

## Hospital Managers' Power of Discharge Handbook

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<p><b>Documents to read alongside this Policy , Procedure etc (delete as necessary)</b></p>	<ul style="list-style-type: none"> <li>• The Mental Health Act 1983 (as amended by the Mental Health Act 2007)</li> <li>• Mental Health (hospital, guardianship, community treatment and consent to treatment)(Wales) regulations 2008</li> <li>• The Mental Capacity Act 2005 (including the Deprivation of Liberty Safeguards delegated to this Act under the Mental Health Act 2007)</li> <li>• The respective Codes of Practice of the above Acts of Parliament</li> <li>• The Human Rights Act 1998 (and the European Convention on Human Rights)</li> <li>• Domestic Violence, Crime and Victims Act, 2004</li> </ul> <p>All Cardiff and Vale UHB policies on the Mental Health Act 1983 as appropriate including:</p> <p>Hospital Managers' Scheme of Delegation Policy  Receipt of applications for detention under the Mental Health Act  Mental Health Review Tribunal Procedure and Guidance  Section 5(4) Nurses' Holding Power Policy  Section 5(4) Nurses' Holding Power Procedure  Section 5(2) Doctors' Holding Power Policy  Section 5(2) Doctors' Holding Power Procedure  Community Treatment Order Policy  Community Treatment Order Procedure</p>
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<b>Version Number</b>	<b>Date of Review Approved</b>	<b>Date Published</b>	<b>Summary of Amendments</b>
Mental Health Document only	11/04/2018	20/07/2018	<p>Amendments made to reflect the changes made to the Mental Health Act Code of Practice, (Revised 2016).</p> <p>Supervised Community Treatment has been replaced with Community Treatment Order.</p> <p>Includes further information on types of mental disorder.</p> <p>Guidance included on what to do if the panel cannot reach a unanimous decision.</p> <p>Amendments made to reflect changes made to the Police and Crime Act 2017, in relation to section 135 and 136.</p>

# **Hospital Managers' Power of Discharge Handbook**

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## **1. INTRODUCTION**

This handbook has been prepared with the needs of new Mental Health Act Power of Discharge Hospital Managers in mind, and as an aide memoir to existing members of the Power of Discharge Sub-committee, it is intended to support them in their role and to ensure that all hearings follow a recognised standard of good practice.

It should be read in conjunction with the Mental Health Act 1983 Code of Practice for Wales, (Revised 2016)) the Cardiff and Vale University Health Board Conduct of Power of Discharge Hospital Managers' hearings and any other guidance that is provided.

As the law changes, all reasonable efforts will be made to provide accurate and timely updates to this handbook.

## **2. EQUALITY STATEMENT**

Cardiff and Vale University Health Board (UHB) is committed to ensuring that, as far as is reasonably practicable, the way it provides services to the public and treats its staff, patients and others reflects their individual needs and does not discriminate, harass or victimise individuals or groups. These principles run throughout our work and are reflected in our core values, our staff employment policies and our service standards.

If, in future, there are any changes to this handbook that impact on any groups in respect of gender (including maternity and pregnancy, as well as marriage or civil partnership issues), race, disability, sexual orientation, Welsh language, religion or belief, transgender, age or other protected characteristics, every effort would be taken to make plans for the necessary actions required to minimise any stated impact to ensure that we meet our responsibilities under mental health legislation as well as that of equalities and human rights legislation.

Copies of this document in alternative formats, including Welsh can be provided, if required.

## **3. CONFIDENTIALITY**

This is covered in the document that sets out principal terms and conditions of appointment.

## **4. THE MENTAL HEALTH ACT 1983(2007) “THE ACT”**

The Mental Health Act 1983 (2007) is an Act of Parliament which applies to people in England and Wales. It also contains specific cross border provisions for the:

- removal of a patient from England or Wales to Scotland
- removal of a patient to and from Northern Ireland
- removal of a patient to and from Channel Islands and Isle of Man

- removal of alien patients
- return of patients absent without leave from hospitals in Northern Ireland, England and Wales and patients absent from hospitals in the Channel Islands or the Isle of Man.

The Act is the legislation that governs the formal detention, treatment and care of mentally disordered people in hospital. In particular, it provides the authority by which people diagnosed with a mental disorder can be detained in hospital, or police custody for their disorder to be assessed or treated, or treated in the community, if necessary without their consent.

The sections of the Act that specifically provide the power to detain a person vary in several ways including:

- The duration of detention.
- The professionals involved.
- Treatment,
- discharge or
- entitlement to appeal.

The powers of the Act are considerable as they override two basic human rights. Usually a person can only be detained if they have committed an offence however, under the Mental Health Act a person is detained not necessarily because of a crime, but because they have a mental disorder that needs hospital care and treatment. The other basic right is that an adult with mental capacity to consent can only be given treatment with their consent; again the Act overrides this and makes psychiatry unique in that treatment can be authorised that can override refusal of consent by an adult with capacity.

The use of the Act is regulated and reviewed in Wales by Healthcare Inspectorate Wales (HIW) and in England by the Care Quality Commission (CQC).

#### **4.1 Protection from liability**

There is provision within the Act to provide staff with protection from civil or criminal liability for all actions they take when using the legislative powers to physically detain and forcibly treat people. This protection is only available if the Act has been used properly; it does not apply if the actions in question were done in bad faith or without reasonable care.

Independent members of the Board and members of the Power of Discharge Sub-Committee are not personally liable for decisions taken about the discharge of detained patients; liability will rest with the University Health Board as a body.

## **4.2 Rights**

People detained under the Act are given legal rights, the most prominent being the right of appeal for discharge to the Mental Health Review Tribunal and the Hospital Managers.

## **4.3 Limitations**

Even though the powers of the Act are considerable, the legislation is limited in its application. To be detained, a person has to meet certain legal criteria all of which are designed to reduce the number of people affected by the legislation. The Act is largely confined to inpatient settings and treatment under the Act can only be given for mental disorder. Being on a section does not mean that staff can take control of a patient's finances or make any other treatment decisions without consent. In certain cases, other legislation such as the Mental Capacity Act may be used if applicable.

## **4.4 Age range of the Act**

The Act does not have a lower or upper age limit except in the case of guardianship. However, certain parts of the legislation contain several rules that apply when the person is under 18; the Mental Health Act then overlaps with the Children Act 1989 and other legislation. In such cases, services should choose the most appropriate legislation according to each situation.

## **4.5 Where does the Act apply?**

The Act is effective in and its powers limited to, England and Wales. As indicated above, cross-border arrangements apply between certain areas in the United Kingdom.

# **5. KEY PARTS OF THE ACT**

## **5.1 Definition of mental disorder**

The Act is limited in its use to people who have a mental disorder which is defined in the legislation as "any disorder or disability of mind". Where a patient has a serious learning disability, this must also be associated with abnormally aggressive or seriously irresponsible conduct to meet the criteria.

## **5.2 Powers to admit and treat people in hospital**

Over 20 different sections provide the power to detain a person for assessment and/or treatment of a mental disorder. Each section differs in relation to a number of matters including the maximum detention period allowed, the professionals required, the appeal procedures and the treatment regulations.

### **5.3 Criminal and Court related powers**

The Act includes a series of sections that allow courts and prisons to transfer people from the criminal justice system to hospital for assessment and treatment of mental disorder.

### **5.4 Community powers**

Guardianship and Community Treatment Orders provide the means to deliver supervised care in the community for certain people.

### **5.5 Treatment**

The Act provides a power to override a detained person's wishes and give them treatment for mental disorder without their consent. The legislation provides a number of mechanisms to safeguard this power and limit its use.

### **5.6 Mental Health Review Tribunal for Wales (The Tribunal)**

"The Mental Health Review Tribunal for Wales" is the statutory independent judicial body to which many patients can appeal against detention or be referred to within statutory timescales. It is administered and based in Cardiff.

A Tribunal panel will consist of a lawyer, a doctor and a lay member. The patient, their responsible clinician and care co-ordinator /social worker will also be at the hearing together with the patient's nearest relative, advocate and/or solicitor, unless the patient objects. The legal member will chair the proceedings.

The Tribunal's principal powers are to:

- Discharge a detained patient from hospital immediately or after a short further period of detention.
- Recommend leave of absence.
- Recommend CTO.
- Recommend transfer to another hospital.

There are separate Tribunals in England and Scotland.

### **5.7 Hospital Managers**

Under the Act, the Hospital Managers represent the organisation that formally detains a person. The Hospital Managers have a number of duties under the legislation including holding appeal hearings and reviews in accordance with the rules set out in section 20, the renewal of authority to detain and section 20A when a report has been made

extending the community treatment period. They also have the power to discharge patients from section following a hearing.

### **5.8 Independent Mental Health Advocacy**

Most patients with mental disorder have the right to advocacy provided by independent and specially qualified advocates.

### **5.9 Healthcare Inspectorate Wales**

This is the official body in Wales that monitors the use of the Act and makes regular visits to inpatient settings where it reviews the care and treatment of detained patients.

### **5.10 Nearest Relative**

The nearest relative role is an important part of the Act that formally assigns a person to act as the nearest relative for a detained patient; a nearest relative is not chosen or appointed by the patient, instead it is dictated by legislation. The Act gives specific legal powers to a detained patient's nearest relative and the term should not be confused with next of kin.

### **5.11 Conflicts of interest**

These are rules that protect from potential conflicts of interest in the use of the Act by staff and others.

## **6. THE MENTAL HEALTH (HOSPITAL, GUARDIANSHIP, COMMUNITY TREATMENT AND CONSENT TO TREATMENT) (WALES) REGULATIONS 2008 (the REGULATIONS)**

The regulations deal with the use of compulsory powers under the Act for those who are liable to be detained in hospital and in the community under guardianship or supervised community treatment. They also provide for the prescribed forms (section papers) which are used in the application of certain functions under the Act.

## **7. THE MENTAL HEALTH ACT 1983 CODE OF PRACTICE FOR WALES, (REVISED 2016)**

The Code provides guidance to practitioners, managers and staff of hospitals on how to proceed when undertaking duties under the Act; it also gives guidance about certain aspects of medical treatment for mental disorder. However it does not set out to explain each and every aspect of the Act and the regulations. The Code is intended to be helpful to patients, their representatives, carers, families and friends and others who support them. It should also be beneficial to the police and ambulance services and others in Health and Social Services (including the independent and voluntary sectors)

involved in providing services to people who are or who may become subject to compulsory measures under the Act.

**N.B:**

This is a statutory code concerning the practical use of the Act. It represents current thinking on best practice when using the legislation.

The Act does not impose a legal duty to comply with the Code, but due regard must be paid to it by those involved in the application of the Act and reasons for any departure from it should be recorded. Departures from the Code could give rise to legal challenge. In reviewing any such departure, a court will scrutinise the reasons for doing so to ensure that there is sufficiently convincing justification under the circumstances.

## **7.1 The Guiding Principles**

The Code includes a statement of guiding principles which the Welsh Ministers think should inform decisions under the Act, the primary intention being the safeguarding of patients' rights. They also cover carers and family who have the right to a fair and sensitive service for their relative.

Although all the principles must inform every decision made under the Act, the weight given to each in reaching a particular decision will depend on the context. In making some decisions it may be that greater weight should be given to some principles over others.

## **8. HUMAN RIGHTS ACT 1998**

The Human Rights Act must be considered with regard to the impact it has and duties it places on hospitals and Hospital Managers. It should be noted that as long as they are working within the guidance given by the Code, the requirements of the Human Rights Act are generally satisfied. The Articles (with a brief explanation) most commonly associated with Mental Health are:

### **8.1 Article 2 – The Right to Life**

A person has the right to have their life protected by law. There are only certain very limited circumstances where it is acceptable for the state to take away someone's life e.g. if a police officer acts justifiably in self-defence.

### **8.2 Article 3 – Protection from Torture and Inhuman and Degrading Treatment**

A person has the absolute right not to be tortured or subjected to treatment or punishment that is inhuman or degrading.

### **8.3 Article 5 - Right to Liberty and Security**

A person has the right not to be deprived of their liberty “(arrested or detained)” – except in limited cases specified in the article (e.g. where they are detained under the Mental Health Act) and provided there is a proper legal basis in UK law. This right has been central to many human rights based challenges brought by patients detained and treated under the Mental Health Act 1983.

### **8.4 Article 8 – Right to a Private Life**

A person has the right to respect for their private and family life, their home and their correspondence. This right can be restricted only in specified circumstances.

### **8.5 Article 14 – Prohibition of Discrimination**

The enjoyment of the rights and freedoms set out in the European Convention on Human Rights and the Human Rights Act shall be secured without discrimination on any ground such as sex, race, colour, language, religion, political or other opinion, national or social origin, association with a national minority, birth or other status.

## **9. THE HOSPITAL MANAGERS – WHO ARE THEY?**

The Hospital Managers have a central role in operating the provisions of the Act. They retain the final responsibility for the performance of their delegated duties including considering whether patients should be discharged.

The use of the term “Hospital Managers” in this context can be confusing because it does not mean the people responsible for the day to day management of the hospital.

In Wales, NHS hospitals are managed by Local Health Boards and it is the Board members who are defined as the Hospital Managers for the purposes of the Act. In practice, most of the decisions of the Hospital Managers are actually taken by individuals or groups of individuals on their behalf. In Cardiff and Vale UHB, the arrangements for authorising decisions are set out in a Scheme of Delegation which has been approved by the Board.

It is the Hospital Managers who have the authority to detain patients under the Act; they have the primary responsibility for seeing that the requirements of the Act are followed. In particular, they must ensure that patients are detained only as the Act allows, that their treatment and care accord fully with its provisions and that they are fully informed of, and supported in exercising their statutory rights. As managers of what the Act terms “responsible hospitals”, the Hospital Managers have equivalent responsibilities towards patients on a Community Treatment Order (CTO), even if those patients are not being treated at one of their hospitals.

Ultimately it is the Hospital Managers who are responsible for ensuring that patients are detained lawfully.

### **9.1 Duties of Hospital Managers:**

- To ensure that the grounds for admission under the Mental Health Act are valid and that all documentation is in order.
- That those formally delegated to receive documents and those who are authorised to scrutinise them have a thorough understanding of the Act.
- Review of patients' detention in hospital.
- To provide relevant information to patients and with the consent of the patient, their nearest relative.
- To ensure that any patient who wishes to apply to, or who needs to be referred to the Mental Health Review Tribunal for Wales and/or the Hospital Managers is given the necessary assistance to do so.
- To authorise the transfer of certain patients to the care of another set of managers.
- To consent to the rectification of certain defined errors identified during the scrutiny process.

### **9.2 Powers of Hospital Managers:**

- To review the grounds for detention and discharge.
- To withhold mail.
- To transfer a patient.
- To discharge a patient.

### **9.3 Hospital Managers' Power of Discharge**

The Hospital Managers do not conduct reviews of informal patients.

Section 23 gives Hospital Managers the power to discharge (absolutely) an unrestricted patient from detention or CTO. (Discharge of a restricted patient requires the consent of the Secretary of State for Justice).

Special rules apply to the exercise of the Hospital Managers' power to discharge patients from detention or CTO. The power can be delegated only to Hospital Managers' panels made up of independent members of a Board and/or people specially appointed for the purpose. Currently, in Cardiff and Vale UHB, it is the members of the Power of Discharge Sub-Committee who undertake this role on behalf of the Hospital Managers.

Power of Discharge panels must comprise of least three members and the Hospital Managers should ensure that those appointed are fully informed and receive suitable training to ensure that they are equipped for the role.

## **9.4 The Mental Health and Capacity Legislation Committee**

Cardiff and Vale UHB retains responsibility for the performance of all Hospital Managers' functions exercised on its behalf and must ensure that the people acting on its behalf are competent to do so.

The Mental Health and Capacity Legislation Committee has been formed to consider and monitor the use of the Mental Health Act 1983, Mental Capacity Act 2005 (MCA) which includes the Deprivation of Liberty Safeguards (DoLS) and the Mental Health (Wales) Measure 2010 (the Measure).

## **10. MENTAL DISORDER**

Mental disorder is defined in section 1 of the Mental Health Act as any disorder or disability of mind.

It is up to the relevant professionals involved to determine whether a person has a disorder or disability of the mind in accordance with good clinical practice and accepted standards of what constitutes such a disorder or disability.

The fact that someone has a mental disorder is never sufficient grounds for any compulsory measure to be taken under the Act. Compulsory measures are only permitted where specific grounds about the potential consequences of the person's mental disorder are met. There are many forms of mental disorder which are unlikely ever to call for compulsory measures.

### **10.1 Dependence on alcohol or drugs**

There are no grounds under the Act for detaining a person in hospital on the basis of alcohol or drug dependence alone. However, alcohol or drug dependence may be accompanied by, or associated with, a mental disorder which does fall within the Act's definition. Individuals with a dual diagnosis<sup>1</sup> should receive equitable care and treatment and support. If the criteria for detention are met, it is appropriate to detain people who are diagnosed with a mental disorder, even though they are also dependent on alcohol or drugs and/or if the mental disorder in question results from the person's alcohol or drug dependence.<sup>2</sup>

Disorders or disabilities of the mind which are related to the use of alcohol or drugs e.g. withdrawal state with delirium or associated psychotic disorder, acute intoxication, or

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1

<http://gov.wales/docs/dhss/publications/150909reporten.pdf>

2

2.6 MHA CoP for Wales, (Revised 2016)

organic mental disorders associated with prolonged abuse of drugs or alcohol remain mental disorders for the purposes of the Act.<sup>3</sup>

### **10.2 Learning disabilities**

Learning disabilities are forms of mental disorder as defined in the Act. However someone with a learning disability and no other form of mental disorder may not be detained for treatment or made subject to guardianship or a Community Treatment Order under the Act unless their learning disability is associated with abnormally aggressive or seriously irresponsible conduct on the part of the person concerned. They can however be detained for assessment under section 2 of the Act.<sup>4</sup>

### **10.3 Autistic spectrum disorders**

It is possible for someone with an autistic spectrum disorder to meet the criteria for compulsory measures under the Act without having any other form of mental disorder, even if their autistic spectrum disorder is not associated with abnormally aggressive or seriously irresponsible behaviour.<sup>5</sup>

### **10.4 Personality disorders**

The Act does not distinguish between different forms of mental disorder and therefore applies to all types of personality disorders in exactly the same way as it applies to other mental disorders. Personality disorder must never be viewed as a diagnosis of exclusion.<sup>6</sup>

## **11. ASSESSMENT FOR POSSIBLE ADMISSION UNDER THE ACT**

Most people with a mental illness receive medical treatment and personal support at home from their GP, Primary Mental Health services and Community Mental Health Team (CMHT). Generally, people are only admitted to hospital when they become extremely unwell or when they are in crisis.

If a person needs treatment in hospital, a referral is usually made by their GP or CMHT. If they are not already known to the local Mental Health Services they may be admitted urgently for assessment.

The aim of an assessment is to find out whether the grounds and criteria for detention in hospital under the Act are met. All relevant factors will be taken into account by the assessing team and any appropriate alternative means of providing care and treatment will be considered.

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2.7 MHA CoP for Wales, Revised 2016(Revised 2016)

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2.9 MHA CoP for Wales, Revised 2016(Revised 2016)

5

2.12 MHA CoP for Wales, Revised 2016(Revised 2016)

6

2.13 MHA CoP for Wales, Revised 2016(Revised 2016)

The disorder must be sufficiently serious that admission is necessary for the person's health or their safety or for the protection of other people and they need to be in hospital for assessment or treatment and are unwilling or incapable of agreeing to admission. Appropriate treatment must be available at the hospital to which the person is to be admitted.

## **12. ADMISSION TO HOSPITAL FOR ASSESSMENT/ TREATMENT UNDER THE ACT**

Admission may either be informal or formal.

### **12.1 Informal Admission**

A person may be admitted informally when they agree to admission and treatment in hospital; they are then referred to as either voluntary or informal patients. Voluntary patients can discharge themselves and leave hospital at any time without the agreement of staff. However, section 5 of the Act gives nurses and specified doctors the authority to stop a voluntary patient discharging him or herself if they are seriously mentally unwell.

### **12.2 Formal Admission**

A person becomes a formal patient when they are admitted to hospital under a section of the Mental Health Act. This compels them to remain in hospital even against their wishes, for set periods to be assessed or receive treatment.

Some people are detained in hospital by the courts after being charged for having committed a crime under what is commonly known as a "forensic section".

The legal authority for such an admission to hospital comes from the Mental Health Act.

### **12.3 Who decides if a person needs to be admitted under a Part 2 section of the Act?**

The process usually starts because the person's GP, family member, psychiatrist or a police officer is concerned about their mental health.

The decision to admit a person to hospital is usually made by two doctors (other than in an emergency when the Act provides for one medical recommendation only) and an Approved Mental Health Professional (AMHP). At least one of the doctors must be section 12 approved by Welsh Ministers or the Secretary of State. Wherever possible, the second doctor (usually the patient's GP) should have had previous acquaintance with the patient.

AMHPs apply a social perspective to care; they are usually a social worker, but could be a mental health nurse, clinical psychologist or occupational therapist.

In most cases, the AMHP assessor will consult with the patient's nearest relative. The role of the nearest relative is an important patient safeguard so it is important to identify the correct person (see role of nearest relative below).

#### **12.4 Who decides in an emergency?**

This would depend on the location of the person at the time:

- If in a public place, the person could be arrested by a police officer under section 136 and taken to a place of safety if that person was deemed to be suffering from mental disorder and in need of immediate care and control. In Cardiff and Vale, the designated place of safety is Hafan Y Coed.
- If the person is already in hospital, certain nurses and doctors can detain a person pending further assessment.
- If a person is in their own home and refuses to let a doctor or AMHP in to see them, a magistrate can issue a warrant under section 135(1) that enables the individual's home to be entered with the aim of removing the person to a place of safety.

#### **12.5 Appropriate medical treatment test**

When a patient has been detained under a treatment section of the Act, there must be appropriate medical treatment available for their mental disorder. This is to ensure that nobody is detained unless they are actually to be offered treatment for their mental disorder.

Medical treatment for mental disorder means medical treatment for the purpose of alleviating or preventing a worsening of a mental disorder or one or more of its symptoms or manifestations.

Appropriate medical treatment does not have to involve medication or individual or group psychological therapy. In particular cases appropriate treatment consists solely of nursing and specialist day to day care under the clinical supervision of an approved clinician.

The appropriate medical treatment test requires a clinical judgment about whether an appropriate package of treatment for the mental disorder is available and accessible for the individual within the setting in which they are receiving that treatment. Where the appropriate medical treatment test forms part of the criteria for detention, the medical treatment in question is treatment for the mental disorder in the hospital in which the patient is to be detained. Where it is part of the criteria for CTO, it refers to the treatment for mental disorder that the person will be offered while on CTO.

## **12.6 What happens when the patient arrives at the hospital?**

Every patient who is admitted under the Mental Health Act must be allocated a responsible clinician. This is the approved clinician who will have overall responsibility for the patient's case.

The patient's responsible clinician is the available approved clinician with the most appropriate expertise to meet the patient's main assessment and treatment needs. This is usually a consultant psychiatrist, although it could be a senior nurse, psychologist, occupational therapist or social worker.

## **12.7 What is the role of the nearest relative?**

The role of the nearest relative is an important patient safeguard for patients subject to Part 2 of the Act and those who have been placed under hospital or guardianship orders by a court. Nearest relative is a specific legal term defined in section 26 of the Act. The Mental Health Act gives the nearest relative powers in relation to detention, discharge and being informed or consulted when certain actions have been taken under the Act or when these are being proposed. However, the role is limited to these rights and powers under the Act.

## **12.8 Identifying the nearest relative**

Initially, a person assessed as requiring admission to hospital for treatment for mental disorder has no choice over who is defined as his or her nearest relative. Only certain relations can be treated as nearest relatives under the Act; identifying the nearest relative is a complex process usually undertaken by the AMHP during the assessment.

In accordance with the hierarchy (below) set out in section 26 of the Act i.e.:

- **Husband or wife or civil partner**  
This includes people who have lived together as husband and wife or civil partners for at least six months, as long as they are not married to someone else. If they are permanently separated, or one has deserted the other, they are excluded.
- **Son or daughter**  
The Act states an "illegitimate child" will be treated as a legitimate child of their mother. Such a child will also be the legitimate child of their father if the father has parental responsibility for them within the meaning of the Children Act.
- **Father or mother**
- **Brother or Sister**  
The Act does not distinguish between half and full-blood relations so, a half-sister can be treated as a sister for the purposes of this section. However, a full-blood sister will take precedence over a half-blood sister.
- **Grandparent**
- **Grandchild**

- **Uncle or Aunt**
- **Nephew or Niece**

For all the above, if there is more than one person of equal standing in a category (e.g. two full blood sisters) the eldest one will be classed as the nearest relative.

- **Carers**

If the patient was living with, and/or cared for by any one of the relatives in the list above, that relative will be preferred as the nearest relative regardless of their position in the hierarchy. If there are two such relatives, the hierarchy will again take effect to decide which one of them will assume the position of nearest relative.

If no one qualifies as a nearest relative under the rules in section 26, the County Court can appoint someone to act as nearest relative.

The County Court also has the power to make an order replacing the Nearest Relative with another person if the nearest relative as defined by section 26 is shown to be unsuitable to act as nearest relative. The patient also has the right to apply for such an order under certain circumstances.

## **12.9 Exclusions**

Patients subject to certain “forensic sections” will not be appointed a nearest relative.

The following people are excluded from being a nearest relative:

- A non-resident of the UK, Channel Islands or the Isle of Man
- Anyone under the age of 18 unless they are the husband, wife or civil partner
- Anyone subject to an un-rescinded order under section 38 of the Sexual Offences Act 1986.

## **12.10 Nearest Relatives of detained patients who are not UK residents**

Normally, if a relative is not resident in the UK they are excluded by the Act. However, if the patient is not a UK resident themselves e.g. they are a tourist or recent migrant, then the nearest relative may be a person not resident in the UK.

## **12.11 Unrelated Nearest Relatives**

A person who is unrelated to the patient may also be classed as the nearest relative if they have lived with the patient (but not as husband or wife) for at least five years. However, this person will be considered last in the hierarchy.

## **12.12 Information for patients and nearest relatives**

On admission and at certain times during their detention, patients will be provided with written and oral information specific to their status as a detained patient.

The patient will be offered the assistance of an Independent Mental Health Advocate (IMHA) to specifically provide specialist advocacy support within the framework of Mental Health legislation in the United Kingdom and Wales. Information on Advocacy Support Cymru is given to all patients on admission under the Act, at key stages during their detention in hospital and on request.

In its "Interpretation and Translation Services Policy", Cardiff and Vale UHB provides a process for health professionals to support and enable patients to communicate effectively during their encounter with health service providers.

At the time of admission and at certain other times during detention, staff will make every effort to ensure that detained patients are aware of their right to apply for discharge from detention by the Hospital Managers. Where patients lack the mental capacity to understand this information, all attempts at explaining the right will be recorded.

Wherever possible, the distinction between the patient's right to apply to the Hospital Managers for discharge and their right to make an application for discharge to the Mental Health Review Tribunal for Wales must be made clear to the patient.

In the case of Part 2 patients, provided that the patient consents, the nearest relative will also be given relevant information.

N.B. Nearest Relative status does not apply to relatives of Part 3 patients, with the exception of those subject to a section 37 hospital order for admission which has been made by the court.

## **12.13 What power does the hospital have over the patient when they are detained?**

A patient can be held in the hospital, on a locked ward if necessary for safeguarding reasons. They may only leave the ward if authorised to do so by the RC when conditions may be attached.

The choice of medication should be discussed with the patient unless they are unable or unwilling to discuss it. Patients may be forced to take medication if their RC thinks it is necessary.

If after three months, the patient is still detained and does not wish to take medication, or does not have the mental capacity to consent to it, but the RC still thinks it is necessary, the patient will be seen by an independent consultant psychiatrist known as a Second Opinion Approved Doctor (SOAD), appointed by Healthcare Inspectorate Wales.

A patient cannot be forced to have electroconvulsive therapy (ECT) unless in an emergency to save their life or prevent a serious deterioration in their health. They can only have ECT if they consent to it. If they are too ill to be able to make a decision regarding ECT, it may only be administered if certified by a SOAD.

#### **12.14 Options available to a patient if they disagree with their detention in hospital:**

- **Discussion with their Responsible Clinician-** Patients are advised to discuss the situation with their RC or other members of the clinical team in the first instance. As soon as the RC thinks it is safe to do so, they will discharge the patient. If however, the RC thinks the patient still needs to be detained there are two **other avenues** for review of detention available to the patient.
- **Application for discharge to the Mental Health Review Tribunal (MHRT) for Wales** - The main purpose of the Tribunal is to review the cases of detained patients, conditionally discharged patients and those subject to CTO and to direct the discharge of any such patients where the statutory criteria for detention are not met. In doing so, they make a balanced judgment on a number of issues such as:
  - The patient's diagnosis and the need for medical treatment.
  - The freedom of the individual.
  - The protection of the public and
  - The best interests of the patient.

Tribunal panels include three members, a lawyer or judge a medical member and a lay member. Tribunal hearings take place at the hospital or community setting.

The Hospital Managers have various duties to refer cases to the MHRT for Wales and they may also ask Welsh Ministers to refer a patient.

Tribunals usually take place when patients detained in hospital under certain sections apply for a hearing, a solicitor or advocate may also make an application on behalf of the patient. Patients under certain sections may also be referred to the Tribunal by the Hospital Managers (Mental Health Act Administrators) at specific times during their detention.

Tribunals have the power to:

- Discharge patients from hospital.
- Recommend leave of absence.
- Recommend CTO, decide on a deferred discharge, conditional discharge or transfer to another hospital or

- Reconvene if their recommendations are not complied with – however, the hospital is not obliged to follow up recommendations of a Tribunal.
- **Hospital Managers' Review (Hearings)** - Section 23 gives the Hospital Managers the power to discharge an unrestricted detained patient from detention or CTO.

When deciding whether to consider the case, Hospital Managers' are entitled to take into account whether the Tribunal has recently considered the patient's case, or is due to do so in the near future.

The Act does not define the legal criteria or the procedure for reviewing a patient's detention but essentially the process will mirror that of the Mental Health Review Tribunal. However, the exercise of this power is subject to the general law and public law duties which arise from it. The Hospital Managers' conduct of reviews must abide by the rules of natural justice:

- They must adopt and apply a procedure that is fair and reasonable
- They must not make irrational decisions i.e. decisions which no body of hospital managers properly directing themselves as to the law and on the available information could have made.
- They must not act unlawfully – that is, contrary to the provisions of the Act and any other legislation including the Mental Capacity Act 2005 (MCA), the Human Rights Act 1998 (HRA) and the Equality Act 2010.

As the Hospital Managers Power of Discharge panels carry out a high number of reviews across the Health Board, the number and types of detention orders (sections) they come across will vary. In the main, their reviews will be of sections 2, 3, 37, Community Treatment Order (CTO).

Listed below are the more commonly used detention orders, community orders and parts of the Act which members of the Hospital Managers' Power of Discharge sub-committee will come into contact with on a regular or fairly regular basis:

### **12.15 Section 2 – Admission for Assessment**

The detention period lasts for a period of up to 28 days to enable assessment or assessment followed by treatment for mental disorder to take place.

Patients have the right of appeal to the Hospital Managers at any time and without limit to the number of appeals (at the discretion of the Hospital Managers) during the 28 days but they may only appeal to the Mental Health Review Tribunal within the first fourteen days of detention.

Section 2 cannot be renewed but under certain circumstances, the 28 day period may be extended whilst an application is made to a county court to have another person appointed as nearest relative depending if certain grounds are met.

### **12.16 Section 3 – Admission for Treatment**

This admission is initially for a period of up to six months; if it runs its full course, the section may be renewed for a further six months and twelve monthly periods thereafter.

Patients may appeal to the Hospital Managers at any time during a period of detention but they can only appeal to the Mental Health Review Tribunal once in each period of detention.

Where the patient has recently had a hearing (either MHRT or Managers), the chair of the Hospital Managers Power of Discharge Sub-committee may refuse for the case to be considered unless there has been a significant change in the patient's circumstances or condition since that hearing. This prevents unnecessary hearings taking place which may distress the patient and impact on those involved in their care. This is known as the 28 day rule.

### **12.17 Section 37 – Hospital Order**

Section 37 provides for a court to sentence a person to hospital for treatment (or guardianship) for up to six months.

The criteria and resulting admission work in the same way as a section 3 except for the appeal process. A section 37 patient has:

- The right of appeal to the Crown Court or Court of Appeal to have the conviction quashed or a different sentence imposed.
- The right to appeal to the Tribunal, but only in the second six months and then once in each subsequent period of detention.
- The right of appeal to the Hospital Managers at any time and without limit to the number of appeals at the discretion of the Hospital Managers.

### **12.18 Section 4 – Emergency Admission for Assessment**

Provides the power to forcibly admit and detain a person in hospital for up to 72 hours where it is of urgent necessity for the person to be admitted and detained under section 2 but only one doctor is available at the time to make a medical recommendation.

### **12.19 Section 5(2) – Doctor's Holding Power**

This section provides the authority for a doctor or approved clinician to detain either a voluntary inpatient or a patient who lacks capacity for up to 72 hours. It is designed to provide the time required to complete an application for section 2 or section 3 if the

person wishes to leave hospital before the necessary arrangements for these applications can be made.

### **12.20 Section 5(4) – Nurse’s Holding Power**

Section 5(4) allows a nurse (registered with the Nursing and Midwifery Council mental health or learning disability) to detain a voluntary inpatient or a patient lacking capacity for up to 6 hours. The person already has to be receiving treatment for mental disorder as an inpatient and is indicating that they wish to leave hospital and there has to be an immediate need to prevent this where a doctor or approved clinician is not available to complete a section 5(2) instead. This section is intended as an emergency measure.

### **12.21 Section 135(1) – Warrant to search for and forcibly remove a person**

Provides the power to forcibly enter a property to look for and remove a person to a place of safety (usually a hospital) for a maximum period of up to 24 hours for assessment, if it appears to a magistrate that there is reasonable cause to suspect that a person believed to be suffering from mental disorder; has been ill-treated, neglected or kept otherwise than under proper control or is living alone and unable to care for themselves. This period can be extended for a further 12 hours by the responsible medical practitioner if a Mental Health Act assessment cannot be completed within the permitted period due to the person’s mental or physical condition.

### **12.22 Section 135(2) – Warrant to search for and remove a patient**

Authorises forcible entry of a property to look for and remove a detained patient who is absent without leave (AWOL) from hospital if on information given, it appears to a magistrate that there is reasonable cause to believe that a patient already subject to a section is to be found on premises within the jurisdiction of the magistrate **and** admission to the premises has already been refused or a refusal of entry is predicted.

If the person allows entry to the property voluntarily, there is no need to obtain a section 135(2) warrant.

### **12.23 Section 136 – Police power of arrest**

Under this section, if a police officer believes that a person in a public place is “suffering from mental disorder” and is in “immediate need of care and control”, the police officer can take that person to a “place of safety” for a maximum of 24 hours so that the person can be examined by a doctor, interviewed by an AMHP and any necessary arrangements can be made for the person’s treatment and care. This period can be extended for a further 12 hours by the responsible medical practitioner if a Mental Health Act assessment cannot be completed within the permitted period due to the person’s mental or physical condition.

## **12.24 Section 17A – Community Treatment Order (CTO)**

This allows for a patient to receive the care and treatment they need for their mental disorder in the community rather than in hospital. To be eligible for CTO the patient must have been detained on one of the treatment sections when the application for the CTO was made.

Each time a period of section 17 leave is granted to a detained patient for more than 7 consecutive days, their RC must consider whether it would be appropriate for the patient to be subject to CTO.

The patient's responsible clinician may specify conditions to be applied by the CTO. The only limitation on conditions is that they are "necessary" or "appropriate" for:

- Ensuring the patient receives medical treatment
- Preventing the risk of harm to the patient's health or safety
- Protecting other persons.

Once on CTO, the patient may be recalled to hospital for up to 72 hours where the treatment rules under the Act apply during that period of recall.

## **12.25 Section 7 – Guardianship**

For patients in the community, guardianship allows their responsible clinician and others to specify a place of residence. Guardianship is initially for a period of six months; it can be renewed for a further six months by the RC and yearly thereafter. The Local Authority would manage the guardianship rather than Cardiff and Vale UHB.

## **12.26 Part 4 – Treatment**

Part 4 of the Act allows patients under certain sections; for example sections 2, 3 and 37 to be compulsorily treated for mental disorder if necessary.

Treatment may only be given for the first three month period of detention following which; treatment may only be given with the patient's consent or second opinion.

## **12.27 Part 4A – Treatment of a community patient (CTO)**

Patients subject to a CTO (community patients) are covered by Part 4A.

A community patient with capacity to make treatment decisions who has not been recalled may not be given treatment unless they consent to that treatment. The position is the same even if they need emergency treatment for their mental disorder. However, if recalled to hospital, a community patient would then be subject to the rules of Part 4 in the same way as other detained patients.

A patient subject to a community order who has not been recalled and lacks capacity to consent to treatment may be given treatment under the Act if:

- They have an attorney or deputy who can give authority for the treatment; or if the Court of Protection is asked to give authority, through an order of the court;
- or**
- It does not conflict with an advance decision made by the patient or the views of an attorney, deputy or the Court of Protection **and** there is no reason to believe that the patient would object to the treatment or, if there is a belief that the patient may object, it is not necessary to use any force in order to give the treatment against these objections.

Community patients need a certificate, for medication after one month and for ECT at any time regardless of their consent.

### **12.28 Section 17 – Leave of absence**

Under section 17, the RC may grant leave of absence to a patient from the hospital in which that patient is liable to be detained. Leave authorisation can be subject to any conditions which the RC considers necessary in the interests of the patient or for the protection of other persons. Only the RC can grant leave.

### **12.29 Section 18 – Absent without leave (AWOL)**

If a patient takes leave of absence from the hospital without a section 17 leave authorisation in place, or does not return from authorised leave, the patient is classed as AWOL.

If a CTO patient is recalled to hospital and does not return, they are also classed as AWOL.

### **12.30 Section 20 – Renewal of authority to detain**

If a section is to be renewed, sections 3, 37, 17A and 47 (transfer of sentenced prisoners to hospital and treated as section 37) require the RC to complete a “renewal of authority to detain report” before expiry of the section. This allows for the section to continue for a further period of six or twelve months, dependent upon the time that the patient has already been detained.

Once a report has been completed, the Hospital Managers (Power of Discharge panel) are obliged to consider it and whether it is appropriate to exercise their discretion of discharge before the end of the current period of detention or community treatment.

### **12.31 Section 20A – Extending a Community Treatment Order**

Once a report has been completed, the Hospital Managers (Power of Discharge panel) are obliged to consider it and whether it is appropriate to exercise their discretion of discharge before the end of the current period of community treatment ends.

### **12.32 Section 23 – Discharge from detention**

Sections can end in a number of ways including:

- Discharge of the patient by the RC before the end of the section period.
- Discharge by the Mental Health Review Tribunal following review
- Discharge by the Hospital Managers following review
- Discharge by the nearest relative (the nearest relative may order the discharge of a patient detained under certain Part 2 sections, CTO or guardianship, however, the RC may issue a “barring certificate” provided that sufficient grounds existing to prevent the discharge.

### **12.33 Section 117 – Aftercare**

This section provides a legal right to aftercare services for anyone who has ever been detained under s.3, s.37, s.45A (power of higher courts to direct hospital admission), s.47 (transfer to hospital of sentenced prisoners) and s.48 (transfer to hospital of unsentenced prisoners).

Once triggered, the right to aftercare is ongoing and remains in place regardless of the person’s circumstances. It only ends when both authorities jointly agree that the person no longer needs aftercare; however, they cannot arrive at this conclusion as long as a person remains subject to a community treatment order.

## **13. ARRANGEMENTS FOR HOSPITAL MANAGERS’ POWER OF DISCHARGE HEARINGS**

### **13.1 When to hold a review**

Hospital Managers:

- May undertake a review of whether or not a patient should be discharged at any time, at their discretion.
- Must undertake a review if the patient’s responsible clinician submits to them a report under section 20 renewing detention or under section 20A extending CTO.
- Should consider holding a review when they receive a request from (or on behalf of) a patient.

- Should consider holding a review when the RC makes a report under section 25 barring an order by the nearest relative to discharge the patient.

In Cardiff and Vale UHB, the review of a patient's detention or CTO is carried out by a panel of three members drawn from the Hospital Managers' Power of Discharge Sub-committee. Reviews are often referred to as hearings; they may be contested or uncontested.

### **13.2 Chairing a panel**

This is a key role with particular responsibility for the conduct of the hearing, for initiating any further action and for recording the decision, any concerns and/ or comments.

### **13.3 Agreeing key questions**

Before a hearing commences, the panel should identify key questions to raise with members of the clinical team and patient, the patient's advocate or legal representative whilst recognising that additional questions or issues may emerge as the hearing progresses.

### **13.4 Location**

Hearings will be held in various locations across UHB sites depending on where the patient is liable to be detained. If the patient is subject to CTO, arrangements will be made for hearings to be held at their Community Mental Health Team base if appropriate.

There will be times when following risk assessment by clinical staff, hearings may need to be held in ward areas; this may not appear to be conducive to proceedings but panel members have to be guided by the expertise of staff working with the patient.

### **13.5 Uncontested Hearings**

In Cardiff and Vale UHB, all uncontested renewals take place through the full hearing process with all relevant people and professionals present, including the patient if they so wish.

### **13.6 Contested Hearings**

In Cardiff and Vale UHB, all contested renewals take place through the full hearing process with all relevant people and professionals present, including the patient if they so wish.

The Mental Health Act Administrator will not normally be present during a contested hearing; they will however be available to contact if required.

### 13.7 Potentially Complex Hearings

“Potentially Complex” hearings would include those where a patient is being legally represented or where a nearest relative is exercising their power to discharge a patient from sections 2, 3, or a community treatment order. The exercise of this power is limited because it can be barred by the RC if they believe that the patient, if discharged, would be likely to act in a manner dangerous to themselves or others.

If discharge is barred, the nearest relative may not exercise their power of discharge for a further six months. However, the nearest relative may appeal against the RC’s veto to discharge by applying to the Mental Health Review Tribunal within 28 days but this only applies if the patient is detained under section 3 or a Community Treatment Order at the time.

For any hearing which is likely to be contentious a decision will be made by the Mental Health Act Manager as to the level of administrative support provided on the day.

Any request a panel makes for legal advice to support a hearing must be escalated to the Mental Health Act Manager via the Mental Health Act Office.

### 13.8 Mental Health Act Office Responsibilities

Leading up to a hearing, Mental Health Act Office staff will make the following arrangements:

- Ensure that the patient is aware that advocacy support is available.
- Wherever possible, make suitable arrangements to accommodate those patients and/or their nearest relatives who have a physical disability or need an interpreting service.
- Identify panel members and select a chairperson in accordance with the rota in place for each role to ensure that duties are allocated fairly and skills are maintained.
- Where the patient is an inpatient, taking into account any clinical advice, identify the most appropriate venue for the hearing i.e. meeting room or ward venue will be identified.
- Where the patient is subject to CTO, consider the most appropriate location for the hearing i.e. community venue wherever possible. Under no circumstances will a hearing be held at a patient’s or any other person’s home.
- Ascertain if the patient wishes the nearest relative/others to attend the hearing; if the patient does not consent to the attendance of his/her nearest relative, the appropriate professional involved in the patient’s care will obtain the views of the nearest and/or most concerned relatives and include these in his or her report.
- Ensure that panel members are sent relevant reports and care plans electronically; **it is expected that they will bring these reports (printed or tablet versions) with them on the day.** Panel members are also able to receive verbal evidence in the absence of a written report e.g. if it has not been

possible to complete a full mental health assessment in time for a report to be completed prior to a hearing or to provide a contemporaneous written update if the report was compiled some time before the hearing.

- Ensure that all reports are circulated to the patient and others as appropriate other than in circumstances where elements of the report may be withheld.
- On the day of the hearing, check with ward staff to ascertain whether or not it is the intention of the patient to attend the hearing.

**N.B. at the end of each hearing, printed copies of reports must be handed in to the Mental Health Act office or to the team administrator for destruction if the hearing is held at a community venue.**

### 13.9 Conduct of proceedings

“The Act does not define the criteria or the procedure for reviewing a patient’s detention however the exercise of this power is subject to the general law and public law duties which arise from it. The Hospital Managers’ conduct of reviews must satisfy the fundamental legal requirements of fairness, reasonableness and lawfulness. Managers’ discharge panel should therefore:

- Adopt and apply a procedure which is fair and reasonable.
- Not make irrational decisions, that is, decisions which no managers’ panel properly directing itself as to the law and on the available information could have made, nor
- Act unlawfully – that is contrary to the provisions of the Act and any other legislation including the Mental Capacity Act 2005 (MCA), the Human Rights Act 1998 (HRA) and the Equality Act 2010.

*Mental Health Act 1983 Code of Practice for Wales, Revised 2016(Revised 2016).*

Hospital Managers panels should ensure that guiding principles set out in the Code are applied.

**N.B.** “The procedure for the conduct of any hearing is for managers’ discharge panels themselves to decide, but generally it needs to balance informality against the rigour demanded by the importance of the task, as this promotes the empowerment and involvements principle. Key points are:

- The patient should be allowed to be accompanied by a representative of their own choosing to help in putting their point of view to the panel. If the patient lacks capacity to put their point of view, their deputy, attorney or other representative of their choosing should be allowed to represent them.
- The patient should also be allowed to have a relative, friend, carer, deputy, attorney or advocate attend to support them.

- The responsible clinician and other professionals should be asked to give their views on whether the patients continued detention or a CTO is justified and to explain the grounds on which those views are based.

*Mental Health Act 1983 Code of Practice for Wales, Revised 2016(Revised 2016)*

The panel has discretion as to how a hearing is run but normally all those attending should be present throughout the entire proceedings. This promotes an open exchange of views and statements and can have a therapeutic benefit. However, circumstances and natural justice may mean that alternative models will have to be considered.

The order of giving evidence is also for the panel to decide. However it can be less intimidating if the panel acknowledges the importance of the patient in the proceedings by asking the patient to speak first (particularly if the review is being held at the patient's request) rather than asking the RC to give evidence first to justify the reasons for detention.

The form of the hearing is inquisitorial not adversarial and the prime concern of the panel must be the patient's wellbeing and the lawfulness of their detention. However, it is essential that all panel members are able to ask their own questions and that the patient and the professionals are given the opportunity to ask questions of each other; an attitude of objectivity is important. The same opportunity should be offered to nearest relatives (where applicable) and to the patient's advocate or representative.

There is no objection to a "round table" discussion provided that it is controlled by the chair. Formal cross examination between professionals or by a legal representative should not be encouraged. Questions from these sources should be addressed to the chair in the first instance.

Panel members should always bear in mind the intellectual, social, cultural, gender, sexual orientation, ethnic and religious background of the patient and most importantly, the risk of making assumptions based on those factors.

Before a hearing starts, the panel, normally through the chair, should check if the patient and/or their representative has had the opportunity to read the written reports, or wish to do so, in which case an opportunity must always be granted before an adjournment is considered.

Where the patient does not have a representative, the panel should assist the patient as much as possible to make his or her case for discharge effectively.

There is no set time for the length of a hearing however the panel should consider the possible effect of a lengthy review on the patient's wellbeing.

If the patient chooses to leave the hearing before it has run its course, the panel should decide whether to continue with the hearing.

Procedures for the hearing should be informal e.g. hearsay evidence may be accepted but where possible should be substantiated. Although all parties should be actively and positively questioned, formal cross-examination should be avoided.

Any questions should be asked of all parties in a manner that is thorough, fair and courteous.

Care should be taken not to undermine the patient's relationship with the patient's care team or his/her family.

Subject to the patient's right to object to the presence of relatives, all parties should normally be present throughout the hearing; exceptions are when the patient wishes to speak with the panel privately or when the patient does not wish to be present.

The panel should always bear in mind that the hearing may be a stressful event for the patient. If the patient becomes distressed, a short break may be directed by the chair.

### **13.10 Questioning the clinical team**

Some essential questions which must be asked:

### **13.11 Medical Staff:**

The nature of a patient's mental illness; the form and effectiveness of present and future treatment, including community care arrangements (under Section 117 of the Act, where this is indicated); possible side effects of medication and the likely effect of the discontinuation of medication; possible danger to the patient and others; the appropriateness of continuing treatment in hospital; specific reasons why continued detention is thought necessary.

In particular, either at this stage or at the conclusion of the hearing, for those patients who are detained or liable to be detained, the Mental Health Act Code of Practice for Wales (revised 2016) 38.15 stated "*to promote equality of decision making, managers' discharge panel should consider the questions set out below in the order stated*" these should be put to the RC in order to ascertain unequivocally his/her professional opinion, namely:

### **Section 2 patients:**

- Is the patient still suffering from mental disorder?
- If so, is the disorder of a nature or degree which warrants the continued detention of the patient in hospital?
- Should the detention continue in the interests of the patient's health or safety or for the protection of other people?

### **Other detained patients:**

- Is the patient still suffering from mental disorder?
- If so, is the disorder of a nature or degree which makes treatment in hospital appropriate?
- Is continued detention for medical treatment necessary for the patient's health or safety or for the protection of other people?
- Is appropriate medical treatment is available for the patient?

### **CTO patients:**

- Is the patient still suffering from mental disorder?
- If so, is the mental disorder is of a nature or degree which makes it appropriate for the patient to receive medical treatment?
- It is necessary in the interests of the patient's health or safety or for the protection of other people that the patient should receive such treatment?
- Is it still necessary for the responsible clinician to be able to exercise the power to recall the patient to hospital, if that is needed?
- Is appropriate medical treatment (for the mental disorder) is available for the patient?

The RC should also be asked specifically whether, in the event that the Managers Discharge Panel decide to uphold an appeal, there are any other issues to be considered.

The Code of Practice for Wales (Revised 2016 38.16) recommends that if the Panel are satisfied from the evidence presented to them that the answer to any of these questions is no **then the patient must be discharged.**

### **Section 25 barring order**

In a case where the responsible clinician makes a report under section 25 barring a nearest relative's attempt to discharge the patient, and the answer to all the relevant questions above is affirmative, the Hospital Managers' Power of Discharge panel must also consider the responsible clinician's answer to the following question:

- If discharged, would the patient be likely to act in a manner that is dangerous to other people or to themselves?

This question focuses on the probability of a dangerous act, such as causing serious physical harm, not just the patient's general need for safety and others' general need for protection. It provides a more stringent test for continuing the detention or the CTO. (CoPW 38.18)

If the panel is satisfied from the evidence presented that the answer to any of the questions is "no", the patient should be discharged, providing there is evidence that adequate aftercare would be in place.

If aftercare arrangements are not in place and its absence makes it likely that the patient's health or safety would be compromised if they were to be discharged, the panel has the power to adjourn the hearing for a reasonable specified period for further information to be provided.

### **13.12 Nursing staff:**

Recent behaviour on the ward, compliance with medication, and details of any Section 17 leave.

### **13.13 Social Worker/Care Coordinator:**

These professionals, usually social workers should be asked about the patient's:

Past circumstances, social behaviour and ability to maintain themselves in the community e.g. issues regarding accommodation etc, detailed planning for community care arrangements, the views of the nearest relative.

### **13.14 The Patient**

Panel members must ascertain if the patient would:

- Whether the patient would stay in hospital as an informal patient if the Section was lifted; would they continue to comply with treatment as an outpatient (the credibility of the answers would have to be assessed in the light of past evidence).
- The patient's right to a **Mental Health Review Tribunal** should be clarified, and the patient's understanding of his or her rights should be ascertained.

### **13.15 The nearest relative**

It would be courteous to accord the patient's nearest relative the same formal opportunity to be heard by the panel. Members of the panel should be sensitive to the widespread perception of stigma attached to being detained.

When discussion and questioning has been completed, the Chair should thank all those who have attended and indicate that the panel will reach their decision in private.

### **13.16 Appraising Professional views and reports**

Reports for Managers' hearings should assist a panel members' understanding of the case and contribute to a decision being made that is consistent with the Act. To this end, panel members should be able to:

- Distinguish between opinion and fact.
- Be wary of personal views and impressions and of stereotyping a patient.
- Note uncertainties of diagnosis and prognosis,
- Enquire about the updated care plan.
- Consider conflicting professional opinions.
- Evaluate the reliability of data relating to risk, behaviour, events and reports.
- Have special regard to any developments in diagnosis and treatment in the period since any earlier hearings.
- Ask for an opinion of the future vulnerability of the patient or of possible danger to the patient or to others and the severity and likelihood of these.
- Question hearsay evidence e.g. by asking “why do you think that?”

### **13.17 Reaching a decision**

When discussion and questioning has been completed, the Chair should thank all who have attended and indicate that the panel will retire to reach their decision in private.

Whether the panel members leave the room themselves, or the other people present (which is normally the case) will depend on local circumstances and will be the decision of the panel at the time of the hearing.

The panel should decide whether the legal criteria for detention or CTO have been fully met. When there is an element of doubt, they should also consider whether on pragmatic grounds, discharge would be in the patient’s interest e.g. the patient might still be vulnerable and uncooperative over treatment.

If the Managers Discharge Panel disagree with the RC or any of the professionals and decide to discharge the patient, it is extremely important that cogent and clear reasons are provided for departing from any professional advice and any risk assessment which has been conducted by the clinical staff must be taken into account.

If a panel decide to discharge a patient from Section, the panel will initiate the action, and complete HO17 or CP8 (Section 23 Discharge) and the Mental Health Act Administrator will facilitate the procedure, but it is essential that the RC is immediately informed.

### **13.18 Recording hearings and decisions**

Hospital Managers’ hearings in Cardiff and Vale are held in accordance with UHB checklists for managers’ hearings (**example in appendix 1**), the content of which varies slightly depending on whether the hearing is a:

- renewal of authority to detain a patient,
- patient appeal against detention or
- barring of discharge order by a nearest relative.

The purpose of the checklist is to ensure that the recording of proceedings and decisions are recorded systematically and consistently.

Managers' panels should follow the order of questions as set out in the order stated on the UHB record form (included with the checklist documentation) provided by Mental Health Act office staff for each hearing.

Hospital Managers' panels may only order the absolute discharge of a patient, not the deferred discharge which is an option only available to the Tribunal.

The Hospital Managers' power to discharge a patient can only be exercised when all three members of the panel are in favour of discharge, otherwise the decision would be unlawful. Existing case law, R(on the application of Tagoe-Thompson) – v –Hospital Managers of the Royal Park Centre[2002] All ER 113; determines that a majority decision will not suffice.

In the event of a disagreement between panel members at a renewal hearing, provided that there is sufficient time remaining up until the expiry date of the section to enable another hearing to be arranged, proceedings should be adjourned before expiry (best practice); this also applies to postponement of a hearing.

Members of the Hospital Managers' Power of Discharge Sub-committee should bear in mind that where a Responsible Clinician has submitted a report to renew the authority to detain or extend CTO, the purpose of the Hospital Managers' review hearing is to determine whether they should exercise their discretion of discharge before the current period of detention ends. Therefore, such hearings will always take place before the current period of detention ends.

### **13.19 Adjourning/ postponing a hearing**

The Code states that:

“Managers' discharge panels need to have before them sufficient information about the patients past history of care and treatment, and details of any future plans.

If managers' discharge panels believe they have not been provided with sufficient information about arrangements that could be made were the patient discharged, they should consider adjourning and request further information. ”

Additional information may be required if there are:

- Unsatisfactory written/verbal reports.
- Undeveloped plans for care/treatment, both in and out of inpatient care.
- Concerns regarding safety of all in attendance during appeals.

Other reasons for adjourning may include:

- Non-attendance of a panel member.
- Unresolved differences between professionals. *The Code recognises that “members of managers’ discharge panels will not normally be qualified to form clinical assessments of their own. They should give full weight to the evidence in relation to the patient care. If there is a divergence of views among the professionals about whether the patient meets clinical grounds for continued detention or CTO, managers’ discharge panels should reach an independent judgement based on the evidence they hear. Regard should be had to the least restrictive option and maximising independence principle. In some cases, it might be necessary to consider adjourning to seek further medical or other professional advice”.* In the first instance such advice should be sought from the Mental Health Act Manager.
- Non-attendance of key professionals.
- Inability of panel members to reach a unanimous decision.

### **13.20 Unable to reach a unanimous decision**

The decision to discharge the patient can only lawfully take place if all three Managers holding the review agree to the decision and sign the decision form accordingly.

In the event that at the conclusion of the hearing, the Hospital Managers are unable to reach a unanimous decision whether to discharge, the UHB shall, subject to the agreement of the patient, arrange a further hearing with a new panel comprising of three different Managers.

In the meantime, the patient will remain on Section. If the patient does not wish a new panel to be convened, the Section will be upheld.

Any decision by this secondary review panel will be regarded as final unless and until the patient makes a further appeal to the Hospital Managers

### **13.21 Informing the patient of the Hospital Managers’ decision**

When the panel has reached their decision, the reasons for it should be communicated in full, both orally by the chair of the panel (unless the patient has already returned to the ward) and in writing (from the Mental Health Act office), to the patient, to the nearest relative with the patient’s consent, and to the professionals concerned. (not sure it needs the bold)

If the patient has already returned to the ward it may be more appropriate for the decision to be conveyed to the patient by the Chair of the panel, the patient’s advocate or a member of staff. The Chair must be guided on this issue by qualified ward staff.

### **13.22 Recording the Decision**

The Chair will record the decision carefully, mindful of the fact that a transcript of the written decision will, in most cases be sent to the patient by the Mental Health Act Office.

The chair has responsibility to ensure that the following is fully recorded on the decision form:

- The evidence considered in reaching their decision,
- the reasons for the decision and
- the decision itself.

Copies of the papers relating to the review, and the formal record of the decision, will be retained in the patient's records.

### **14. THE MENTAL CAPACITY ACT 2005**

The Mental Capacity Act 2005 (MCA) provides the legal framework for assessing mental capacity and making decisions on behalf of people aged 16 years and over.

It also includes the following:

- **Reasons for doubting a person's capacity**  
There needs to be a reason for doubting a person's ability to take their own decisions. The Mental Capacity Act Code of Practice explains this further.
- **A statutory test for capacity**  
The Act provides the test to be used to decide if someone can take a particular decision for themselves.
- **Identifies who has the authority to make decisions for the person**  
The source of authority for a decision will vary from one context to another. The Act sets out who has the authority in differing circumstances.
- **The IMCA (Independent Mental Capacity Advocate) safeguard**  
The Act sets out when a person is entitled to the support of a statutory advocate.
- **The best interests process**  
Any decision that is made on behalf of a person who lacks capacity must follow the process set out in the Act.

If the powers of the Mental Health Act are being considered to treat a person who is 16 and over and lacks capacity to consent to care or treatment, consideration should first be given to the Mental Capacity Act. In most cases, the Mental Capacity Act represents a less restrictive option than the powers of the Mental Health Act by empowering people to make decisions for themselves wherever possible and reinforcing that where adults lack capacity to make a decision, any decisions made on their behalf should be in that person's best interests. The Mental Health Act provides a legislative framework aimed at providing treatment for patients suffering from mental disorder in addition to the management or reduction of risk arising from the mental disorder. Where the Mental Health Act applies it must be used.

#### **14.1 Deprivation of Liberty Safeguards (DoLS)**

DoLS was introduced into the Mental Capacity Act to deal with a gap in the operation of the Mental Health Act which related to the unlawful detention of "compliant" patients lacking capacity on mental health wards. Reliance on the Mental Health Act means that patients who do not meet the criteria for detention under the Mental Health Act may be inadvertently detained, as "informal" or "voluntary" patients.

Both the Mental Health Act and DoLS provide the authority to detain people with mental disorder, but in different ways. The Mental Health Act requires professionals to consider whether a person's mental disorder is of a nature or degree that "**warrants**" detention under the Act whereas DoLS adopts a different stance from the beginning with a more fundamental question i.e. "**is the person deprived of their liberty?**"

In the case of the Mental Health Act, the problem is the patient who is compliant with their care and treatment but lacks capacity to consent to it. Their detention under the Mental Health Act may or may not be warranted, but in reality compliant, non-capacious individuals may be detained on a ward by virtue of restrictions placed upon them. It is only by looking at cases through the DoLS framework that the question of detention may be properly addressed and assessment may be incomplete if professionals rely solely on the Mental Health Act.

The recent decision of the Supreme Court in the Cheshire-West case reinforced the legal test (the acid test) for a Deprivation of Liberty (DoL) and therefore, who should be subject to DoLS. The purpose of the acid test is to determine whether a person is subject to continuous supervision and control **and** is not free to leave; DoLS should therefore always be considered where the acid test is met, but the patient does not meet the criteria for detention under the Mental Health Act. Failure to seek appropriate authorisation when a patient is deprived of their liberty is unlawful and will infringe Article 5 of the European Convention of Human Rights.

## Appendix 1

# Key words and phrases

## A

### **Absent without leave (AWOL)**

When a patient absconds from legal custody in the following circumstances:

- When a detained patient leaves hospital without getting permission first or does not return to hospital when required to do so.
- When guardianship patients leave the place their guardian says they should live
- When CTO patients and conditionally discharged restricted patients don't return to hospital when recalled, or leave the hospital without permission after they have been recalled.

### **The Act**

Unless otherwise stated, the Mental Health Act 1983.

### **Acute confusional state**

A sudden and rapid onset of confusion of an alarmingly high level; usually a symptom of acute physical illness. The duration can be short and the cause treated.

### **Advance decision to refuse treatment**

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

### **Advance statement**

A statement made by a person, when they have capacity, setting out the person's wishes about medical treatment. The statement must be taken into account at a future time when that person lacks capacity to be involved in discussions about their care and treatment. Advance statements are not legally binding although health professionals should take them into account when making decisions about care and treatment.

### **Advocacy**

Independent help and support with understanding issues and assistance in putting forward a patient's own views, feelings and ideas.

### **Affect**

A subjective interpretation of the feelings accompanying an idea or image. Similar in meaning to "mood". It can be defined as a state of emotional tone or feeling which can fluctuate through a range of depression and elation.

**After-care**

Services provided following discharge from hospital; especially the duty of health and social services to provide after-care under section 117 of the Act following the discharge of a patient from detention under the Act. The duty applies to CTO patients and conditionally discharged patients, as well as those who have been absolutely discharged.

**Affective disorder**

Disorder of mood including the commoner disturbances in emotional equilibrium that may form part of an overall clinical picture in mental disorder, depression, anxiety, incongruity and blunting of affect, la belle indifference, lability, hostility, depersonalisation. There may be difficulty in differentiating the symptoms of major affective disorder from an environmental causation or organic illness, therefore careful assessment and history taking is important.

**Akathisia**

A motor restlessness ranging from a feeling of inner disquiet, often localised in the muscles, to an inability to sit still or lie quietly; a side effect of some antipsychotic drugs.

**Antecedent**

The stimulus or cue that occurs before behaviour that leads to occurrence.

**Antisocial personality disorder**

A disorder occurring in adult patients with a history of conduct disorder; behaviour which is often characterised by poor work record, disregard for social norms, aggressiveness, financial irresponsibility, impulsiveness, lying, recklessness, inability to maintain close relationships or to meet responsibilities for significant others and a lack of remorse for harmful behaviour.

**Anxiety**

A diffuse apprehension, vague in nature and associated with feelings of uncertainty and helplessness. It is an emotion without a specific object, is subjectively experienced by the individual and is communicated interpersonally. It occurs as a result of a threat to the person's being, self-esteem or identity.

**Apathy**

Lack of feelings, emotions, interests or concerns.

**Application for detention**

An application made by an approved mental health professional (AMHP) or nearest relative for detention of a person under Part 2 of the Act for assessment or for medical treatment.

**Appropriate medical treatment**

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

**Appropriate medical treatment test**

The requirement in some of the criteria for detention and for CTO that appropriate medical treatment must be available.

**Approved Clinician**

A mental health professional approved by Welsh Ministers in Wales or the Secretary of State in England to act as an approved clinician for the purposes of the Act. Some decisions under the Act can only be taken by people who are approved clinicians. All responsible clinicians must be approved clinicians.

**Approved Mental Health Professional (AMHP)**

A professional with training in the use of the Act, approved by a local authority to carry out a number of functions under the Act.

**Assessment**

Examining a patient to establish whether the patient has a mental disorder and, if they do, what treatment and care they need. It is also used to mean examining or interviewing a patient to decide whether an application for detention or a guardianship application should be made.

**Assessor**

An approved mental health professional or a doctor who undertakes an assessment or examination under the Act to decide whether an application for detention or guardianship should be made.

**Attorney**

Someone appointed under the Mental Capacity Act who has the legal right to make decisions (e.g. decisions about treatment) within the scope of their authority on behalf of the person (the donor) who made the power of attorney. Also known as a 'donee of lasting power of attorney'.

**Automatic thoughts**

These are contained in a stream of thoughts which are usually going on in an individual's head. They affect the person's feelings and inform their behaviour, but often occur without the person being aware of them. It is only when individuals are asked to focus in on their unreported thoughts that they become aware of them.

**Best Interests**

Any decisions made, or anything done for a person who lacks capacity to make specific decisions, must be in the person's best interests.

**Blanket restrictions**

A blanket restriction or a blanket restrictive practice is any practice that restricts the freedom (including the freedom of movement and communication with others) of all patients on a ward or in a hospital, which is not applied on the basis of an analysis of the risk to the individual or others.

**Bipolar affective disorder**

A sub-group of the affective disorders, characterised by at least an episode of manic behaviour, with or without a history of episodes of depression. Also known as manic depression.

**Borderline personality disorder**

A specific personality disorder with the essential features of unstable mood, interpersonal relationships and self image; characteristic behaviours may include unstable relationships, exploitation of others, impulsive behaviour, labile affect, problems expressing anger appropriately, self-destructing behaviour and identity disturbances.

**C****Capacity**

The ability to make a decision about a particular matter at the time the decision needs to be made. Some people may lack capacity to make a particular decision (e.g. to consent to treatment) because they cannot understand, retain, use or weigh up the information relevant to the decision.

**Care and treatment Plan –see Mental Health (Wales) Measure 2010**

A statutory plan prepared for the purpose of achieving the outcomes which the provisions of mental health services for a relevant mental health patient are designed to achieve.

**Care co-ordinator**

The qualified and registered professional who is responsible for ensuring that a patient's written care and treatment plan has been developed. The care and treatment plan may be informed and delivered by a range of professionals and it is the care co-ordinator who will have oversight in the delivery of services, including where the care and treatment plan may require review.

**Care Programme Approach (CPA)**

A system of care and support for individuals with complex needs which includes an assessment, a care plan and a care co-ordinator. It is used in England mainly for adults who receive specialist healthcare. There are similar systems for supporting other groups of individuals, including children and younger people, older adults and people with learning disability.

**Care Worker**

Someone employed to give personal care for people who need help because of sickness, age or disability. They could be employed by the person themselves, by someone acting on the person's behalf or by a care agency.

**Carer**

Someone who provides voluntary care by looking after and assisting a family member, friend or neighbour who requires support because of their mental health needs.

**Catatonia**

A syndrome of motor abnormalities which occurs in schizophrenia and (less commonly) in organic cerebral disease. It is characterised by stupor and the adoption of unusual postures or outbursts of excitement and hyperactivity.

**Child and adolescent mental health services (CAMHS)**

Specialist mental health services for children and adolescents over all types of provision and intervention – from mental health promotion and primary prevention, specialist community based services through to specialist care as provided by inpatient units for children and young people with mental illness.

**Children Act 1989**

A law relating to children and young people and those with parental responsibility for them which also describes the roles, duties and responsibilities of statutory agencies, such as local authority social services.

**Chronic confusional state**

A slow and insidious onset of confusion which is likely to go unnoticed. It is a symptom of chronic physical illness such as thyroid gland underactivity. May occur over a period of years but can be reversed with treatment.

**Cognitive disorder**

Disorder associated with the way in which the individual interprets the world. The underlying thought processes are seen as instrumental in determining how a person behaves and their emotional reactions.

**Cognitive disturbance**

A self defeating attitude or responses which may become habitual, particularly directed towards lowered self esteem.

**Community Treatment Order**

The legal authority for the discharge of a patient from detention in hospital, subject to the possibility of recall to hospital for further medical treatment if necessary. Community patients are expected to comply with the conditions specified in the community treatment order.

**Competence**

Similar to capacity to consent but specifically about children. As well as covering a child's inability to make particular decisions because of their mental condition, it also covers children who do not have the maturity to make the particular decision in question.

**Compulsion**

A recurring irresistible impulse to perform an act.

**Compulsory**

Compulsory measures that can be taken by certain individuals to admit someone to hospital without their agreement and detain them there for assessment and/or treatment under the Act, make them subject to supervised community treatment or guardianship.

**Compulsory medical treatment**

Under the Act, treatment can be given for mental disorder without a patient's consent.

**Concreteness**

Use of specific terminology by the patient rather than abstraction in describing feelings, experiences and behaviour.

**Conditional discharge**

In certain "forensic" cases, the Secretary of State for Justice or the Mental Health Review Tribunal can instigate an order which means that a person can leave hospital and live in the community but with a number of conditions imposed on them. The section lasts for as long as the period of the original restriction order which may be indefinite.

**Confabulation**

A patient's more or less plausible response to questions that is completely invented.

**Congruent communication**

A communication pattern in which the sender is communicating the same message on both verbal and non-verbal levels.

**Consent**

Consent is the voluntary and continuing permission of a patient to be given a particular treatment, based on a sufficient knowledge of the purpose, nature, likely effects and risks of that treatment, including the likelihood of its success and any alternatives to it. Permission given under unfair or undue pressure is not consent.

By definition, a person who lacks capacity to consent does not consent to treatment, even if they co-operate with the treatment or actively seek it.

### **Convey (and conveyance)**

Transporting a patient under the Act to hospital (or anywhere else), compulsorily if necessary.

### **Court of Protection**

The specialist court set up under the Mental Capacity Act to deal with issues relating to people who lack capacity to take decisions for themselves.

### **Criteria for detention under the Act**

A set of criteria that must be met before a person can be detained. The criteria vary for different sections of the Act.

### **Criteria for CTO**

A set of criteria that must be met before a patient can become subject to CTO or remain subject to CTO.

## **D**

### **Data Protection Act**

A law controlling the handling of and access to personal information, such as medical records, files held by public bodies and financial information held by credit reference agencies.

### **Decision-maker**

Under the Mental Capacity Act, many different people may be required to make decisions or act on behalf of someone who lacks capacity to make decisions for themselves. The person making the decision is referred to as the decision-maker, and it is the decision-maker's responsibility to work out what would be the in the best interests of the person who lacks capacity.

### **Deprivation of Liberty**

A term used in Article 5 of the European Convention on Human Rights to mean the circumstances in which a person's freedom is taken away. Its meaning in practice has been developed through case law.

### **Deprivation of Liberty Safeguards (DoLS)**

The framework of safeguards under the Mental Capacity Act (as amended by the Mental Health Act 2007) for those who need to be deprived of their liberty in their best interests for care or treatment, where they lack the capacity to consent themselves.

### **Deputy (or Court appointed deputy)**

A person appointed by the Court of Protection under section 16 of the Mental Capacity Act to take specified decisions on behalf of someone who lacks capacity to make those decisions themselves.

This is not the same thing as a nominated deputy appointed by a doctor or approved clinician in charge of a patient's treatment.

### **Detained patient**

Unless otherwise stated, a patient who is detained in a hospital under the Act, or who is liable to be detained in a hospital but who is (for any reason) currently out of that hospital.

### **Detention**

Unless otherwise stated, a patient who is being held compulsorily in a hospital under the Act for a period of assessment or medical treatment for mental disorder.

### **Detention for assessment**

Section 2 provides for the detention of a person in a hospital in order to carry out an assessment. Normally lasts for a maximum of 28 days but under certain circumstances can be extended to enable an application to be made to the County Court to have another person appointed as nearest relative.

### **Detention for medical treatment**

The detention of a person in a hospital in order to give them medical treatment they need for their mental disorder. There are various types of detention for medical treatment under Parts 2 and 3 of the Act, including hospital directions, hospital orders and interim hospital orders.

### **Discharge**

Unless otherwise stated, a decision that a patient should no longer be subject to detention, supervised community treatment, guardianship or conditional discharge. Discharge from detention is not the same as being discharged from hospital; the patient may already have left hospital on section 17 leave of absence; they may also agree to remain in hospital informally.

### **Displacement of nearest relative**

Section 29 of the Act provides for a County Court to order that the functions of the nearest relative be carried out by another person or by a local social services authority.

### **Doctor**

A registered medical practitioner.

### **Doctor approved under section 12**

A doctor who has been approved under the Act by the Welsh Ministers in Wales or the Secretary of State in England as having special experience in the diagnosis or treatment of mental disorder. The practice in Wales is that Local Health Boards take these decisions on behalf of the Welsh Ministers.

Some medical recommendations and medical evidence to courts under the Act can only be made by a doctor who is approved under section 12. Doctors who are approved clinicians are automatically treated as though they have been approved under section 12.

### **Dangerousness**

The probability of dangerous acts, such as causing serious physical injury, not just the patient's general need for safety and others' general need for protection.

### **Delusions**

A false belief that is firmly held even though it is not shared by others and is contradicted by social reality.

### **Dementia**

A progressive organic mental disorder resulting in a lowering of the usual level of mental ability.

### **Denial**

Avoidance of disagreeable realities by ignoring or refusing to recognise them.

### **Depersonalisation**

A characteristic of depression when a person is aware of a change in self and may feel that they have become so different as to have become detached from their personality. The person may describe the feeling as "if in a dream" or "like automatism". Mild depersonalisation can occur in states of physical and mental fatigue.

### **Depression**

An abnormal extension of, or over-elaboration of sadness or grief.

### **Disassociation**

The separation of any group of mental or behavioural processes from the rest of a person's consciousness or identity.

### **Dysphasia**

A disturbance of either the comprehension or expression of speech.

### **Dystonia**

Acute tonic muscle spasms, often of the tongue, jaw, eye and neck but sometimes the whole body. Usually occurs as a result of medication.

## **E**

### **Echolia**

Heard speech is repeated, usually only a word or phrase.

**Electro-convulsive therapy (ECT)**

A form of medical treatment for mental disorder in which seizures are induced by passing electricity through the brain of an anaesthetised patient; generally used as a treatment for severe depression.

**Emergency application**

An application for detention for assessment in cases of urgent necessity where there is only one supporting medical recommendation. The patient may only be detained for a maximum of 72 hours unless a second medical recommendation is received. Also known as a section 4 application.

**European Convention of Human Rights**

The European Convention for the Protection of Human Rights and Fundamental Freedoms. The substantive rights it guarantees are largely incorporated into UK law by the Human Rights Act 1998.

**E****Family Carer**

A family member who looks after a relative who needs support because of sickness, age or disability.

**Flight of ideas**

Over productive speech characterised by rapid shifting from one topic to another and fragmented ideas.

**“Forensic sections”**

Sections that individuals have been placed on to admit them or transfer them to hospital from a court of law or from a prison where an individual may have been on remand or serving a sentence.

**Free association**

The verbalisation of thoughts as they occur, without any conscious screening or censorship.

**G****GP**

A patient's general practitioner (or “family doctor”).

**Grandiose delusions**

A psychological symptom in which patients believe they are a person of great importance or influence with elaborate beliefs as to why they were chosen.

## **Guardianship**

The appointment of a guardian to help and supervise patients in the community for their own welfare or to protect other people. The guardian may be either a local social services authority (LSSA) or someone else approved by an LSSA (a private guardian).

## **Guiding Principles**

The principles set out in the Mental Health Act 1983 Code of Practice for Wales that have to be considered when decisions are made under the Act.

# **H**

## **Habilitation**

Equipping someone with skills and abilities they have never had as opposed to rehabilitation which means helping them recover skills and abilities they have lost.

## **Hallucinations**

Perceptual distortion arising from any of the five senses (ie. seeing, hearing, feeling, tasting, smelling something that is not present).

## **Health Service Ombudsman**

An independent person whose organisation investigates complaints about National Health Service care or treatment that has not been resolved through (in Wales) the “Putting Things Right Procedure”.

## **Healthcare Inspectorate Wales Review Service for Mental Health**

The role of the Review Service for Mental Health within Healthcare Inspectorate Wales (HIW) is to review the use of the Mental Health Act 1983 and check that it is being used properly on behalf of Welsh Ministers. The review service is independent of all staff and managers of hospitals and mental health teams.

## **Holding powers**

These are the powers in section 5 of the Act which allow hospital inpatients to be detained temporarily to provide sufficient time for a decision to be made about whether an application should be made for admission under the Act. There are two holding powers: under section 5(2), doctors and approved clinicians can detain patients for up to 72 hours; and under section 5(4), certain nurses can detain patients for up to 6 hours.

## **Hospital Direction**

An order made by the Court under Part 3 of the Act for the detention in hospital of a mentally disordered offender for medical treatment.

## **Hospital Managers**

The organisation (or individual) with responsibility for the operation of the Act in a particular hospital. Hospital Managers have various functions under the Act which include the power to discharge a patient. In practice, most of the Hospital Managers’

decisions are taken on their behalf by individuals (or groups of individuals) authorised by the Hospital Managers to do so. Hospital Managers' decisions about discharge are normally delegated to a "managers' panel" of three or more people.

### **Hospital Order**

An order made by a court under Part 3 of the Act for the detention for medical treatment in hospital of a mentally disordered offender, given instead of a prison sentence or other form of punishment.

### **Human Rights Act 1998**

A law largely incorporating into UK law the substantive rights set out in the European Convention on Human Rights.

### **Hysteria**

When anxiety created by emotional conflict is converted into physical symptoms (e.g. paralysis, tics, mutism). A state of tension or excitement where there is a temporary loss of control over the emotions.

## **!**

### **Ideas of reference**

The incorrect interpretation of casual incidents and external events as having direct personal references.

### **Ill Treatment**

Section 44 of the Mental Capacity Act introduced an offence of ill treatment of a person who lacks capacity by someone who is caring for them, or acting as a deputy or attorney for them. That person can be guilty of ill treatment if they have deliberately ill-treated a person who lacks capacity, or been reckless as to whether they were ill-treating the person or not. It does not matter whether the behaviour was likely to cause, or actually caused harm or damage to the victim's health.

### **Illusions**

False perceptions or false responses to a sensory stimulus.

### **Independent Hospital**

A hospital which is not managed by the NHS.

### **Independent Mental Capacity Advocate (IMCA)**

The Mental Capacity Act 2005 introduced the new statutory role of the IMCA to support people who lack capacity to make certain decisions. Local Authorities and Health Boards in Wales have a duty to instruct an IMCA to support an individual if they meet the criteria as laid out in the Act.

**Independent Mental Health Advocate (IMHA)**

An advocate available to offer help to patients under arrangements which are specifically required to be made under the Act.

**Informal patient**

Someone who is being treated for a mental disorder and who is not detained under the Act; sometimes referred to as a voluntary patient.

**Institutionalisation**

The habituation of an individual to the patterns of behaviour and routines associated with and expected in an institution. This requirement to conform is associated with restriction in personal freedom and choice, creating loss of individuality.

**Interim Hospital Order**

An order made by a court under Part 3 of the Act for the detention for medical treatment in hospital of a mentally disordered offender on an interim basis to enable the court to decide whether to make a hospital order or deal with the offender's case in some other way.

**Introjection**

An intense type of identification in which a person incorporates the qualities or values of another person or group into their own ego structure.

**J**  
**K**  
**L**

**Learning disability**

A learning disability is a state of arrested or incomplete development of the mind which includes significant impairment of intelligence and social functioning. It is a form of mental disorder.

**Learning Disability defined in the Mental Health Act**

The rule which states that that certain parts of the Act only apply to a learning disability if it is associated with qualification of abnormally aggressive or seriously irresponsible behaviour on the part of the person concerned.

**Leave of absence**

Permission for a patient who is detained in hospital to be absent from the hospital for short periods or longer periods; an important part of the patient's treatment plan. Patients remain under the powers of the Act whilst on leave and can be recalled to hospital if necessary in the interests of their health or safety or for the protection of others.

**Life sustaining treatment**

Treatment, that in the view of the person providing healthcare is necessary to keep a person alive.

**Local Social Services Authority (LSSA)**

The local authority (or council) responsible for social services in the particular area where the patient resides in hospital.

**La belle indifference**

A term sometimes applied to an apparent lack of concern commonly associated with symptoms of hysteria.

**Lability**

A rapid change in mood which can occur especially in elderly people with a mental disorder.

**Loose association**

Lack of a logical relationship between thoughts and ideas which renders speech and thought inexact, vague, diffuse and unfocussed.

**Low stimulus environment**

An area away from more general ward areas where the patient is less aroused by the environment and where nursing is more intense. Relative to Psychiatric Intensive Care Unit (PICU).

**M****Makaton**

A language programme using signs and symbols for the teaching of communication, language and literacy skills for people with communication and difficulties in learning.

**Managers' panel**

A panel of three or more people appointed to take decisions on behalf of the Hospital Managers about the possible discharge from detention or supervised community treatment.

**Medical recommendation**

Normally means a recommendation provided by a doctor in support of an application for detention or a guardianship application.

**Medical treatment**

In the Act this covers a wide range of services; as well as the care and treatment given by doctors, it also includes nursing, psychological therapies, specialist mental health habilitation, rehabilitation and care.

**Medical treatment for mental disorder**

This is medical treatment which is for the purpose of alleviating, or preventing a worsening of the mental disorder or one or more of its symptoms or manifestations. It includes nursing and psychological intervention as well as specialist mental health habilitation, rehabilitation and care. It also includes treatment of physical health problems but only to the extent that such treatment is part of, or ancillary to mental disorder.

**Mental Capacity Act 2005**

The Mental Capacity Act provides the legal framework to assess a person's mental capacity to make decisions about themselves in relation to finance, health and social care. It provides additional powers to make decisions on behalf of a person who lacks capacity to make such decisions for themselves.

**Mental disorder**

This means any disorder or disability of the mind. As well as mental illness, it includes conditions such as personality disorders, autistic spectrum disorders and learning disabilities.

**Mental Health Review Tribunal**

An independent judicial body with powers to direct the discharge of patients who are detained under the Mental Health Act.

**Mental illness**

An illness of the mind including common conditions such as depression and anxiety and less common conditions as schizophrenia, bipolar disorder, anorexia nervosa and dementia.

**Mentally disordered offender**

A person with a mental disorder who has committed a criminal offence.

**Mania**

A condition characterised by a mood that is elated, expansive or irritable.

**Morbid jealousy**

Conviction that a partner is having an affair; denial is interpreted as proof.

**Mood**

A general overview of predominant feelings; includes past and current affective experiences.

## N

### **Nearest relative**

A person defined in section 26 of the Act who has certain rights and powers under the Act in respect of a patient for whom they are a nearest relative. A patient's nearest relative is not necessarily the same person as their "next of kin"; the "next of kin" has no powers under the Act unless they are also the nearest relative. The identity of the nearest relative may also change over time.

### **Neurosis**

A relatively mild mental illness that is not caused by organic disease, involving symptoms of stress (depression, anxiety, obsessive behaviour, hypochondria) but not a radical loss of touch with reality.

### **Nominated deputy**

A doctor or approved clinician who may make a report detaining a patient under the holding powers in section 5 in the absence of the doctor or approved clinician who is in charge of the patient's treatment.

## O P

### **Part 2**

The part of the Act which deals mainly with the detention, guardianship and supervised community treatment of civil i.e. non-offender patients.

Some aspects of Part 2 also apply to some patients who have been detained or made subject to guardianship by the courts or who have been transferred from prison to detention in hospital by the Secretary of State for Justice under Part 3 of the Act.

### **Part 2 patient**

A civil patient who became subject to compulsory measures under the Act as a result of an application for detention or guardianship by a nearest relative or an approved mental health professional.

### **Part 3**

The part of the Act that deals with mentally disordered offenders and defendants in criminal proceedings. It allows courts to detain people in hospital for treatment instead of punishing them where particular criteria are met. It also allows the Secretary of State for Justice to transfer certain individuals from prison to detention in hospital for treatment.

**Part 3 patient**

A patient made subject to compulsory measures under the Act by the courts or by being transferred to detention in hospital from prison under Part 3 of the Act. Part 3 patients can be either “restricted” ie. subject to special restrictions on when they can be discharged, given leave of absence and various other matters, or unrestricted meaning that they are treated for the most part like a Part 2 patient.

**Part 4**

Part 4 of the Act deals mainly with the medical treatment for mental disorder of detained patients and those CTO patients who have been recalled to hospital. In particular, it sets out when they can and cannot be treated for their mental disorder with or without their consent.

**Part 4A**

The part of the Act which deals with the medical treatment for mental disorder of CTO patients when they have not been recalled to hospital.

**Part 4A certificate**

A certificate issued by a SOAD or Approved Clinician certificate approving particular forms of medical treatment for mental disorder for a CTO patient.

**Part 4A patient**

A Part 4A patient is a CTO patient who has not been recalled to hospital.

**Patient**

A reflection of the terminology used in the Act itself and also the Code of Practice for Wales to describe an individual who is or appears to be suffering from a mental disorder.

**Place of Safety**

A place in which a person may be temporarily detained under the Act; in particular, a place to which the police may remove a person from a public place for assessment under section 135 or 136 of the Act.

**Polypharmacy**

Where combinations of psychoactive drugs are used at the same time.

**Projection**

Projection is when a person attributes their own thoughts or impulses to someone else. Through this process, the person can attribute intolerable wishes, emotional feelings or motivations to another person.

**Protection of Vulnerable Adults (POVA) list**

A register of individuals who have abused, neglected or otherwise harmed vulnerable adults in their care or placed vulnerable adults at risk of harm. Providers of care must not offer such individuals employment in care positions.

**Psycopath**

A psychopath is a person with an antisocial personality, also known as a sociopath. Not connected to psychosis.

**Psychosis**

A category of health problems that are distinguished by regressive behaviour, personality disintegration, reduced level of awareness, great difficulty in functioning adequately and gross impairment in reality testing.

**Q****Qualifying patients**

Patients who are eligible for support from independent mental health advocacy services.

**R****Recall**

A requirement that a patient who is liable to be detained returns to hospital. It can apply to patients who are subject to leave of absence, on CTO or those who have been conditionally discharged from hospital.

**Regulations**

Secondary legislation made under the Act. In Wales it means the Mental Health (Hospital, Guardianship and Treatment (Wales) Regulations 2008.

**Rehabilitation**

See habilitation.

**Remand to hospital**

An order by the Court under Part 3 of the Act for the detention in hospital of a defendant in criminal proceedings for a report to be made or for medical treatment for mental disorder.

**Responsible Clinician**

The approved clinician with overall responsibility for a patient's case. Certain decisions such as renewing a patient's detention or pacing a patient on CTO can only be taken by a responsible clinician.

**Responsible Hospital**

The hospital whose managers are responsible for a CTO patient. To begin with at least, this is the hospital in which the patient was detained before being discharged onto CTO.

### **Responsible Local Social Services Authority**

The local social services authority (LSSA) responsible for a patient who is subject to guardianship under the Act. The responsible LSSA is normally the LSSA for the area where the patient lives. If the patient has a private guardian, it is the LSSA for the area where the guardian lives.

### **Restraint**

The use or threat of force to help do an act which the person resists or the restriction of the person's liberty of movement, whether or not they resist. Restraint may only be used where it is necessary to protect the person from harm and is proportionate to the risk of harm.

### **Restricted patient**

A Part 3 patient who, following criminal proceedings, is made subject to a restriction order under section 41 of the Act, a limitation direction under section 45A or a restriction direction under section 49. The order or direction will be imposed on an offender where it appears that it is necessary to protect the public from serious harm. One of the effects of the restrictions imposed by these sections is that restricted patients cannot be given leave of absence or be transferred to another hospital without the consent of the Secretary of State for Justice and only the Mental Health Review Tribunal can discharge them without the Secretary of State's agreement. **See also Unrestricted Part 3 patient.**

### **Revocation**

A term used in the Act to describe the rescinding of a community treatment order (CTO) when an CTO patient needs further treatment in hospital under the Act. If a patient's CTO is revoked, the patient is detained under the powers of the Act in the same way as before the CTO was made.

### **Reality orientation**

Formal process of keeping a person alert to events in the here and now.

### **Relapse**

Return of symptoms.

## **S**

### **Scheme of Delegation**

A scheme in which arrangements for authorising decisions are set out and approved by a resolution of the organisation itself.

### **Schizoaffective disorder.**

A diagnosis given to patients who meet the diagnostic criteria for schizophrenia as well as one or both of the major mood disorders of bipolar disorder and major depression.

**Schizophrenia**

Umbrella term for a range of symptoms which result in a person being unable to distinguish their own intense thoughts, ideas, perceptions and imaginings from reality. Among other symptoms, a person might be hearing voices or may believe that others can read their mind and control their thoughts. Schizophrenia does not mean a “split personality”.

**Self-esteem**

A person’s judgement of personal worth obtained by analysing how well his or her behaviour conforms to self-ideal.

**Community patient**

A patient who is supervised on a community treatment order.

**Section 12 Doctor**

A doctor with special experience in the diagnosis and treatment of mental disorder.

**Second Opinion Appointed Doctor (SOAD)**

An independent doctor appointed in Wales by Healthcare Inspectorate Wales who gives a second opinion on whether certain types of medical treatment for mental disorder should be given without the patient’s consent.

**Section 57 treatment**

A form of medical treatment for mental disorder to which the special rules in section 57 of the Act apply, especially neurosurgery for mental disorder, sometimes referred to as psychosurgery.

**Section 58 treatment**

Medical treatment for mental disorder to which the special rules in section 58 apply in respect of medical treatment for mental disorder for detained patients after an initial three month period.

**Section 58A treatment**

Medical treatment for mental disorder to which the special rules in section 58A apply, especially electro-convulsive therapy.

**Section 117**

See aftercare.

**Section 135(1)**

The power to forcibly enter a property to look for and remove a person to a place of safety (usually hospital) for assessment for a period of up to 24 hours.

## **Section 135(2)**

The power to forcibly enter a property to look for and remove a detained patient who is absent without leave (AWOL) from hospital. If the person allows entry to the property voluntarily, there is no need to obtain a section 135(2).

## **Splitting**

Viewing people and situations as either all good or bad. Failure to integrate the positive and negative qualities of oneself and of objects.

## **Symptoms of schizophrenia**

- **positive symptoms** – any change in behaviour or thoughts, such as hallucinations or delusions.
- **negative symptoms** – a withdrawal or lack of function that you would not usually expect to see in a healthy person; for example, people with schizophrenia often appear emotionless and flat.

## **I**

### **Tardive dyskinesia**

Literally “late appearing abnormal movements”, a variable complex of movements developing in patients exposed to antipsychotic drugs. Typical movements include tongue withering or protrusion, chewing, lip puckering, jerky involuntary (chorieform) finger, toe and ankle movements, leg jiggling and movements of the neck, trunk and pelvis.

### **Thought blocking**

Sudden cessation in the train of thoughts or midst of a sentence.

### **Thought broadcasting**

A person believes that everyone can hear their thoughts.

### **Thought withdrawal**

A belief that thoughts are being taken away from an individual.

### **Thought insertion**

A belief that thoughts are being inserted into an individual’s head.

### **Tribunal**

For the purpose of this document, this means the Mental Health Review Tribunal for Wales, a judicial body which has the power to discharge patients from detention, community treatment, guardianship and conditional discharge.

## **U**

**Unrestricted Part 3 patient**

A patient subject to a hospital order or guardianship order under Part 3 of the Act, or one who has been transferred from prison to detention in hospital under Part 3 who is not also subject to a restriction order or direction. For the most part, unrestricted patients are treated in the same way as Part 2 patients, although a nearest relative will not be appointed for section 35, 36, 38 or restricted patients. **See also Restricted patients.**

**V****Voluntary Patient.**

See Informal patient.

**W****Welsh Ministers**

Ministers of the Welsh Government.

**Wilful neglect**

An intentional or deliberate omission or failure to carry out an act of care by someone who has care of a person who lacks (or whom the person reasonably believes lacks) capacity to care for themselves. The Mental Capacity Act introduced a new offence of wilful neglect of a person who lacks capacity.