitor the completion of the process and where there are problems, liaise with the Responsible Clinician and CQC.
- 5.38 When the SOAD 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.)
- 5.39 It is for the SOAD 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.
- 5.40 The SOAD will also expect to see the clinical records, and interview the patient.
- 5.41 It is a legal requirement³ for the reasons given by the SOAD to be communicated to the patient. It is the responsibility of the clinician in charge of the treatment to communicate the reasons to the patient. This must be documented within the EPR system under the Mental Health Act & Mental Capacity Act - SOAD's Decision by Responsible Clinician form.
- 5.42 The role of the Mental Health Law Office
- 5.43 Mental Health Law Offices have electronic systems for alerting Responsible Clinicians of the expiry of a period of treatment without consent/certificate.
- 5.44 Reminders are sent via email on a weekly basis to the Approved Clinician in charge of the treatment together with the relevant clinical team, and colour coded Amber for those due in one month, and Red if overdue (for section 58 type treatments).
- 5.45 However, this does not preclude the clinical team from also ensuring systems are in place for recording when a period of treatment without consent/certificate might expire or when a certificate will expire.
- 5.46 The above is vitally important because if a patient is treated under section 57/58/58A without a valid form of authority, apart from the distress this may cause, it will

² <https://webdataforms.cqc.org.uk/Checkbox/SOAD.aspx>

³ R (on the application of Wooder) v Dr Feggetter and the MHAC [2002] EWCA Civ 554

potentially be deemed unlawful and the Trust will be at risk of a legal claim that could result in both reputational and financial loss.

- 5.47 Statutory Consent to Treatment certificates will be uploaded onto the EPR document store by MHL Offices once received via eMHA or other electronic means. What about certificates not done electronically?

6.0 Part 4A of the Mental Health Act 1983 – CTOs

- 6.1 Please see CTO Policy for guidance.

7.0 Consent and the Mental Capacity Act 2005

- 7.1 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.

- 7.2 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 7.3 below).

- 7.3 **Test for Capacity** – Please refer to the MCA policy for guidance on testing capacity

8. *Advance decisions to refuse Medical Treatment and wishes expressed in advance*⁴

- 8.1 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 anticipate on that at some point in the future the person may lose the capacity to refuse the treatment.

- 8.2 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.

- 8.3 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.

- 8.4 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

⁴ 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>

(sometimes known as an advance statement or directive), and a valid and applicable advance decision to refuse treatment which healthcare professionals must follow.

9. Lasting Power of Attorney & Court Appointed Deputies⁵

- 9.1 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 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.
- 9.2 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.
- 9.3 With the exception of Electro Convulsive Therapy (see 5.33 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 6). 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.
- 9.4 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 of Practice at 7.7.
- 9.5 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).
- 9.5 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).

10. Treatment for Physical Disorder and the Mental Capacity Act

- 10.1 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.
- 10.2 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-

⁵ 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>

inflicted as a result of mental disorder; feeding by naso-gastric tube of a patient with anorexia nervosa⁶). In these cases, the ancillary treatment may be given under the authority of section 63 of the Mental Health Act 1983.

- 10.3 For a person who lacks capacity, treatment for physical disorder may be given under the authority of the MCA if it is in the persons 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 patients⁷.
- 11.1 **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.
- 11.2 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

12.0 Children and young people

- 12.1 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.
- 12.2 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.
- 12.3 *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 responsibility⁸.

⁶ B v Croydon District Health Authority [1995] 1 ALL ER 683 (CA)

⁷ See chapter 13 of Mental Health Act Code of Practice for more information on the relationship between the MCA and the MHA

⁸ 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.

- 12.4 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.
- 12.5 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).
- 12.6 For children or young people who are informal patients but for whom electro-convulsive therapy is prescribed, please see below, para 12.8.
- 12.7 *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.
- 12.8 *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 SOAD has certified (Form T5) that the patient is capable of understanding the nature, purpose and likely effects and it is appropriate that the treatment be given.
- 12.9 When a person under 18 is not capable of consenting, a SOAD 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).
- 12.10 If the child/young person is under the age of 18 and not detained, a SOAD 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.
- 12.11 *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 5.25 above) apply.
- 12.12 *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.

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

12.14 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).

12.15 For children under the age of 16 who are CTO patients, practitioners must assess whether they are “Gillick competent” (see footnote to para 6.6 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.

12.16 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 6.10-6.11 above).

12.17 *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.

12.18 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 consents⁹ in these circumstances it is prudent to seek advice from the local Mental Health Law office before proceeding.

⁹ 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

12.19 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.

13.0 Other issues regarding consent

13.1 *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.

13.2 *Covert medication*

Please refer to Covert Administration Policy for guidance

14.0 Monitoring

14.1 The Mental Health Law Department will monitor and audit the following in line with the above policy across Mental Health directorates:

Elements to be Monitored	Lead	How Trust will monitor compliance	Frequency	Reporting	Parent Committee
Compliance with treatment certificate under Part IV of the MHA 1983	Mental Health Law Manager (MHA)	Audit	Every 2 years	MHLMG	Quality Committee
Concordance between treatment certificates and prescription charts	Nursing Directorate & Pharmacy	Audit	Every 2 years	MHLMG	
Seeking of consent and acknowledgement/assessment of capacity prior to first administration of treatment to patients subject to the MHA 1983	Mental Health Law Manager (MHA)	Audit	Every 2 years	MHLMG	
Communication of outcome of SOAD visit to patients	Mental Health Law Manager (MHA)	Audit	Every 2 years	MHLMG	

15.0 Associated Documentation – Appendices

Appendix 1

Record of Urgent Treatment - Section 62

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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.....

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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)

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

OR

Exceptional reasons for not doing so:

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

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)

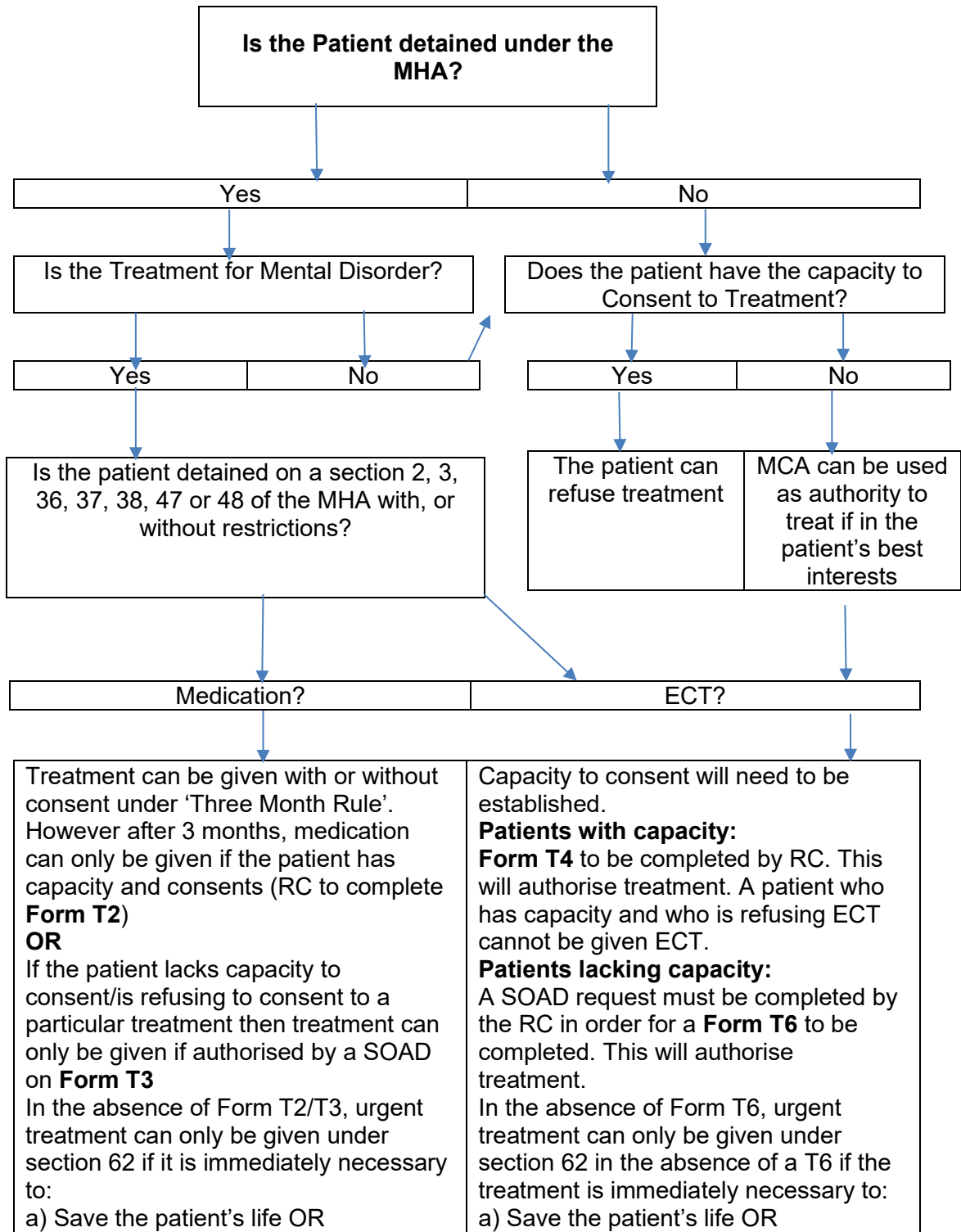
1. is emergency treatment which is authorised under Section 64G as the patient lacks the capacity to consent to it;

(PLEASE TICK)

AND

Consent to Treatment Flowcharts

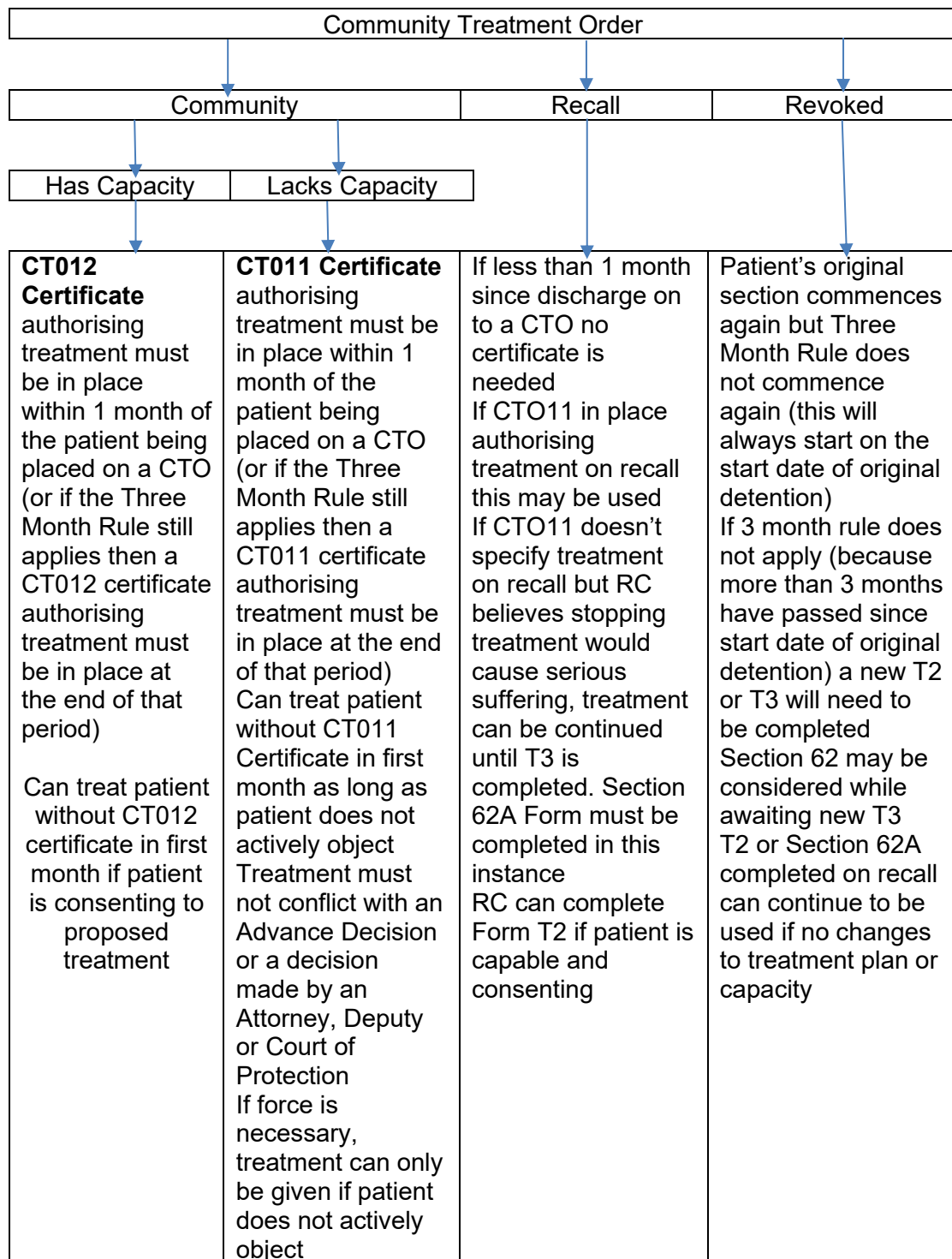
Part 4 - Inpatients



<p>b) Prevent a serious deterioration of the patient's condition OR</p> <p>c) Alleviate serious suffering by the patient OR</p> <p>d) Represent the minimum interference necessary to prevent the patient from behaving violently or being a danger to themselves or others.</p> <p>Section 62 – Urgent Treatment – Medication (S58) Form must be completed</p>	<p>b) Prevent a serious deterioration of the patient's condition</p> <p>Section 62 – Urgent Treatment – ECT (S58) Form must be completed</p>
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Flowchart of Consent to Treatment

Part 4A MHA – CTOs



	<p>Emergency treatment under Section 64G must be immediately necessary to:</p> <ul style="list-style-type: none">e) Save the patient's life ORf) Prevent a serious deterioration of the patient's condition ORg) Alleviate serious suffering by the patient ORh) Represent the minimum interference necessary to prevent the patient from behaving violently or being a danger to themselves or others		
--	-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	--	--