Islamic Republic of Afghanistan

Ministry of Public Health

Mental Health & substance Abuse Department

Mental Health Act 2014:
Proposed Code of Practice

Introduction

This Code of Practice (‘the Code’) has been prepared in accordance with section 108 of the Mental Health Act 2014 (‘the Act’) by the Minister of Public Health after consulting such bodies as appeared to him to be concerned. The Code will come into force on 2015. The Minister of Public Health is required to keep the operation of the Code under review every three years.

Purpose and legal status of the Code of Practice

Statutory guidance:

The Code provides statutory guidance to facilities directors, psychiatrists, approved clinicians and other mental health professionals including in the private, independent and voluntary sectors, on how they should proceed when undertaking duties under the Act in relation to persons with mental disabilities.

The people listed above to whom the Code is addressed should have regard to the Code. It is important that these persons have training on the Code and ensure that they are familiar with its requirements. As departures from the Code could give rise to legal challenge, reasons for any departure should be recorded clearly. Courts will scrutinize such reasons to ensure that there is sufficiently convincing justification in the circumstances.

Non-statutory guidance:

The Code will not be statutory guidance, but will nonetheless be beneficial for others in carrying out their duties. This includes inspectors of health services, the police and ambulance services, and others in health and social services (including the private, independent and voluntary sectors) involved in commissioning or providing services to people who are, or may become, subject to measures under the Act. It is important that these persons have training on the Code and ensure that they are familiar with its requirements.

The Code should assist MHCs and others responsible for inspecting or monitoring the quality of such services, including, local authorities and the AIHRC.
It is intended that the Code will be helpful to patients, their persons of trust, carers and families.

The Code describes legislative functions and duties and provides guidance. Whilst the whole of the Code should be followed, please note that where ‘should’ is used, it reflects legal obligations in legislation, and should be followed. Where the Code uses the term ‘should’ then departures should be documented and recorded; Where the Code gives guidance using the terms ‘may’, ‘can’ or ‘could’ then the guidance in the Code is to be followed wherever possible.

Scope of the Code

The Code applies to the care and treatment of all patients in Afghanistan who are subject to the exercise of powers and the discharge of duties under the Act, including voluntarily and involuntarily admitted patients and those being evaluated for admission.

Presentation

Throughout the Code, the Mental Health Act 2014 is referred to as ‘the Act’. Where there is reference to articles of other Acts, the relevant Act is clearly indicated. Where the Code refers to ‘the regulations’ it means regulations made under the Act.

The Code is intended to offer guidance on the operation of the Act and does not set out to explain each and every aspect of the Act and the regulations which should be read with it. The Code is divided into … chapters, plus … annexes, to help readers navigate to what is of most interest or relevance to them.

References

The Code refers throughout to ‘patients’ when it means persons with mental disabilities, including those being evaluated for admission. This use of the term is not a recommendation that the term ‘patient’ should be used in practice in preference to other terms such as ‘mental health service users’, ‘clients’, ‘service users’ or “persons with mental disablities”.

When the Code refers to ‘children’ it means people under the age of 16. The term ‘young people’ refers to minors aged 16 or 17.

Annex A contains key words and phrases used throughout the Code.

Mental Health Councils (MHCs)

MHCs make sure health and/or mental health and/or social care services provide people with safe, effective, compassionate, high-quality care and encourage them to improve. MHCs have specific duties under the Act to act as a general protection for patients by reviewing, and where appropriate, investigating the exercise of powers and the discharge of duties in relation to involuntary admission, and support for facilitated decision-making under the Act. MHCs also have a duty to appoint second opinion appointed doctors, monitor, inspect and regulate services to make sure providers meet fundamental standards of quality and safety. MHC’s findings should be published.

Providers and professionals should not use the Code in isolation. They will also need to consider relevant developments in professional practice, professional guidelines and legislation to ensure they are consistently delivering the highest standards of care and professional practice. The introduction and guiding principles encourage health and care providers and professionals to deliver a holistic, whole person approach to care that is reflective of clinical best practice and quality. MHCs in their monitoring of services will seek to ensure that this takes place.

When the Code is being inappropriately applied

Everyone has a role in ensuring that the Act and the Code are complied with, however, this is not always the case. In many instances opportunities for professionals across the health and social care system to spot and report abuse or neglect are missed allowing harm to continue unchecked.

MHCs, mental health and other health and social care practitioners and professional regulators all have an interest in identifying concerns about how the Act is being applied, whether it is being ignored and to stop abuse or neglect taking place. To minimize the

chance of this happening all mental health, health and social care staff need to be trained in spotting the signs of potential abuse or neglect, listening to concerns raised by patients and should understand their role in responding.
If you think the Code is being inappropriately applied you should report this to the Department of Mental Health & Substance Abuse of the Ministry of Public Health.

Chapter 1: Guiding principles

It is essential that all those undertaking functions under the Act understand the overarching principles which should always be considered when making decisions in relation to care, support or treatment provided under the Act. This chapter provides an explanation of the overarching principles and stresses that they should be considered when making decisions under the Act. Although all are of equal importance the weight given to each principle in reaching a particular decision will depend on context and the nature of the decision being made. The overarching principles are:

Principle 1: Respect for inherent dignity, "will and preferences", individual autonomy, self-determination, diversity and privacy of the person

Patients and carers should be treated with respect and dignity. Practitioners performing functions under the Act should respect the rights and dignity of patients and their carers, while also ensuring their safety and that of others. Persons' will and preferences should be taken into account to ensure a human rights-compliant approach. Therefore, the "best interests" approach is replaced with a "best interpretation" approach. What this means is that in the very rare instance where a person's will and preferences cannot be understood (after having tried various creative communications methods and the best-placed people to communicate with the person), then decisions should be taken which respect an account which best interprets what the person would have chosen. Everyone has the right to make their own choices, to develop their own opinions and make decisions. People, including children, with disabilities have the same right to privacy as everyone else, including privacy in respect of personal, health and rehabilitation information. People taking decisions under the Act should recognize and respect the diverse needs, values and circumstances of each patient, including their age, disability, gender, race, religion or belief, sex, and culture. There should be no unlawful discrimination.

Principle 2: Non-discrimination and equality of opportunity

"Discrimination on the basis of disability means any distinction, exclusion or restriction on the basis of disability which has the purpose or effect of impairing or nullifying the recognition, enjoyment or exercise, on an equal basis with others, of all human rights and fundamental freedoms in the political, economic, social, cultural, civil or any other field. It includes all forms of discrimination, including denial of reasonable adjustments. The core message of human rights refers to the process through which the various systems of society and the environment, such as services, activities, information and documentation are made available to all.

Principle 3: Equality for all regardless of sex or gender status

Equality between men and women and equality regardless of gender status is a core principle underlining the issue of multiple and aggravated forms of discrimination. Providers and other relevant organizations should ensure that their staff have sufficient skills, information and knowledge about the Act and provision of services to support all their patients. There should be clear mechanisms for accessing specialist support for those with additional needs. Providers, including their staff, should give equal priority to mental health as they do to physical health conditions.

Equality means also equity in the provision of efficient services. Where patients are subject to involuntary admission, health and social care agencies should work together to deliver a programme of care that, as far as practicable, minimizes the duration of involuntary admission, facilitates safe discharge from facility and takes into account the patient's wishes. Providers and other relevant organizations should establish effective relationships to ensure efficient working with accountability defined through joint governance arrangements. Joint working should be used to minimize delay in care planning needed to facilitate discharge.

Purpose and effectiveness constitute an integral part of the principle of equality for all. Care, support and treatment given under the Act should be given in accordance with up-to-date national guidance and/or current best practice from professional bodies, where this is available. Treatment should address an individual patient's needs, taking account of their circumstances and preferences where appropriate.

Patients should be offered treatment and care in environments that are safe for them, staff and any visitors and are supportive and, therapeutic. Practitioners should deliver a range of treatments which focus on positive clinical and personal outcomes, where appropriate. Care plans for patients should focus on maximizing recovery and ending involuntary admission as soon as possible. Providers and professionals should consider the broad range of interventions and services needed to promote recovery not only in the facility but after a patient leaves the facility, including maintaining relationships, housing, opportunities for meaningful daytime activity and employment opportunities,

Physical healthcare needs should be assessed and addressed including promotion of healthy living and steps taken to reduce any potential side effects associated with treatments.

Principle 4: Respect for the evolving capacities of children

The best interest of the child should be a primary consideration in all actions concerning children taken by public and private bodies. Services, facilities and institutions caring for children should comply with appropriate standards in respect of health, safety, quality of staff and proper supervision. Caregivers have responsibilities to provide direction to children to enable them to exercise their rights. Any direction and guidance should be appropriate and take account of the evolving capacities of the child.

Principle 5: Accessibility

Accessibility is a precondition for persons with disabilities to live independently, participate fully and equally in society, and have unrestricted enjoyment of all their human rights and fundamental freedoms on an equal basis with others. According to the 2005 Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health accessibility for persons with mental disabilities (patients under the Act) has four overlapping dimensions:

i. Physical accessibility. Health facilities, goods and services should geographically accessible, for example rural areas should be covered. Facilities should be physically accessible to persons with disabilities (eg. installing ramps, Braille signs etc).

ii. Economic accessibility. Health facilities, goods and services should be affordable for all, including socially disadvantaged groups. Equity demands that poorer households should not be disproportionately burdened with health expenses as compared to richer households.

iii. Information accessibility. Information given about a particular diagnosis or treatment option should be accessible to everyone, such as people from minority languages, and people with intellectual disabilities who may need the information in easy to read format. It should also be available in Braille for people with visual disabilities. Accessibility of information should not impair the right to have personal health data treated with confidentiality.

iv. Non-discrimination. All healthcare goods and services should be accessible to people with mental disabilities, and should not discriminate on the grounds of race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth, physical or mental disability, health status (including HIV/AIDS), sexual orientation and civil, political, social or other status, which has the intention or effect of nullifying or impairing the equal enjoyment or exercise of the right to health. Persons with mental disabilities should get the same level of medical care within the same system as other members of society, and do not face discrimination on the basis of presumptions of their quality of life and potential.

Principle 6: Full and effective participation and inclusion in the society

People with mental disabilities experience wide-ranging violations and discrimination, which prevent them from living and being included in the community. They are denied opportunities to work and get an education and access to the social and financial support they require to live in the community. Part of the problem is that both inpatient and outpatient services for people with mental disabilities are focused on treatment and care rather than on providing or facilitating access to the full range of support to allow these people to live independently in the community and participate fully in society. Professionals should facilitate their full inclusion and effective participation in society by providing them recovery-oriented mental health services

Principle 7: Least restrictive option and maximizing independence

Where it is possible to treat a patient safely and lawfully without admitting them under the Act, the patient should not be admitted.

MHCs, providers and other relevant agencies should work together to prevent mental health crises and, where possible, reduce the use of involuntary admission through prevention and early intervention by providing a range of services that are accessible, responsive and as high quality as other health services.

If the Act is used, involuntary admission should be used for the shortest time necessary in the least restrictive health and or mental health and or social care setting available, and be delivered as close as reasonably possible to a location that the patient identifies they would like to be close to (e.g. their home or close to a family member or carer). In cases where the patient needs support for facilitated decision-making to decide about the location they would like to be close to, a best interpretation decision on the location should be taken. This will promote recovery and enable the patient to maintain contact with family, friends, and their community.

Any restrictions should be the minimum necessary to safely provide the care or treatment required having regard to whether the purpose for the restriction can be achieved in a way that is less restrictive of the person's rights and freedom of action.

Restrictions that apply to all patients in a particular setting (blanket or global restrictions) should be avoided. There may be settings where there will be restrictions on all patients that are necessary for their safety or for that of others. Any such restrictions should have a clear justification for the particular hospital, group or ward to which they apply. Blanket restrictions should never be for the convenience of the provider. Any such restrictions, should be agreed by facility directors, be documented with the reasons for such restrictions clearly described and subject to governance procedures that exist in the relevant organization.

Principle 8: Recovery approach

To facilitate recovery patients should be empowered. In the mental health context, empowerment refers to the level of choice, influence and control that people using mental health services can exercise over events in their lives. The key to empowerment is the removal of formal and informal barriers and the transformation of power relations between individuals, communities and services. Professionals should recognize and respect the uniqueness of the individual, acknowledge choices, promote rights, challenge discrimination and stigma, promote dignity and respect, value the importance of partnership and communication, and ensure continuous evaluation of recovery based practice.

Patients should be empowered and supported to be involved in planning, developing and reviewing their own care and treatment to help ensure that it is delivered in a way that is as appropriate and effective for them as possible. Wherever possible, care plans should be produced in consultation with the patient.

A patient's views, past and present wishes and feelings (whether expressed at the time or in advance), should be considered so far as they are reasonably ascertainable. Patients should be encouraged and supported to develop advance statements of wishes and feeling and express their views about future care and treatment when they are well.

The patient's choices and views should be fully recorded. Where a decision in the care plan is contrary to the wishes of the patient or others the reasons for this should be transparent, explained to them and fully documented.

Patients should be enabled to participate in decision-making as far as they are capable of doing so. Consideration should be given to what assistance or support a patient may need to participate in decision-making and any such assistance or support should be provided, to ensure maximum involvement possible. This includes being given sufficient information about their care and treatment in a format that is easily understandable to them.

Professionals should listen to, learn from and act upon communications from the patients and their carers about what is important to each individual, to promote human rights, to support individuals to maintain and develop social, recreational, occupational and vocational activities which are meaningful to the individual and to instil hope in an individual's future and ability to live a meaningful life.

Patients should be encouraged and supported in involving carers (unless there are particular reasons to the contrary). Professionals should fully consider their views when making decisions.

Using the principles

All decisions should be lawful and informed by good professional practice. All sets of principles are of equal importance, and should inform any decision made under the Act. The weight given to each principle in reaching a particular decision will need to be balanced in different ways according to the circumstances and nature of each particular decision. The guidance in the Code is based on these principles and reference is made to them throughout the Code. Providers, professionals and others providing care under the Act should document, and justify, any decision to depart from the Code or a particular guiding principle.

Chapter 2: Mental Disorder

Mental disorder is defined for the purposes of the Act as a state of mind which affects the person's thinking, perceiving, emotion or judgment and which seriously impairs the mental, social and behavioural functioning of the person and causes dysfunction, disability, and disadvantage.

Examples of clinically recognized conditions which could fall within this definition are:

- Affective disorders, such as depression and bipolar disorder
- Psychotic disorders
- Substance abuse/dependence disorders
- Neurotic, stress-related and somatoform disorders, such as anxiety, phobic disorders, obsessive compulsive disorders, post-traumatic stress disorder and hypochondriacal disorders
- Organic mental disorders such as dementia and delirium (however caused)

- Personality and behavioural changes caused by brain injury or damage (however acquired)
- Personality disorders
- Mental and behavioural disorders caused by psychoactive substance use
- Eating disorders, non-organic sleep disorders and non-organic sexual disorders
- Intellectual disabilities
- Autistic spectrum disorders (including Asperger's syndrome)
- Dementia
- Behavioural and emotional disorders of children and young people

(Note: this list is not exhaustive)

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 permitted only where specific criteria are met. There are many forms of mental disorder which are unlikely to call for compulsory measures.

Care should always be taken to avoid diagnosing, or failing to diagnose, mental disorder on the basis of preconceptions about people or failure to appreciate cultural and social differences. What may be indicative of mental disorder in one person, given their background and individual circumstances, may be nothing of the sort in another person.

Difference should not be confused with disorder. No-one may be considered to have a mental disorder solely because of their political, religious or cultural beliefs, values or opinions, unless there are proper clinical grounds to believe that they are the symptoms or manifestations of a mental disorder. The same is true of a person's involvement, or likely involvement, in illegal, anti-social or 'immoral' behaviour. Beliefs, behaviours or actions which do not result from a mental disorder are not a basis for compulsory measures under the Act, even if they appear unusual or cause other people alarm, distress or danger.

Dependence on drugs

Drug dependence may be accompanied by, or associated with, a mental disorder. If the relevant criteria are met, it is therefore possible, for example, to detain people who are suffering from mental disorder, even though they are also dependent on drugs. This is true even if the mental disorder in question results from the person's drug dependence.

The Act does not exclude other disorders related to the use of drugs. These disorders – eg withdrawal state with delirium or associated psychotic disorder, acute intoxication, organic mental disorders associated with prolonged abuse of drugs– remain mental disorders for the purposes of the Act. Medical treatment for mental disorder under the Act (including treatment with consent) can include measures to address drug dependence if that is an appropriate part of treating the mental disorder which is the primary focus of the treatment.

Intellectual disabilities and autistic spectrum disorders

Intellectual disabilities and autistic spectrum disorders are forms of mental disorder.
Someone with an intellectual disability may be admitted under the Act where there is a co-morbid condition of such a severity to meet the threshold for mental disorder. Professionals

should record their reasons excluding others factors such as an unmet physical health, social or emotional needs.

This ‘intellectual disability qualification’ only applies to specific sections of the Act. In particular, it does not apply to involuntary admission for assessment.

The intellectual disability qualification does not apply to autistic spectrum disorders (including Asperger’s syndrome). 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 it is not associated with abnormally aggressive or seriously irresponsible behaviour. While experience suggests that this is likely to be necessary only very rarely, the possibility should never automatically be discounted.

Personality disorders

Apart from the intellectual disability qualification described above, the Act does not distinguish between different forms of mental disorder. The Act therefore applies to personality disorders (of all types) in exactly the same way as it applies to mental disorders.
No assumptions should be made about the suitability of using the Act – or indeed providing services without using the Act – in respect of personality disorders or the people who have them. The needs of the individual patient, the risks posed by their disorder and what can be done to address those needs and risks, both in the short and longer term should inform decisions.

Chapter 3: Human rights

Individual chapters explain relevant human rights issues and give good practice guidance. This chapter builds on this to highlight specific examples of good practice in service delivery and professional practice. Providers will need to consider the legislation and international conventions listed below:

• UN Declaration of Human Rights	http://www.un.org/en/documents/udhr/
• UN Convention on the Rights of the Child	http://www.ohchr.org/en/professionalinterest/pages/crc.aspx UNCRC_PRESS200910web.pdf http://www.unicef.org/crc/files/Rights_overview.pdf
• UN Convention on the Elimination of All Forms of Discrimination against Women	http://www.ohchr.org/EN/ProfessionalInterest/Pages/CEDAW.aspx
• UN Covenant on Economic, Social and Cultural Rights	http://www.ohchr.org/EN/ProfessionalInterest/Pages/CESCR.aspx
• UN Covenant on Civil and Political Rights	http://www.ohchr.org/en/professionalinterest/pages/ccpr.aspx

• UN Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families	http://www.ohchr.org/EN/ProfessionalInterest/Pages/CMW.aspx
• UN Convention on the Rights of Persons with Disabilities	http://www.un.org/disabilities/convention/conventionful

Human rights

Human rights legislation provides a framework for providers to deliver the best possible outcomes for everyone who uses services. This means:

- putting human rights principles and standards into practice
- aiming to secure the full enjoyment of human rights for all, and
- ensuring rights are protected and secured.

Participation – enabling meaningful participation of key stakeholders in policy development.
Accountability – ensuring clear accountability for human rights, through the system. Accountability requires strong governance including effective monitoring of human rights standards as well as effective remedies for human rights breaches. For this there should be appropriate laws, policies, institutions, administrative procedures and mechanisms of redress in order to ensure compliance with human rights legislation.

Non-discrimination and equality – working to eliminate discrimination by embedding equality through systems processes and outputs. All forms of discrimination in the realisation of rights should be prohibited, prevented and eliminated. It also requires the prioritization of those in the most marginalized situations who face the biggest barriers to realising their rights.
Empowerment of all with knowledge, skills and commitment to realising human rights. Individuals and communities should know their rights. It also means that they should be fully supported to participate in the development of policy and practices which affect their lives and to claim rights where necessary.

Legality – expressly applying the Constitution and linking to international standards and bodies. A human rights-based approach requires the recognition of rights as legally enforceable entitlements and is linked in to national and international human rights law.
The international human rights standards framework to which the GoA is a party places a duty on public authorities to respect and protect people’s human rights. A wide range of bodies carrying out public functions, including the delivery of public services by private and contracted-out providers, have legal obligations to respect and protect human rights.

In some instances, competing human rights will need to be considered, which may require finely balanced judgments. Such decisions and the reasons for them should be clearly documented. Decisions restricting a person’s rights will need to be justifiable as necessary and proportionate in the circumstances of the specific case. Any restriction imposed should be kept to the minimum needed to meet the purpose and aim of the restriction.

Public and private sector equality duty

The international human rights standards framework, and especially the UN Convention on the Rights of Persons with Disabilities, makes it unlawful to discriminate (directly or indirectly) against a person on the basis of a protected characteristic or combination of protected characteristics. Protected characteristics under this Act include age, disability, gender, race, religion or belief, sex. The protected characteristic of disability includes a mental impairment that has a substantial and long-term adverse effect on the person's ability to carry out normal day-to-day activities.

Public authorities including private health, mental health and social care providers and organizations should have due regard to the need to:

- eliminate unlawful discrimination, harassment and victimisation
- advance equality of opportunity between people who share a protected characteristic and those who do not, and
- foster good relations between people who share a protected characteristic and those who do not.

Complying with the public and private sector equality duty may involve treating persons with mental health problems more favourably than others in order to achieve equality of access to services and outcomes.

Reasonable adjustments

A duty is placed on providers of services to the public and those exercising public functions, including public health and social care services, and private health and social care services, and mental health care professionals to make reasonable adjustments for people with an impairment (including mental impairment) that constitutes a disability under the Act. Providers should take reasonable steps to avoid putting a person with a disability at a substantial disadvantage compared with those without a disability.

The reasonable adjustments a person may need could be considered as part of a person-centred care planning process in all facilities. The duty applies where:

- a provision, criterion or practice puts persons with mental disabilities at a substantial disadvantage compared with those who have no disability;
- a physical feature puts persons with mental disabilities at a substantial disadvantage compared with people without disabilities, and
- not providing an auxiliary aid puts persons with mental disabilities at a substantial disadvantage compared with people without disabilities.

Examples of reasonable adjustments:

- Assessment for admission is undertaken by professionals with the appropriate specialist skills to assess the person based on their individual needs, e.g. adjustments if the person has a intellectual disability or an autism spectrum disorder.
- Ensuring the care environment is as accessible as possible, e.g. through appropriate signage and lighting.

- Ensuring information for patients is in a format accessible to the person, e.g. using pictures and big print, or providing translations into the person’s first language.
- Ensuring there are adequate numbers of staff with the right skills and experience to communicate effectively with patients, e.g. staff who can use sign language or communicate in the person’s first language.
- Providing specific or additional training for staff who work with people with intellectual disabilities or autism spectrum disorders.
- Ensuring meetings are accessible to people, e.g. providing materials in an appropriate format and holding the meeting in an accessible venue.

Duty to reduce inequalities

Mental health care professionals, in the exercise of their functions, have due regard to the need to reduce health inequalities between patients with respect to (i) their ability to access health services and (ii) the outcomes achieved for them by the provision of services. The legal duties apply to the exercise of any functions, which includes decision made and policy developed.

Monitoring and compliance

Providers should have in place a human rights and equality policy for service provision and practice in relation to the Act, which should be reviewed at Board (or equivalent) level at least annually. As a minimum the human rights and equality policy should:

- set out how the organization complies with the Mental Health Act 2014
- ensure that there is robust monitoring of equalities so that the organization can better understand how people with protected characteristics are affected by the Act. Information gathered should be made publicly available in a clear and transparent manner. Details of any action that will be taken in light of the information collected should also be made available. Consideration should be given to whether other bodies can assist in any action that is required e.g. the MHCs and the AIHRC.
- set out how the organization will ensure the organization is providing therapeutic environments and patients are treated with dignity and respect, involved in discussions about their care and treatment and their culture and ethnicity are respected
- set out how the organization will obtain qualitative evidence on patients’ experiences and how it will ensure that the information is gathered at an appropriate time. This could include feedback on a patient’s involvement in care planning and on their relationships with staff and other patients
- describe consideration given of the need for reasonable adjustments, and
- set out how staff will be provided with intellectual, development and training on human rights legislation and the Mental health Act.

Chapter 4: Mental Health Councils (MHCs)

This chapter provides guidance on the role of MHCs and related duties. MHCs are independent bodies with quasi-judicial and other functions established under the Mental Health Act 2014 to promote, encourage and foster the establishment and maintenance of high standards and good practices in the delivery of mental health inpatient and community-based services, and to take all reasonable steps to protect the rights of persons receiving care and/or treatment in in-patient facilities and/or in community-based services.

Purpose of the MHCs

MHCs are bodies with quasi-judicial and other functions which are established under of the Mental Health Act 2014 (chapter 2 of the Act) to promote, encourage and foster the establishment and maintenance of high standards and good practices in the delivery of mental health inpatient and community-based services, and to take all reasonable steps to protect the rights of persons receiving care and/or treatment in in-patient facilities and/or in community-based services.

There four primary principles to be followed in setting up and overseeing the functioning of MHCs: Firstly the body should be independent of political and bureaucratic interference. Secondly, it should cover all parts of the country. Thirdly it should include a range of individuals with different experiences and skills to be able to carry out the mandate of the body and fourthly, the members of the body should have a clear understanding of human rights standards.

MHCs as monitoring mechanisms

MHCs can act as mental health inspectorates and scrutinize all facilities and any other place where mental health services are provided, assess strategies, policies and plans and make recommendations for change on the basis of findings. MHCs can examine actual facilities, care pathways, care planning, treatment interventions and discharge protocols and quality of care. They are also be responsible for monitoring and ensuring that the relevant legal provisions are being respected and implemented and that government policy and legislation meets international human rights standards.

Patients, including former service users as well as their relatives, friends, family members and personal representatives have the right to complain regarding any aspect of care and treatment provided. MHCs may utilize checklists, conduct interviews with staff and users of services as well as undertake observations to reach their conclusions. By undertaking regular visits, conducting inspections, being available to hear complaints (and acting on these), and generally advancing and upholding the rights of people with mental disabilities, human rights can be genuinely promoted.

The awareness by facilities staff or other service providers that they are being “watched” is alone likely to impact on care and the way service users are treated. Moreover, awareness that action can be taken if abuses are found, in all likelihood results in fewer abuses occurring. In addition to providing the relevant establishments with a report, the findings and recommendations of MHCs may be given directly to the Minister of Public Health. MHCs have powers to act directly on services and may, for example, disapprove licenses of private mental health facilities, clinics, other inpatient facilities and community-based mental health services for the care and/or treatment of persons with mental disabilities.

When conducting inspections and acting on the findings it is important that sanctions are not simply taken against people, establishments or authorities without simultaneous consultation and collaboration with service providers and those who control budgets. If this is not done properly it is possible that the good intentions of sanctions could even prejudice service users care. For example if a decision is made by an independent monitoring body to close a facility because most of the people within it have no reason to be there, and that the conditions are extremely poor (both of which are common), the closure of this facility without ensuring that the service providers have made alternative arrangements for service users, could result in dire consequences for the people within the facility and would not necessarily be a positive move towards better human rights protection for people with mental disabilities.
MHCs can also make use of the national legal system. For example if they find that a staff member at an establishment has abused a service user, they may facilitate or take legal action against such person. Moreover if they find that whole facilities are in violation of human rights due to poor living condition, lack of treatment and rehabilitation etc, they may decide to litigate against the particular establishment or the Ministry itself rather than merely report such facts.

MHCs as Review Bodies

MHCs can also act as Mental Health Review Special Tribunals to make decisions regarding involuntary admission and treatment. They have powers to authorize or prohibit admission, treatment and discharge involuntary patients; to transfer patients to less restrictive environments and to monitor intrusive treatments such as ECT. The main functions of MHCs as Review Bodies relate mainly to the human rights principles of liberty, freedom and autonomy of the person.

MHCs provide a significant safeguard for patients who have had their liberty curtailed under the Act. Those giving evidence at hearings should do what they can to help enable MHCs hearings to be conducted in a professional manner, which includes having regard to the patient’s wishes and feelings and medical condition and ensuring that the patient feels as comfortable as possible with the proceedings.

It is for those who believe that a patient should continue to be admitted to prove their case, not for the patient to disprove it. They will therefore need to present the MHCs with sufficient evidence to support continuing liability to involuntary admission. Clinical and social reports form the backbone of this evidence. Care should be given to ensure that all information is as up-to-date as possible to avoid adjournment. In order to support the MHC in making its decision, all information should be clear and concise.

Informing the patient and relative of rights to apply to the MHC

Directors are under a duty to take steps to ensure that patients understand their rights to apply for a MHC hearing. Directors should also advise patients of their entitlement to free legal advice and representation. They should do both whenever:

- patients are first admitted in hospital

- whenever their admission is extended, and
- whenever their status under the Act changes – eg if they move from voluntary admission to involuntary admission

Unless the patient requests otherwise, and the patient should be asked, the information should normally also be given to their relative.

Directors and professionals should enable admitted patients to be visited by their legal representatives at any reasonable time. This is particularly important where visits are necessary to discuss a MHC or a Court application. Where the patient consents, legal representatives and independent doctors should be given prompt access to the patient's medical records. Delays in providing access can hold up MHC or Court proceedings and should be avoided.

In connection with an application (or a reference) to a MHC or a Court, an independent psychiatrists or approved clinician authorized by (or on behalf of) a patient has a right to visit and examine the patient in private. Those psychiatrists and approved clinicians also have a right to inspect any records relating to the patient's admission, treatment and (where relevant) after-care.

Where relatives have a right to apply to the MHC, they too may authorize independent psychiatrists or approved clinicians in the same way. The patient's consent is not required for authorized psychiatrists or approved clinicians to see their records, and they should be given prompt access to the records they wish to see.

Directors' duty to refer cases to the MHC

Directors have various duties to refer patients to the MHC. They may also request the Minister of Public Health to refer a patient, and there are certain circumstances where they should always consider doing so (see paragraphs ……and for children and young people, paragraphs…).

Reports for the MHC

It is important that documents and information are provided in good time for any MHC hearing. Missing, out-of-date or inadequate reports can lead to adjournments or unnecessarily long hearings. Where responsible clinicians, social workers or other professionals are required to provide reports, they should do this promptly and within the statutory timescale.

Directors should ensure that the MHC is notified immediately of any events or changes that might have a bearing on MHC proceedings – eg where a patient is discharged or one of the parties is unavailable.

Reports should be sent to the MHC office, preferably by secure e-mail, otherwise by post. Up-to-date reports prepared specifically for the MHC will normally include a report completed by the patient's responsible clinician. Where possible, reports should be written by the professionals with the best overall knowledge of the patient's situation. The reports should be submitted in good time to enable all parties to fulfil their responsibilities.

Medical examination

In certain categories of case, a medical member of the MHC may be asked to examine the patient, sometime before the hearing. Directors should ensure that the medical member can see patients who are in the facility in private, where this is safe and practicable, and make provision for the member and the MHC panel at the hearing to be able to examine the patient's medical records, if necessary. It is important that the patient is told of any visit in advance, so that they can be available when the medical member visits.

Withdrawing the application

A request to withdraw an application may be made by the applicant. An application will be considered to be withdrawn if the patient is discharged. If this happens outside office hours, someone acting on behalf of the Director should contact the MHC office as soon as possible, to inform them. For involuntary patients, this could be done by a member of the ward staff.

Representation

Directors should inform patients of their right to present their own case to the MHC and their right to be represented by someone else (whether legally qualified or not) and of any free legal advice and representation available. Staff should be available to help patients make an application and prepare them for the MHC.

If a patient has not appointed a representative and they do not wish to present their own case, or the patient needs support for facilitated decision-making to decide whether they want a representative and the MHC considers it is important for the patient to be represented, then the MHC can appoint a person before the hearing, or permit a person who has accompanied the patient to the hearing, to be a representative for the patient. A patient's family member, carer or person of trust could be their representative.

The hearing

Attendance at hearings

Normally patients will be present throughout hearings. Patients and carers do not need to attend the MHC hearing, but professionals should encourage and support them to attend.

A carer will only be able to present the patient's case if they are appointed by the patient, and given permission by the MHC as a representative. If the patient is not well enough to attend the hearing or speak on their own behalf then a legal representative or a carer should be given the opportunity to attend and speak on their behalf.

It is important that the patient's responsible clinician/s attend the MHC, supported by other staff involved in the patient's care, where appropriate, as their evidence is crucial for making the case for a patient's continued admission under the Act. Wherever possible the responsible clinician, and other relevant staff, should attend for the full hearing so that they are aware of all the evidence made available to the MHC and the MHC decision and reasons.

Responsible clinicians can attend the hearing solely as a witness or as the nominated representative of the responsible authority. As a representative of the responsible authority, the responsible clinician has the ability to call and cross-examine witnesses and to make submissions to the MHC. This may not always be desirable where it is envisaged that the responsible clinician will have to continue working closely with a patient.

Responsible authorities should therefore consider whether they want to send an additional person to represent their interests, allowing the responsible clinician to appear solely as a witness. Responsible clinicians should be clear in what capacity they are attending the MHC, as they may well be asked this by the panel.

It is important that other people who prepare reports submitted by the responsible authority attend the hearing to provide further up-to-date information about the patient, including (where relevant) their home circumstances and the aftercare available in the event of a decision to discharge the patient.

MHC hearings may find it helpful to speak to a nurse, particularly a nurse who knows the patient. It is often helpful for a nurse who knows the patient to accompany them to the hearing.

Directors should ensure that all professionals who attend MHC hearings are adequately prepared. They should provide patients and their carers with sufficient information to understand the matters the MHC is considering in a format and language that patients and their carers understand.

Accommodation for hearings

The Director of a facility in which a MHC hearing is to be held should provide suitable accommodation for that purpose. The hearing room should be private, quiet, clean and adequately sized and furnished. It should not contain confidential information about other patients. If the room is used for other purposes, care should be taken to ensure that any equipment (such as a video camera or a two-way mirror) would not have a disturbing effect on the patient.

The patient should have access to a separate room in which to hold any private discussions that are necessary – e.g. with their representative – as should the MHC members, so that they can discuss their decision.

Interpretation

The MHC should ensure that MHC panel members understand equality issues and that there are sufficient numbers of panel members with a specialized understanding of the specific needs of particular groups including those listed below, and that panel members can communicate effectively with them:

- patients from minority cultural or ethnic backgrounds
- patients with physical impairments and/or sensory impairments, and/or
- patients with intellectual disabilities and/or autistic spectrum disorders.

It is important that patients and their representatives are able to understand and participate in the MHC hearing. This includes providing information in formats that they understand and, if required, providing interpretation services free of charge, including sign language. Directors should inform the MHC well in advance if they think any such services might be necessary.

Communication of the decision

The MHC will normally communicate its decision to all parties orally at the end of the hearing. Provided it is feasible to do so, and the patient wishes it, the MHC will speak to them personally. Otherwise, the decision will be given to the patient's representative (if they have one). If the patient is unrepresented, and it is not feasible to discuss matters with them after the hearing, the Directors should ensure that they are told the decision as soon as possible. All parties to the hearing should receive a written copy of the reasons for the decision.

Complaints

Complaints from users about the MHC should be sent to the MHC offices. The MHC should have procedures in places to deal with complaints promptly.

Chapter 5: Rights of patients and families

Ironically, some of the worst human rights violations and discrimination experienced by people with mental disabilities, intellectual disabilities and substance abuse problems is in health-care settings. In many countries, the quality of care in both inpatient and outpatient facilities is poor or even harmful and can actively hinder recovery. The treatment provided is often intended to keep people and their conditions 'under control' rather than to enhance their autonomy and improve their quality of life. People are seen as 'objects of treatment' rather than human beings with the same rights and entitlements as everybody else. They are not consulted on their care or recovery plans, in many cases receiving treatment against their wishes. The situation in inpatient facilities is often far worse: people may be locked away for weeks, months and sometimes years in psychiatric hospitals or social care homes, where they experience terrible living conditions and are subject to dehumanizing, degrading treatment, including violence and abuse.

This chapter gives detailed information on the sets of patient rights (articles 12-17 of the Act), families rights (article 18 of the Act), and guidance on the information that should be given to patients, and their relatives. It also gives guidance on communication with patients, their families and carers, and other people. Effective communication is essential in ensuring appropriate care and respect for patients' rights, and those responsible for caring for patients should identify any communication difficulties and seek to address them. The Act requires Directors to take steps to ensure that patients who are admitted understand important information about how the Act applies to them.

Part I: Rights of patients in the facilities defined in Article 2 of the Act

The right to health (Article 12 of the Act)

Rationale

In many cases, people do not have access to the basic mental health care and treatment that they require. Services are often too far from their homes or unaffordable. In other cases, the services themselves are of poor quality: ineffective or harmful treatments are applied, and co morbid general health problems are ignored. Institutional services are emphasized to the detriment of outpatient community-based facilities, and the focus of many services is on detaining people rather than helping them to develop their abilities in order to recover and (re)integrate into the community. Furthermore, people living in residential facilities are often unable to access services for general and sexual and reproductive health. Article 25 of the CRPD requires that people with disabilities be given the health services they need, as close as possible to their communities. It also requires that they be given the same range, quality and standard of free or affordable health care, including sexual and reproductive health, as all other people.

In many instances, people are exposed to physical, sexual and mental abuse. Many spend days, months and even years living aimless, inactive lives in excruciating boredom and total social isolation. They are often secluded (for example in isolation cells) or placed in restraints (such as chains, shackles and caged beds). In addition they are often over-medicated, so that they remain docile and ‘easy to manage’. In many instances and according to international human rights law, this treatment amounts to ill-treatment and in some cases even torture.

Article CRPD 15 requires that all appropriate measures be taken to prevent people with disabilities from being subjected to torture or cruel, inhuman or degrading treatment or punishment. This Article also states that no one should be subjected to medical or scientific experimentation without his or her free consent. Article CRPD 16 requires that all measures be taken to protect people against and prevent all forms of exploitation, violence and abuse. This Article also requires that all appropriate measures be taken to promote the physical, cognitive and psychological recovery, rehabilitation and social reintegration of people with disabilities who become victims of any form of exploitation, violence or abuse, including by the provision of protection services. In addition, recovery and reintegration should take place in an environment that fosters the health, welfare, self-respect, dignity and autonomy of the person and takes into account gender- and age-specific needs. Importantly also, Article 16 requires that all facilities and programmes designed to serve people with disabilities be effectively monitored by independent authorities

As is recognized in international instruments such as the U.N. Declaration of Human Rights and in General Comment 14 on the ICESCR, the right to health – including mental health – is typified by four factors: publicly funded health facilities and services should be available in sufficient quantity; treatment, care and information should be geographically and economically accessible to all persons without discrimination; facilities and services should be acceptable, meaning appropriately delivered for vulnerable or minority groups such as women, children, and ethnic or cultural minorities and respectful of medical ethics; and care should be of good quality. In addition, the right to health does not simply mean delivery of health services but also includes many other factors that are related to health outcomes: socioeconomic factors such as clean living conditions; non-discrimination and equal access to care; freedom from interference; access to medications; equitable distribution of care; and adequate and up to date training of professionals. Most importantly, the right to health does not distinguish between physical and mental health.

Patients under the Act should have their right to health respected, meaning that third parties do not harm the right to health of persons with mental disabilities. Patients under the Act should have their right to health protected, meaning being ensured that third parties do not harm this right. This might include protections against violence against women with mental health problems. Patients under the Act should further have their to health fulfilled, meaning that laws, policies, programmes and projects should be available to embody human rights and empower people with mental disabilities to make choices about their lives; give legal protections relating to the establishment of (and access to) quality facilities, as well as care and support services; establish robust procedural mechanisms for the protection of those with mental disabilities; ensure the integration of persons with mental disabilities into the community; and promote mental health throughout society.

The discrimination faced by people with mental disabilities within the healthcare system is addressed by the UN Convention on the Rights of Persons with Disabilities in its Article 25 in which people with disabilities should be given “the same range, quality and standard of free or affordable health care and programmes as provided to other persons”, provides for medical treatment to be provided “on the basis of free and informed consent”, and includes health-related rehabilitation, linking with Article 26 on habilitation and rehabilitation which provides for health-related re/habilitation to “enable persons with disabilities to attain and maintain maximum independence, full physical, mental, social and vocational ability, and full inclusion and participation in all aspects of life.

Accordingly, providers of services to persons with mental disabilities should:
- Ensure that the right to free and informed consent is recognized and enforced without discrimination;
- End forced medication in emergency rooms and inpatient facilities;
- Develop and promote alternatives to medical model psychiatry;
- Provide accurate information to people considering the use of psychotropic drugs;
- Ensure that physical health problems are not misidentified as psychosocial disability;

For this right to be fulfilled the following standards should be met:

- Facilities are available to everyone who requires treatment and support
- Facilities have skilled staff and provides good-quality mental health services
- Treatment, psychosocial rehabilitation and links to support networks and other services are elements of patient-driven recovery plans and contribute to patient’s ability to live independently in the community
- Psychotropic medications are available, affordable and used appropriately
- Adequate services are available for general and reproductive health
- Patients have the right to be free from verbal, mental, physical and sexual abuse and physical and emotional neglect
- Alternative methods are used in place of seclusion and restraint as means of de-escalating potential crises.
- Medical procedures that may have permanent or irreversible effects, whether performed at the facility or referred to another facility, should not be abused and can be administered only with the free and informed consent of the patient
- No patient is subjected to medical or scientific experimentation without his or her informed consent
- Safeguards are in place to prevent torture or cruel, inhuman or degrading treatment and other forms of ill-treatment and abuse

The right to an adequate standard of living and social protection (Article 13 of the Act)

Rationale

Many people staying in residential facilities have inhuman living conditions, including overcrowding and poor sanitation and hygiene. Residents lack proper clothing, clean water, food, heating, decent bedding and privacy. The social environment is often no better: people are denied the opportunity to communicate with the outside world, their privacy is not respected, they experience excruciating boredom and neglect and little or no intellectual, social, cultural, physical or other form of stimulation. Article 28 of the CRPD requires, among other things, that people with disabilities are provided with an adequate standard of living, including adequate food, clothing, clean water, devices and other assistance for disabilities and continuous improvement of their living conditions.

For this right to be fulfilled the following standards should be met:

- Buildings should be in good condition
- Sleeping conditions should be comfortable and allow for sufficient privacy
- Hygiene and sanitary requirements should be met
- Patients should be provided with food, clothing and safe drinking water
- Patients should be able to communicate freely and their right to privacy be respected
- Facilities should provide a welcoming, comfortable and stimulating environment

The right to equal recognition before the law (Article 14 of the Act)

Rationale

People with mental and intellectual disabilities routinely experience violations of their right to exercise their legal capacity. They are often considered incapable of making decisions about their own lives, and key choices that concern them (e.g. about their place of residence, their medical treatment, their personal and financial affairs) are made by families, carers, guardians or health professionals. Furthermore, people are given medical treatment or admitted to residential facilities without their express informed consent. Article 12 of the CRPD states that ‘people with disabilities have the right to recognition everywhere as persons before the law’. It also re-asserts the rights of people with disabilities to exercise their legal capacity on an equal basis with others in all aspects of life. They should therefore remain central to all decisions that affect them, including about their treatment, where they live and their personal and financial matters. Article 12 also states that, when needed, people should be given sup port in exercising their legal capacity. This means that they should have access to a trusted person or group of people, who can explain issues related to their rights, treatment and other relevant matters and who can help them to interpret and communicate their choices and preferences. The people providing support could include advocates, community services, personal assistants and peers.

People with mental disabilities are often viewed by the justice system as non-credible victims and witnesses. The person’s mental illness is seen by the system to cloud the person’s judgment. Under the CRPD patients under the Act should be ensured effective access to justice on an equal basis with others.

For this right to be fulfilled the following standards should be met:

- Patients can exercise their legal capacity and are given the support they may require to exercise their legal capacity.
- Patients have the right to confidentiality and access to their personal health information.

The right to liberty and security of the person (Article 15 of the Act)

Rationale

Article 14 of the CRPD is an important provision in relation to admission without informed consent. It states that people with disabilities should not be deprived of their liberty unlawfully or arbitrarily, that any deprivation of liberty (including involuntary admission) should be in conformity with the law and that the existence of a disability shall in no case justify deprivation of liberty.

For this right to be fulfilled the following standards should be met:

- Patient's preferences on the place and form of treatment are always a priority.
- Procedures and safeguards are in place to prevent involuntary admission and treatment without free and informed consent.

The right to social inclusion (Article 16 of the Act)

Rationale

People with disabilities experience wide-ranging violations and discrimination, which prevent them from living and being included in the community. They are denied opportunities to work and get an education and access to the social and financial support they require to live in the community. Part of the problem is that both inpatient and outpatient services for people with mental disabilities are focused on treatment and care rather than on providing or facilitating access to the full range of support to allow these people to live independently in the community and participate fully in society. Article CRPD 19 states that people with disabilities have the right to live in the community and that their full inclusion and participation in society should be facilitated. It further states that people have the right to decide where and with whom they live; they should not be obliged to live in a particular living arrangement. Significantly also, Article 19 states that people should be given access to a range of in-home, residential and other community support services, including the personal assistance necessary to support living and inclusion in the community, and to prevent isolation or segregation from the community.

For this right to be fulfilled the following standards should be met:

- Patients are supported in gaining access to a place to live and have the financial resources necessary to live in the community.
- Patients can access education and employment opportunities.
- The right of patients to participate in political and public life and to exercise freedom of association is supported
- Patients are supported in taking part in social, cultural, religious and leisure activities.

The right to freedom and protection from discrimination (Article 17 of the Act)

Rationale

Article 5 of the CRPD focuses on non-discrimination. All persons are equal before the law and are entitled without discrimination to equal protection and equal benefit of the law. All discrimination on the basis of disability is prohibited persons with disabilities are guaranteed equal and effective legal protection against discrimination on all grounds. The Act ensures that there is no discrimination in the provision of health services to persons with mental disabilities as compared to persons without disabilities, including non discrimination in the quantity, access, and quality of services; provides for penalties when there is discrimination against persons with mental disabilities by any service providers, in particular by health services providers; protects against de facto and de jure discrimination; and includes provisions allowing persons with mental disabilities a right to appeal to the MHCs, the AIHRC and the courts when there is such discrimination. The definition of discrimination provided in Article 2 of the CRPD includes “denial of reasonable accommodation”. The reasonable accommodation duty requires provision of supports in the form of services. For people with mental disabilities, the protection against discrimination would be of limited value if it only meant that people situated similarly are treated equally. Affirmative action measures differ from reasonable accommodation in that these are positive steps taken to enhance the status of certain minority groups, such as people

With mental disabilities, to correct injustices, rather than changes for people with mental disabilities that are meant to provide them with equal opportunities to those without disabilities. Under the ICCPR, special protections or “affirmative action” is permissible – and at times required – to bring about equal protection under the law. Under the CRPD, “[s]pecial measures which are necessary to accelerate or achieve de facto equality of persons with disabilities shall not be considered discrimination under the terms of CRPD Article 5.4. As such, affirmative action measures that protect the rights of individuals with mental disabilities, such as quotas designed to increase representation of disabled persons in the workplace, are not prohibited.

Other rights

Communication with patients

Effective communication is essential in ensuring appropriate care and respect for patients’ rights. It is important that the language used is clear and unambiguous and that people giving information check that the information that has been communicated has been understood.
Everything possible should be done to overcome barriers to effective communication, which may be caused by any of a number of reasons. For example, a patient’s first language may not be Dari. Patients may have difficulty in understanding technical terms and jargon or in maintaining attention for extended periods. They may have a hearing or visual impairment, have difficulty in reading or writing, or have a intellectual disability. A patient’s cultural background may also be different from that of the person speaking to them. Children and young people will need to have information explained in a way they can understand and in a format that is appropriate to their age.

Those with responsibility for the care of patients need to identify how communication difficulties affect each patient so that they can assess the needs of each patient and address them in the most appropriate way. Facilities and other organizations should make people with specialist expertise (eg in sign language) available as required. Often carers can help with or advise on best ways of communicating with a patient.

Where an interpreter is needed, every effort should be made to identify an interpreter who is appropriate to the patient, given the patient's sex, religion or belief, dialect, cultural background and age. Interpreters need to be experienced in health-related interpreting. Using the patient's relatives and friends as intermediaries or interpreters is not good practice, and should only exceptionally be used, including when the patient is a child or a young person. Interpreters (both professional and non-professional) should respect the confidentiality of any personal information they learn about the patient through their involvement.

Persons of trust appointed by patients can be valuable in helping patients to understand the questions and information being presented to them and in helping patients to communicate their views to staff.

Wherever possible, patients should be engaged in the processes of reaching decisions which affect their care and treatment under the Act. Consultation with patients involves helping them to understand the information relevant to decisions, their own role and the roles of others who are involved in taking decisions. Ideally decisions should be agreed with the patient. Where a decision is made that is contrary to the patient's wishes, that decision and the authority for it should be explained to the patient using a form of communication that the patient understands. Carers and persons of trust should be involved where the patient wishes are not known or if the patient lacks ability to understand.

Information for admitted patients

The Act requires Directors to take steps to ensure that patients who are admitted under the Act, understand important information about how the Act applies to them. This should be done as soon as practicable after the start of the patient's admission.

Information should be given to the patient both orally and in writing, including in accessible formats as appropriate (eg Braille, easy read) and in a language the patient understands. These are not alternatives. Those providing information to patients should ensure that all relevant information is communicated in a way that the patient understands. It would not be sufficient to repeat what is already written on an information leaflet as a way of providing information orally.

Patients should be given all relevant information, including on complaints, legal advice, safeguarding and the role of the MHCs and the Afghan Independent Human Rights Commission (AIHRC). This information should be readily available.

Information about admission

Patients should be informed:

- of the provisions of the Act under which they are admitted and the effect of those provisions
- of the rights (if any) of their relative to discharge them (and what can happen if their responsible clinician does not agree with that decision)
- As part of this, they should be told:
- the reasons for their admission
- the maximum length of their admission
- that their admission may be ended at any time if it is no longer required or the criteria for it are no longer met

Patients should also be told the essential legal and factual grounds for their admission. For the patient to be able to adequately and effectively challenge the grounds for their involuntary admission, should they wish, they should be given the full facts rather than simply the broad reasons. This should be done promptly and clearly. They should be told they may seek legal advice, and assisted to do so if required.

In addition, a copy of the admission documentation should be made available to the patient as soon as practicable and as a priority, unless the Directors are of the opinion (based on the advice of the authors of the documents) that the information disclosed would adversely affect the health or wellbeing of the patient or others. It may be necessary to remove any personal information about third parties.

Where the article of the Act under which the patient is being admitted changes, they should be protected.

Information about consent to treatment

Patients should be told what the Act says about treatment for their mental disorder. In particular they should be told:

- the circumstances (if any) in which they can be treated without their consent – and the circumstances in which they have the right to refuse treatment
- the role of second opinion appointed doctors and the circumstances in which they may be involved, and
- (where relevant) the rules on electro-convulsive therapy (ECT) and medication administered as part of ECT

Information about seeking a review of involuntary admission:

- Patients should be informed of their rights to be considered for discharge, particularly:
- of the right of the responsible clinician and the Directors to discharge them
- of their right to ask the Directors to discharge them
- that the Directors should consider discharging them when their admission is renewed
- of their rights to apply to the MHC and the Courts
- of the rights (if any) of their relative to apply to the MHC on their behalf
- about the role of the MHCs and the role of the AIHRC

Directors should ensure that patients are offered assistance to request a Director' hearing or make an application to the MHC, and that the applications are transmitted to the MHC without delay. They should also be told:

- how to contact a suitably qualified legal representative (and should be given assistance to do so if required)
- that free legal aid may be available, and
- how to contact any other organization which may be able to help them make an application to the MHC.
- If a patient needs support for facilitated decision-making to decide whether to seek a review of involuntary admission, the patient should be provided with the opportunity to supported decision-making.

Information about the MHCs and the AIHRC

Patients should be informed about the role of the MHCs and the AIHRC and of their right to meet visitors appointed by the MHCs and the AIHRC in private. Patients should be told when the MHC or the AIHRC representative is to visit their facility and be reminded of their role. Patients may make a complaint to the MHCs and the AIHRC, and should be informed of the process for this. Support should be made available to patients to do this, if required

Keeping patients informed of their rights

Those with responsibility for patient care should ensure that patients are reminded from time to time of their rights and the effects of the Act. It may be necessary to give the same information on a number of different occasions or in different formats and to check regularly that the patient has fully understood it. Information given to a patient who is unwell may need to be repeated when their condition has improve

A fresh explanation of the patient's rights should be considered in particular where:

- the patient is considering applying to the MHC, or when the patient becomes eligible again to apply to the MHC
- the patient requests the Directors to consider discharging them, or such a request is refused
- the rules in the Act about their treatment change (eg because they need not any more support to consent to treatment)
- any significant change in their treatment is being considered
- there is to be a holistic care programme review (or its equivalent)
- renewal of their admission, is being considered
- a decision is taken to renew their admission.

When an admitted patient is discharged, this fact should be made clear to them. The patient should be given an explanation of what happens next, including any after-care or other services which are to be provided.

Communication with other people nominated by the patient

Patients may want to nominate one or more people who they would wish to be involved in, or notified of, decisions related to their care and treatment. Patients may nominate informal supporters, such as a carer or a person of trust.

The involvement of informal supporters can have significant benefits for the care and treatment of the patient. It can provide reassurance to the patient, who may feel distrustful of professionals who are able to impose compulsory measures on them or are relatively unfamiliar and unknown to the patient. People who know the patient well can provide knowledge of the patient and perspectives that come from long-standing and intimate involvement with the patient prior to (and during) their involvement with mental health services. They can provide practical assistance in helping the patient to articulate information and views and may have knowledge of advance decisions or statements made by the patient.

Professionals should normally agree to a patient’s request to involve carers, relatives, friends or other informal supporters. They should tell the patient whenever such a request will not be, or has not been, granted. Where a patient’s request is refused, it is good practice to record this in the patient’s notes, giving reasons for the refusal.
Professionals should take steps to find out whether patients who need support for facilitated decision-making to take particular decisions for themselves have an attorney or deputy with authority to take the decision on their behalf. Where there is such a person, they act as the agent of the patient, and should be informed in the same way as the patient themselves about matters within the scope of their authority.

Facility’s information policy

The formal duty to ensure that admitted patients, and their relatives, have been informed about their legal situation and rights falls to the Directors of facilities. In practice, it would usually be more appropriate for professionals working with the patient to provide them with the information. In order to fulfil their statutory duties Directors should have policies in place to ensure that:

- the correct information is given to patients and their relatives
- information is given in accordance with the requirements of the legislation, at a suitable time and in an accessible format, where appropriate with the aid of assistive technologies and interpretative services.
- people who give the information have received adequate and appropriate training and guidance and, if relevant, have specialist skills in relation to people with intellectual disability, autism and/or children and young people
- a record is kept of the information given, including how, when, where and by whom it was given, and an assessment made of how well the information was understood by the recipient
- regular checks are made that information has been properly given to each patient and understood by them, and information should be provided in a format and/or language that the individual understands (e.g. Braille, easy read).

Information for voluntary patients

These patients should have their legal position and rights explained to them. Voluntary patients should be provided with relevant information (eg about how to make a complaint and consent requirements for treatment). Voluntary patients should be allowed to leave if they wish, unless they are to be involuntarily admitted under the Act. Both the patient and, where appropriate, their carer should be made aware of this right with information being provided in a format and language the patient understands. Local policies and arrangements about movement around the facility and its grounds should be clearly explained to the patients concerned. Failure to do so could lead to a patient mistakenly believing that they are not allowed to leave hospital, which could result in an unlawful deprivation of their liberty and a breach of their human rights.

Information about complaints or if the Act is not being applied appropriately

A patient and persons supporting them (eg a patient's relative, family, carer, or legal representative), especially a patient, should be supported to make a complaint if they think the safeguards of the Act are not being appropriately applied or they have concerns about the care and treatment being provided.

Staff should be aware that it can be particularly difficult for patients and those supporting them to take forward complaints due to their mental ill-health and fear that this may impact on the quality of care and support they receive. All efforts should be made to support patients (especially those needing support for facilitated decision-making) and those supporting them to make complaints without any negative impact on the quality of care and support provided.

It is usually best for initial concerns to be raised locally. All providers should have clear complaints policies and procedures. Patients and those supporting them (including relatives, family and carers) should be given information about how to make a complaint to the hospital. The information should be in formats that these individuals can understand.

Information about how to make a complaint to the MHCs and the AIHRC should also be readily available.

The AIHRC is likely to ask providers to detail the information provided to patients and those supporting them about how to make a complaint.

Patients can complain to the service providers, MHCs, AIHRC or the police depending upon what the complaint is about. The Act gives specific powers to make complaints about care under the Act and specifies certain criminal offences.

If the complaint is about service provision, a complaint may be made to the service provider or the MHC. If not satisfied with the outcome, the complaint may be taken to the Minister of Public Health. If the complaint is about care and treatment under the Act, the complaint can be made to the service provider, the MHC or the AIHRC. If not satisfied with the outcome, the complaint may be taken to the Minister of Public Health and or Justice, as appropriate.

Every service provider should make reasonable efforts to raise awareness and understanding of the Act and Code among patients and carers and, particularly in relation to their rights under the Act.

Providers should ensure staff are trained appropriately to support patients who have additional needs to access information about complaints and resolution procedures. Every effort should be made to place copies of the Code in areas accessible to patients.

Information about how to make a complaint to the service provider, the MHC and the AIHRC should also be readily available. This should be displayed on all mental health wards. Complaining to the AIHRC may be the right option if the individual is not comfortable complaining directly to the service provider or, if the complaint is under the Act, directly to the MHC. Information should include specific information about the right of patients to complain to the MHC and the AIHRC (contact details …….), and the local support available if they wish to raise a concern or complaint. This should be available in alternative formats, eg easy read or Braille. The information should be explained to all patients, including those who need support for facilitated decision-making to make decisions about complaints, have problems communicating (eg they do not read or write), or whose first language is not Dari.

A patient and persons supporting them (eg a patient's relative, carer, or legal representative), especially a patient needing support for facilitated decision-making, should be supported to make a complaint if they think the safeguards of the Act are not being appropriately applied or they have concerns about the care and treatment being provided.

Staff should be aware that it can be particularly difficult for patients to take forward complaints due to their mental ill-health and fear that this may impact on the quality of care and support they receive. All efforts should be made to support patients (especially those needing support for facilitated decision-making), and those supporting them, to make complaints without any negative impact on the quality of care and support provided. Patients should be encouraged to provide feedback on their general experiences, locally and to national bodies.

Part II: Rights of relatives and carers

Families and carers assume many responsibilities for looking after persons with mental disabilities and often face similar stigma and discrimination. Affording explicit rights to family members and caregivers should be balanced with the right of a person with mental disabilities. When this balance is successfully achieved, the rights held by families and caregivers can increase the quality of community and home life of people with mental disabilities, can empower people with mental disabilities and their families, and can decrease stigma.

Access to information about mental disorder:

Family members and caregivers need information to be able to better able to care for people with mental disabilities where such care is necessary. This information should be provided in a language and manner that understandable to them. The right of family members and caregivers should be balanced against the right of the person with mental disabilities to confidentiality and privacy.

Access to training, counselling and financial assistance:

Providing care for a person with mental disabilities can be financially as well as emotionally demanding. In some cases, caregivers and family members provide housing and food, and may also pay for expenses such as health insurance, medication, or counselling. A caregiver or family members may also have to take time from work to provide transportation to medical appointments, or prolonged emotional support or supervision, as necessary. Article 28 of the CRPD recognizes the right of persons with disabilities and their families to social protection including measures to ensure access to State assistance including adequate training, counselling, and respite care.

Participation in treatment planning:

Family members and caregivers should be given the authority to appeal against involuntary admission and treatment decisions on behalf of their relative, as well as to submit complaints to appropriate judicial bodies in instances in cases of human rights violations. Family members should, with the consent of the service user, also participate in the development of the treatment plan for their family member. Being involved in this way can increase families' and carers' understanding of mental health issues, treatment and care regimens, side effects etc. which can positively impact on the recovery of the person concerned.

Participation of family members and carers in policy, planning, legislation and service development:

Family members and carers very often have first hand experience of the mental health system and are in a key position to advise on ways to ensure services that meet the needs of service users and the needs of their family members and carers. As such they have a fundamental role to play in the design of policies, plans, laws and services in this area.
The Act requires Directors to take such steps as are practicable to give the patient's relative a copy of any information given to the patient in writing, unless the patient requests otherwise. The information should be given to the relative when the information is given to the patient, or within a reasonable time afterwards.

When a patient under the Act is given information, they should be told that the written information will also be supplied to their relative, so that they can discuss their views about sharing this information and following this discussion, raise any concerns or object to the sharing of some or all of this information. There should be discussion with the patient at the earliest possible time as to what information they are having.

The relative should be told of the patient's discharge from involuntary admission (where practicable), unless either the patient or the relative has requested that information about discharge should not be given. If practicable, the information should be given at least five days in advance of the discharge.

In addition, relatives should be informed of various other events, including the renewal of a patient's involuntary admission, and transfer from one facility to another.

These duties to inform relatives are not absolute. In almost all cases, information is not to be shared if the patient objects.

In addition, occasionally there will be cases where these duties do not apply because disclosing information about the patient to the relative cannot be considered practicable, on the grounds that it would have a detrimental impact on the patient that is disproportionate to any advantage to be gained from informing the relative. This would therefore be a breach of the patient's right to privacy under article 22 of the UN Convention on the Rights of Persons with Disabilities (CRPD). The risk of this is greatest where the relative is someone whom the patient would not have chosen themselves. Before disclosing information to relatives without a patient's consent, the person concerned should consider whether the disclosure would be likely to:

- put the patient at risk of physical harm or financial or other exploitation
- cause the patient emotional distress or lead to a deterioration in their mental health, or
- have any other detrimental effect on their health or wellbeing and, if so, whether the advantages to the patient and the public interest of the disclosure outweigh the disadvantages to the patient, in the light of all the circumstances of the case.

Unless there are good reasons to the contrary, patients should be encouraged to agree to their carers being involved in decisions under the Act and to them being kept informed. If patients need support for facilitated decision-making to consent to this, it may be appropriate to involve and inform carers– although that decision should always be made in the light of the specific circumstances of the case.

In order to ensure that carers can, where appropriate, participate fully in decision making, it is important that they have access to:

- practical and emotional help and support to assist them in participating, and
- timely access to comprehensive, up-to-date and accurate information.

Even if carers cannot be given detailed information about the patient’s case, where appropriate, they should be offered general information in an appropriate form, which may help them understand the nature of mental disorder, the way it is treated, and the operation of the Act.

If carers request that the information they provide is kept confidential, this should be respected and recorded in the patient’s notes. A carer should be asked to consent to such information being disclosed. Where a carer refuses to consent, professionals should discuss with the carer the benefits of sharing information in terms of patient care and how their concerns could be addressed.

The above apply equally to children, young people or individuals with an intellectual disability who are supporting parents who have mental disorder. In considering the kind and amount of information which young people (especially young carers) should receive about a parent’s condition or treatment, the people giving the information will need to balance the interests of the child against the patient’s right to privacy and their wishes and feelings. Any such information should be appropriate to the age and understanding of the young person.

Chapter 6: The relatives

Identification of the relatives

Article 5 of the Act defines relative’ for the purposes of the Act. It is important to remember that the relative for the purposes of the Act may not be the same person as the patient’s ‘next of kin’. The identity of the relative may change with the passage of time – eg if the patient enters into a marriage. The relative may be the patient’s carer and it is important that they are recognized, particularly as they may have the most relevant information to share with professionals with regard to the patient’s care and interests. If the relative is not the carer, professionals should also involve the carer.

If the child or young person is subject to an involuntary admission the relevant local authority will be the relative, save for where the young person is married, in which case their spouse will be the relative.

Individuals who have been appointed as guardians and those named in a child arrangements order as a person with whom the child or young person is to live will be the relatives of the child or young.

Delegation of relative functions

A relative is not obliged to act as such. They can authorize, in writing, another person to perform the functions of the relative on their behalf.

Where there is no relative

Where a professional discovers, when assessing a patient for possible admission under the Act (or at any other time), that the patient appears to have no relative, the professional should advise the patient of their right to apply to the local court for the appointment of a person to act as their relative. If the patient needs support for facilitated decision-making to apply themselves, the MHC should apply to the court.

Grounds for displacement and appointment by the local court

An acting relative can be appointed by the local court on the grounds that:

- the relative is incapable of acting as such because of illness or mental disorder.
- the relative has objected unreasonably to an application for admission for treatment.
- the relative has exercised the power to discharge a patient without due regard to the welfare of the patient or the interests of the public.
- the relative is otherwise not a suitable person to act as such, or
- the patient has no relative within the meaning of the Act, or it is not reasonably practicable. to.

The effect of a court order appointing an acting relative is to displace the person who would otherwise be the patient's relative. However, as an alternative to an order by the court, it may sometimes be enough for the actual relative to delegate their role to someone else.

Who can make an application to the court?

An application to displace the relative may be made by any of the following people:
- the patient (or if the patient needs support for facilitated decision-making to make the application, the patient's litigation friend, who could be a carer or a person of trust).
- any other relative of the patient.
- anyone with whom the person is residing (or was residing prior to admission).

Applications to the local court by MHCs

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MHCs will need to consider making an application for displacement or appointment if:

- they believe that a patient should be admitted in a facility, but the relative objects, or
- they believe that the relative is likely to discharge a patient from admission unwisely.

They should also consider doing so if they think that:

- a patient has no identifiable relative or their relative is incapable of acting as such
- they have good reasons to think that a patient considers their relative unsuitable and would like them to be replaced, and
- it would not be reasonable in the circumstances to expect a patient, or anyone else, to make an application.

MHCs should bear in mind that some patients may wish to apply to displace their relative but may be deterred from doing so by the need to apply to the court.

It is entirely a matter for the court to decide what constitutes 'suitability' of a person to be a relative. Factors which MHCs might wish to consider when deciding whether to make an application to displace a relative on those grounds, and when providing evidence in connection with an application, could include

- any reason to think that the patient has suffered, or is suspected to have suffered, abuse at the hands of the relative (or someone with whom the relative is in a relationship), or is at risk of suffering such abuse
- whether the patient is afraid of the relative or seriously distressed by the possibility of the relative being involved in their life or their care, or
- whether the patient and relative are unknown to each other, there is only a distant relationship, or their relationship has broken down irretrievably.

(This is not an exhaustive list).

In all cases, the decision to make an application lies with the MHCs. Before making an application for displacement, MHCs should consider other ways of achieving the same end, including:

- whether the relative will agree to delegate their role as the patient's relative to someone else, or
- providing or arranging support to the patient (or someone else) to make an application themselves.

Making an application

People making an application to the court will need to provide the court with the facts that will help it make a decision on the application. Exactly what will be required will depend on the type of application and the specific circumstances of the case.

When applying to displace a relative, MHCs should nominate someone to become the acting relative in the event that application is successful. Wherever practicable, they should first consult the patient about the patient's own preferences and any concerns they have about the person the professional proposes to nominate. MHCs should also seek the agreement of the proposed nominee prior to an application being made, although this is not a legal requirement.

If the patient has any concerns that any information given to the court on their views on the suitability of the relative may have implications for their own safety, an application can be made to the court seeking its permission not to make the current relative a party to the proceedings. The reasons for the patient's concerns should be set out clearly in the application.

Directors should provide support to admitted patients to enable them to attend the local court, if they wish.

If, exceptionally, the local court decides to interview the patient (as the applicant), the local court has the discretion to decide where and how this interview takes place and whether it should take place in the presence of, or separate from, other parties.

Chapter 7: Privacy, safety and dignity

This chapter deals with privacy, safety and dignity in facilities where patients are admitted under the Act, including access to telephones and other mobile computing devices, access to the internet, and the use of searches.

Privacy, safety and dignity are important constituents of a therapeutic environment and facility staff should respect a patient's privacy as far as possible, while maintaining safety. Patients should have every opportunity to maintain contact with family and friends by telephone, and facilities should ensure they have policies for the use of mobile phones and computing devices.

Sleeping and bathroom areas should be segregated to protect the needs of patients of different genders. The nature of engagement with patients and of therapeutic environments and the structure and quality of life on a ward are important in encouraging patients to remain in the ward and minimizing a culture of containment. The chapter also includes guidance on conducting personal and other searches, enhanced security, physical security and blanket locked door policy.

Respect for privacy

Article 22 of the UN Convention on the Rights of Persons with Disabilities (CRPD) requires public authorities to respect a person's right to a private life. Article 22 has particular importance for people involuntarily admitted under the Act. Privacy, safety and dignity are important constituents of a therapeutic environment. Facility staff should make conscious efforts to respect the privacy and dignity of patients as far as possible, while maintaining safety, including enabling a patient to wash and dress in private, and to send and receive mail, including in electronic formats, without restriction. Respecting patients' privacy encompasses the circumstances in which patients may meet or communicate with people of their choosing in private, including in their own rooms, and the protection of their private property.

Blanket restrictions

In this chapter, the term ‘blanket restrictions’ refers to rules or policies that restrict a patient’s liberty and other rights, which are routinely applied to all patients, or to classes of patients, or within a service, without individual risk assessments to justify their application. Blanket restrictions should be avoided unless they can be justified as necessary and proportionate responses to risks identified for particular individuals. The impact of a blanket restriction on each patient should be considered and documented in the patient’s records.

Restrictions should never be introduced or applied in order to punish or humiliate, but only ever as a proportionate and measured response to an individually identified risk; they should be applied for no longer than can be shown to be necessary.

Blanket restrictions include restrictions concerning: access to the outside world, access to the internet, access to (or banning) mobile phones and chargers, incoming or outgoing mail, visiting hours, access to money or the ability to make personal purchases, or taking part in preferred activities. Such practices have no basis in national guidance or best practice; they promote neither independence nor recovery, and may breach a patient’s human rights.
No form of blanket restriction should be implemented unless expressly authorized by the Directors on the basis of the organization’s policy and subject to local accountability and governance arrangements.

Blanket locked door policy

A blanket locked door policy which affects all patients in a facility or on a ward could, depending on its implementation, amount to a deprivation of liberty.

The impact of a locked door policy on each patient should be considered and documented in the patient’s records. The policy should conform to the guiding principles of the Code.

Facilities should not lock patients in clinical areas simply because of inadequate staffing levels. Local policies for locking clinical areas should be clearly displayed and explained to each patient on admission.

The safety of voluntary patients, who would be at risk of harm if they wandered out of a clinical environment at will, should be ensured by adequate staffing levels, positive therapeutic engagement and good observation, not simply by locking the doors of the unit or ward.

Services should consider how to reduce the negative psychological and behavioural effects of having locked doors, whether or not patients are voluntarily or involuntarily admitted.

Private telephone calls and internet access

Communication with family and friends is integral to a patient’s care and facilities should make every effort to support the patient in making and maintaining contact with family and friends by telephone, mobile, or other electronic means.

Directors should develop policies prohibiting access to illegal or what would otherwise be considered inappropriate material, eg pornography, gambling or websites promoting violence, abuse or hate. A blanket restriction on access to the internet could be considered as a violation of patient's rights if it cannot be justified as necessary and proportionate.

Staff should remind patients of confidentiality requirements and the implications of breaching patient and staff confidentiality. Where wards contain coin-operated and card-operated telephones, facility directors should ensure that patients are able use them without being overheard. Installing booths or hoods around them may help to provide the necessary level of privacy. Some patients may need help to make a phone call, but should still be given privacy during the call.

Private property

Facilities should provide adequate storage in lockable facilities for the clothing and other personal possessions which patients may keep with them at the facility and for the secure central storage of anything of value or items which may pose a risk to the patient or to others, eg razors. Information about arrangements for storage should be easily accessible to patients on the ward. Facilities should compile an inventory of what has been allowed to be kept on the ward and what has been stored and give a copy to the patient. The inventory should be updated when necessary. Patients should always be able to access their private property on request.

Separate facilities for men and women

All sleeping and bathroom areas should be segregated, and patients should not have to walk through an area occupied by another sex to reach toilets or bathrooms. Separate male and female toilets and bathrooms should be provided, as should women-only day rooms. Women-only environments are important because of the increased risk of sexual and physical abuse and risk of trauma for women who have had prior experience of such abuse. Consideration should be given to the particular needs of transgender patients.

A patient should not be admitted to mixed-sex accommodation. It may be acceptable, in a clinical emergency, to admit a patient temporarily to a single room in the opposite-gender area of a ward. In such cases, a full risk-assessment should be carried out and the patient's safety, privacy and dignity maintained. Steps should be taken to rectify the situation as soon as possible.

Separate facilities for other reasons

Arrangements for the patient's accommodation should also consider the patient's history and personal circumstances, including:

- history and personal circumstances where known, including history of sexual or physical abuse and risks of trauma
- the particular needs of transgender patients
- mothers and babies during and after pregnancy, or
- other health conditions (physical disabilities, intellectual disabilities or sensory impairments).

If, in an emergency, it is necessary to treat a patient in an environment that does not fully meet their needs, then senior management should be informed, steps should be taken to rectify the situation as soon as possible, and staff should protect the patient's privacy and dignity against intrusions – particularly in sleeping accommodation, toilets and bathrooms.

Personal and other searches

Directors should ensure that there is an operational policy for searching patients admitted under the Act, their belongings and surroundings and their visitors. When preparing the policy, Directors should consider the position of both voluntary and involuntary patients. The policy should be clearly displayed and communicated to patients in a format and language they understand.

The policy should be based on the following clear principles:

- the intention is to create and maintain a therapeutic environment in which treatment may take place and to ensure the security of the premises and the safety of patients, staff and the public
- the authority to conduct a search of a person or their property is controlled by law, and it is important that staff are aware of whether they have legal authority to carry out any such search
- searching should be proportionate to the identified risk and should involve the minimum possible intrusion into the individual's privacy, and
- all searches will be undertaken with due regard to and respect for the person's dignity and privacy.

The policy may extend to the routine and random searching without cause of admitted patients, if necessary without their consent, but only in exceptional circumstances. For example, such searches may be necessary if the patients admitted in a particular facility tend to have dangerous or violent propensities which mean they create a self-evident pressing need for additional security.

Patients, staff and visitors should be informed that there is a policy on searching. Information about searches should be provided in a variety of formats to meet patients' and visitors' needs and should be readily available.

Conducting personal and other searches

The consent of the person should always be sought before a personal search of them or a search of their possessions is attempted. If consent is given, the search should be carried out with regard to ensuring the maximum dignity and privacy of the person.

Consent obtained by means of a threat, intimidation or inducement is likely to render the search illegal. Any person who is to be searched personally or whose possessions are to be searched should be informed that they do not have to consent.

A person being searched or whose possessions are the subject of a search should be kept informed of what is happening and why. If they do not understand or are not fluent in Dari, the services of an interpreter should be sought, if practicable. The specific needs of people with impaired hearing or a intellectual disability and those of children and young people should be considered.

A personal search should be carried out by a member of the same sex. The search should be carried out in a way that maintains the person's privacy and dignity and respects issues of gender, culture and faith. It is always advisable to have another member of the facility staff present during a search.

A comprehensive record of every search, including the reasons for it and details of any consequent risk assessment, should be made. Staff involved in undertaking searches should receive appropriate instruction and refresher training.

If an admitted patient refuses consent or needs support for facilitated decision-making to decide whether or not to consent to the search, their responsible clinician (or, failing that, another senior clinician with knowledge of the patient's case) should be contacted without delay in the first instance, if practicable, so that any clinical objection to searching by force may be raised. The patient should be kept separated and under close observation, while being informed of what is happening and why, in terms appropriate to their understanding. This is particularly important for individuals who may need support for facilitated decision-making to decide whether or not to consent to the search. Searches should not be delayed if there is reason to think that the person is in possession of anything that may pose an immediate risk to their own safety or that of anyone else.

If a search is considered necessary, despite the patient's objections, and there is no clinical objection to one being conducted, the search should be carried out. If force has to be used, it should be the minimum necessary.

The policy should set out the steps to be taken to resolve any disagreement or dispute where there is a clinical objection to a search.

Separation of a patient under close observation in order to await the arrival of the responsible clinician is different to seclusion.
Where a patient physically resists being personally searched, physical intervention should normally only proceed on the basis of a multi-disciplinary assessment, unless it is urgently required. A post-incident review should follow every search undertaken where consent has been withheld.

There should be support for patients and for staff who are affected by the process of searching. This may be particularly necessary where a personal search has had to proceed without consent or has involved physical intervention.
Where a patient's belongings are removed during a search, the patient should be told why they have been removed, given a receipt for them, told where the items will be stored, and when they will be returned.

The exercise of powers of search should be audited regularly by the MHCs and the outcomes reported to the Directors.

Facility accommodation offering conditions of enhanced security

Some admitted patients may be liable to present a particular danger to themselves or to others and therefore need to be accommodated in wards or units specifically designed to offer enhanced levels of physical security. For patients concerned with criminal proceedings, this may be a requirement of a court or of the Minister of Justice, but in many cases the decision will lie primarily with the patient's responsible clinician.

When considering whether patients should be placed in, moved to or remain in such a ward or unit, responsible clinicians should, in consultation with the multi-disciplinary team, ensure that:

- they have carefully weighed the patient's individual circumstances and the degree of risk involved, and
- they have assessed the relative clinical considerations of placing the patient in an environment with enhanced physical security, in addition to or as opposed to providing care by way of intensive staffing.
- Treatment in conditions of enhanced security should last for the minimum period necessary. Where responsible clinicians have taken the decision to transfer a patient within a facility to a ward with enhanced security, they should ensure that arrangements are made to facilitate the patient's prompt return to a less secure ward when that enhanced security is no longer required.

Where responsible clinicians believe that patients no longer require conditions of enhanced security (or the current level of security), they should take steps to arrange their transfer to more appropriate accommodation. Where necessary, this may involve identifying another facility that is willing and able to offer the patient suitable accommodation.

Directors offering accommodation with enhanced levels of security should ensure that:

- accommodation specifically designated for this purpose has adequate staffing levels, and

- written guidelines are drawn up, setting out the categories of patient for whom it is appropriate to use physically secure conditions and those for whom it is not appropriate.

Physical security in other facility accommodation

Directors will need to consider what arrangements should be put in place to protect the safety of patients who are not subject to enhanced security.

Patients admitted to acute wards, whether or not they are formally admitted there, will have complex and specific needs. In such an environment, ward staff will need to balance competing priorities and interests when determining what safety measures are necessary. This should not amount to a blanket locked door policy.

The intention should be to protect patients, in particular those who are at risk of suicide, self-harm, accidents or inflicting harm on others unless they are prevented from leaving the ward. Arrangements should also aim not to impose any unnecessary or disproportionate restrictions on patients or to make them feel as though they are subject to such restrictions. It may also be necessary to have in place arrangements for protecting patients and others from people whose mere presence on a ward may pose a risk to their health or safety.

It should be borne in mind that the nature of engagement with patients and of therapeutic interventions and the structure and quality of life on the ward are important factors in encouraging patients to remain in the ward and in minimizing a culture of containment. All patients should have regular access to outside space.

Chapter 8: Wishes expressed in advance (Chapter IV of the Act)

This chapter gives guidance on statements by patients who are subject to compulsory measures under the Act about their preferences for what they would, or would not, like to happen if particular situations arise in future. Advance directives strengthen patients' participation in their treatment and recovery and help them to feel more empowered about what may happen to them should they need support for facilitated decision-making to make decisions about their care and treatment in the future.

Advance directives do not legally compel professionals to meet patients' stated preferences, though they should be taken into account when making decisions about care and treatment. Advance decisions to refuse treatment are legally binding. Such decisions should be recorded and documented. Advance decisions are concerned only with refusal of medical treatment and are made in advance by a person with the decision-making ability to do so. The chapter details the circumstances when clinicians may lawfully treat a patent compulsorily under the Act.

Definitions

This chapter distinguishes between advance decisions to refuse medical treatment and other statements of views, wishes and feelings that patients make in advance.

An advance directive means a written statement that an individual makes to specify in detail how they wish to be treated and cared for. Advance directives can be made by a person who has the decision-making ability to do so and can include the appointment of proxy decision makers. They are a way in which people can refuse medical treatment at a time in the future when they may have difficulties to consent to or refuse that treatment.

Advance directives are concerned only with refusal of medical treatment. Other advance expressions of views, wishes and feelings, often referred to as advance statements, may be about preferred medical treatment or other wishes and preferences not directly related to care, and may be about what the patient wants to happen as much as what they would prefer not to happen.

Advance directives

People who have the decision-making ability to do so, and who are at least 18 years old, may make an advance decision to refuse specified treatment which will have effect at a time when they will eventually have difficulties to refuse or consent to treatment. If a valid and applicable advance decision exists, it has the same effect as if the patient has decision-making ability and makes a contemporaneous decision to refuse treatment.

In certain circumstances, such as in emergency cases, patients may be given medical treatment without their consent even though they have made a valid and applicable advance decision to refuse the treatment.

Even where clinicians may lawfully treat a patient compulsorily under the Act, they should, where practicable, try to comply with the patient's wishes as expressed in an advance decision. They should, for example, consider whether it is possible to use a different form of treatment not refused by the advance decision. If it is not, they should explain why to the patient.

Except where the Act means that they need not, clinicians should follow all other advance decisions made by their patients which they are satisfied are valid and applicable, even if the patients concerned are involuntarily admitted under the Act. By definition, this includes all valid and applicable advance decisions made by involuntarily admitted patients to refuse treatment which is not for mental disorder.

Clinicians should always start from the assumption that a person had the decision-making ability at the time in question to make the advance decision.

Advance statements of wishes and feelings

There may be times when, because of their mental disorder, patients who are subject to compulsory measures under the Act are unable or unwilling to express their views, or participate as fully as they otherwise would, in decisions about their care or treatment under the Act. In such cases, patients' past wishes and feelings – so far as they are known – take on a greater significance.

Individuals with mental health conditions should be able to express their views and preferences about their care and treatment. Some patients will deliberately state their wishes in advance about a variety of issues, including their medical treatment, the steps that should be taken in emergencies and what should be done if particular situations occur. Such wishes should be given the same consideration as wishes expressed at any other time.

Encouraging patients to set out their wishes in advance is often a helpful therapeutic tool, encouraging collaboration and trust between patients and professionals. It is a way in which effective use can be made of patients' expertise in the management of crises in their own conditions.

Whenever expressing a preference for their future treatment and care, patients should be encouraged to identify as precisely as possible the circumstances they have in mind. If they are saying that there are certain things that they do not want to happen – eg being given a particular type of treatment, or being restrained in a particular way – they should be encouraged to give their views on what should be done instead.

Where patients express views to any of the professionals involved in their care about how they should be treated or ways they would not wish to be treated in future, the professional should record those views in the patient's notes. The views should be provided in a written form or recorded, and should be kept with the patient's notes.

Whether the patient or the professional records the patient's views, steps should be taken, unless the patient objects, to ensure that the information:

- is drawn to the attention of other professionals who ought to know about it, and
- it is included in care plans and other documentation which will help ensure that the patient's views are remembered and considered in situations where they are relevant in future.

Advance decisions to refuse treatment should be recorded and documented in the same way.

A carer or a person of trust nominated by the patient should be invited to support a patient who may need some support to understand the wish they are expressing. If the professional to whom the wish is being expressed forms the opinion that the patient needs support for facilitated decision-making to understand this, the professional should record their opinion and their reasons for it, alongside the record of the patient's wish.

The fact that a patient has expressed their wishes about a particular matter in the past is not a substitute for seeking their views on it when the situation actually arises, even if they are no longer in a position to think about their views as clearly as they did when they expressed their wishes previously. Everyone has the right to change their mind. In particular, where patients have the decision-making ability to express a clear wish in the present, that wish should always be assumed to have overtaken their previous wishes, even if it is significantly different.

Where patients need support for facilitated decision-making to formulate and express their views on an issue on which they have given their views in advance, the professional should record whether they make a decision under the Act which is contrary to those previously expressed views. They should record their reasons for the decision, just as they would if they were going against wishes that a patient was expressing in the present.

Chapter 9: Persons of trust (Article 20 of the Act)

An adult patient who is capable of understanding the meaning of authorities and the consequences of giving these authorities to a person of trust may appoint a person of trust of his or her choice to consent to mental health care he or she wanted when well but which he or she later refuses, because for example a health problem or other conditions have affected his or her perception and judgment. Such appointments shall be made either in writing or communicated verbally to the person in charge of the person's medical care in a facility where he or she receives or received mental health services, who will note the appointment and the authorities of the person of trust in the person's clinical record, get signature or thumb impression of the person on this record, and notify such appointment to the MHC.

Authorities of the person of trust shall be specific and may include assistance to the patient to make decisions for any of the following standard powers: decisions about admissions, medications, tests, assessments, occupational therapy, psychotherapy, ECT, and ancillary tests and treatment.

An appointed person of trust should be at least 18 years old, competent to fulfill the role as described in the Act, and signify, in writing, his or her willingness to perform the role. A person of trust cannot be someone who is paid or receives other benefit for providing mental health care to the person appointing him or her. A person of trust cannot be an employee of the facility where the person receives mental health services

In fulfilling his or her duties under the Act, the person of trust shall consider the wishes of the patient, both at the time the decision is to be made and in the past, as well as his or her life history, values, cultural background, will and preferences. The person of trust will give particular credence to the views of the individual to the extent that the individual understands the nature of the decisions under consideration.

The appointment of a person of trust, or the inability of a patient to appoint a person of trust, does not presume nor should be taken to presume a lack of legal capacity; rather, it ensures that someone a patient trusts will have legal authority to carry out his or her wishes if he or she is incapable of giving or refusing consent.

Duties of persons of trust

1. A person of trust should act honestly and in good faith, exercise the care, diligence and skill of a reasonably prudent person, and act within the authority given by the mental health service user.
2. When helping the patient to make decisions, a person of trust shall: consult, to the extent reasonable, with the patient to determine his or her current wishes, and comply with those wishes if it is reasonable to do so.
3. If the patient’s instructions or expressed wishes are not known, the person of trust should act on the basis of the patient’s known beliefs and values, or on the patient’s behalf, if his or her beliefs are not known.
4. If the patient’s instructions or expressed wishes are not known and the person of trust should act on the patient’s behalf, he or she should have considered the patient’s current wishes, and known beliefs and values, whether the patient’s condition or well-being is likely to be improved by the proposed health care, whether the patient’s condition or well-being from the proposed healthcare is greater than the risk of harm, and whether a less restrictive or less intrusive form of health care would be as beneficial as the proposed health care.

Revocation of appointments

(a) A patient who has made an appointment of a person of trust may revoke the appointment if there is reason for him or her to believe that:

- undue pressure or some other form of abuse or neglect is being or was used to induce the patient to make the appointment;
- the use of the appointment is clearly inconsistent with the current wishes, values, beliefs, will and preferences of the person who made the appointment;
- the person of trust is abusing or neglecting the patient for whom he or she is acting.

(b) The consultant psychiatrist in charge of the facility where the person receives or received mental health services, will note that revocation in the patient’s clinical record and get signature or thumb impression of the person this record, and notify such revocation to the relevant MHC that shall conduct an investigation.

Review of consent

Consent given by persons of trust shall be reviewed by the relevant MHC every four months.

Chapter 10: Confidentiality

Confidentiality

Confidentiality is the same for patients subject to the Act as it is for any other patients, however there are specific considerations for healthcare professionals such as doctors and nurses to whom the duty of confidentiality applies. The duty arises when one person discloses information to another in circumstances where it is reasonable to expect that the information will be held in confidence. Certain situations, such as discussions with a health professional or social worker, are generally presumed to be confidential.

There are circumstances in which it is both justifiable and important to share otherwise confidential patient information with people outside the immediate team treating a patient.

Before considering such disclosure of confidential patient information, the individual's consent should normally be sought.

If a person needs support for facilitated decision-making to consent to the disclosure, it may be acceptable and appropriate to disclose the information in the person's will and preference best interpretation. Healthcare professionals should use their professional judgment to determine what is the patient's will and preference best interpretation. This should include consultation with colleagues, relatives, carers, and persons of trust and take into account the patient's previously expressed wishes and views. Otherwise, confidential patient information should be disclosed outside the team only:
- with the patient's consent
- if there is a specific legal obligation or authority to do so, or
- where there is an overriding public interest in disclosing the information.

The 'public interest' is not the same as what might be of interest to the public. Where confidential patient information is involved, public interest justifications for overriding confidentiality could include (but are not limited to) preventing serious crime.

A person's right to have their privacy respected is protected by article 22 of the UN Convention on the Rights of Persons with Disabilities (CRPD). The disclosure of confidential information may be a breach of that right unless it is a necessary and proportionate response to the situation.

Information sharing between professionals can contribute to and support the care and treatment of patients. This includes information sharing as part of the holistic care programme (or its equivalent).

A range of agencies is involved in the provision of services to patients who are subject to compulsory measures under the Act, including social services. Patients should be consulted about what information it may be helpful to share with these services and when. Professionals should be clear about how the sharing of such information could benefit the patient.

Sharing information with carers and other people with a valid interest in the care and wellbeing of the patient can contribute to and support their care and treatment. Where patients have decision-making ability to agree and are willing to do so, carers and other people with a valid interest should be given information about the patient’s progress to help them form and offer views about the patient’s care and provide effective care and support to the patient, especially if the individual is a community patient, or on leave. A patient’s agreement to such disclosure should be freely given.

Disclosure of confidential patient information for the purposes of the Act

The Act creates a number of situations where confidential information about patients is legally authorized to be disclosed, even if the patient does not consent.
These include:

- reports to the MHC when a patient’s case is to be considered, and
- reports on forensic patients

The Act also gives certain people and bodies – including the MHCs, the AIHRC and legal representatives – the right to access records relating to patients.

In addition, where the Act allows steps to be taken in relation to patients without their consent, it is implicit that confidential patient information may be disclosed only to the extent that it is necessary to take those steps. For example, confidential patient information may be shared to the extent that it is necessary for:

- medical treatment which may be given without a patient’s consent under the Act
- safely and securely transport a patient to a facility (or anywhere else) under the Act
- transferring responsibility for a patient who is subject to the Act from one set of people to another (e.g. where an involuntarily admitted patient is to be transferred from one facility to another).

Even though information may be disclosed in these cases, it is still necessary for people proposing to disclose the information to be confident that it is necessary in the circumstances, that the aim of disclosure cannot reasonably be achieved without it, and that any breach of the patient’s confidentiality is a proportionate response given the purpose for which the disclosure is being considered. Care should also always be taken to ensure that any information disclosed is accurate.

Limitations on sharing information with carers

Simply asking for information from carers, relatives, friends or other people about a patient without that patient’s consent need not involve any breach of confidentiality, provided the person requesting the information does not reveal any personal confidential information about the patient which the carer, relative, friend or other person being asked would not legitimately know.

Carers cannot be told a patient's particular diagnosis or be given any other confidential personal information about the patient unless the patient consents or there is another basis on which to disclose it in accordance with the law. Carers, including young carers, should always be offered information which may help them understand the nature of mental disorder generally, the ways it is treated and the operation of the Act.

Carers, relatives, friends and other people have a right to expect that any personal information about themselves, or any information about the patient which they pass on to professionals in confidence, will be treated as confidential. Unless there is an overriding reason that makes it necessary and there is legal authority to do so, information they provide about patients should not be repeated to patients in a way that might reveal its source, unless the carer, relative, friend or other person was made aware that that could happen and had not objected to it.

Sharing information to manage risk

Although information may be disclosed only in line with the law, professionals may need to share information to manage any serious risks which certain patients pose to others.

Where the issue is the management of the risk of serious harm, the judgment required is normally a balance between the public interest in disclosure, including the need to prevent harm to others, and both the rights of the individual concerned and the public interest in maintaining trust in a confidential service.

Whether there is an overriding public interest in disclosing confidential patient information may vary according to the type of information. Even in cases where there is no overriding public interest in disclosing detailed clinical information about a patient's state of health there may, nonetheless, be an overriding public interest in sharing more limited information about the patient's current, and past status under the Act, if that will help ensure properly informed risk management by the relevant authorities, families and carers.

Recording disclosure without consent

Any decision to disclose confidential information about patients should be fully documented. The relevant facts should be recorded, with the reasons for the decision and the identity of all those involved in the decision-making. Reasons should be given by reference to the grounds on which the disclosure is to be justified.

Chapter 11: Visiting patients

This chapter covers visiting patients in facilities and circumstances where it may be necessary to consider the exclusion of visitors. It includes particular considerations for child visitors and how far an individual should be placed from their family and/or local community.

All patients have a right to maintain contact with family and friends and to be visited, subject to carefully limited exceptions. The Act gives certain people the right to visit patients in private and arrangements should be in place to enable this to happen. Directors have the right, under certain circumstances to restrict or refuse visitors, or require them to leave.

All facilities should have written policies and procedures concerning the arrangements for children and young people who visit patients and for visits to patients who are children or young people.

Arrangements for visits to patients

All patients have the right to maintain contact with, and be visited by, anyone they wish to see, subject to carefully limited exceptions. The value of visits in maintaining links with family and community networks is recognized as a key element in a patient's care, treatment and recovery. Every effort should be made to support parents to support their children. Patients should be able to see all their visitors in private, including in their own bedroom if the patient wishes.

Visits should be encouraged and made as comfortable and easy as possible for the visitor and the patient. Reasonable and flexible visiting times and pleasant surroundings will all contribute to a sense of respect for the patient's entitlement to be visited.

In addition to visits, every effort should be made to assist the patient, where appropriate, to maintain contact with relatives, friends in other ways. It is good practice for patients to be placed in a facility as close as reasonably practicable to their families, and patients should have readily accessible and appropriate daytime telephone. Where a patient is placed out of area it is good practice to consider the needs of family and carers who have to travel in order to visit.

People with a right to visit patients

The Act gives certain people the right to visit patients in private if they wish. This includes independent psychiatrists or approved clinicians appointed to examine the patient in relation to an application for involuntary admission, members of the MHC and representatives of the AIHRC. These people should be given access to all areas where the patient lives or have access themselves. Directors should ensure that such visits can take place in private.

If there are particular concerns for the security of the visitor, they should be discussed with the visitor with a view to agreeing suitable security arrangements. For the safety of both visitors and patients, visitors should only be in clinical areas under supervision.

Directors should also ensure that patients can communicate with their legal representatives in private and at any time of day and night, and should facilitate visits by those representatives when they request them.

Exclusion or restriction of visitors

There are circumstances where Directors may restrict visitors, refuse them entry or require them to leave. Directors should have a policy on the circumstances in which visits to patients may be restricted, to which both clinical staff and patients may refer, which should be clearly displayed on the ward.

There are two principal grounds which could justify the restriction or exclusion of a visitor: clinical grounds and security grounds.

The decision to prohibit a visit by any person whom the patient has requested to visit or has agreed to see should be regarded as a serious interference with the rights of the patient and a blanket restriction may be considered a breach of patient's rights. There may be circumstances when a visitor has to be excluded, but these instances should be exceptional and any decision should be taken only after other means to deal with the problem have been considered and (where appropriate) tried. Any such decision should be fully documented and include the reasons for the exclusion, and it should be made available for independent scrutiny by the MHC, and explained to the patient. Directors should review the effect on the patient of any decision to restrict visits. These policies should be risk-based and not impose blanket restrictions, eg no visitors for the first two weeks after admission.

Restriction or exclusion on clinical grounds

From time to time, the patient's responsible clinician may decide, after assessment and discussion with the multi-disciplinary team, that some visits could be detrimental to the safety or wellbeing of the patient, the visitor, other patients or staff on the ward. In these circumstances, the responsible clinician may make special arrangements for the visit, impose reasonable conditions or if necessary exclude the visitor. In any of these cases, the reasons for the restriction should be recorded and explained to the patient and the visitor, both orally and in writing (subject to the normal considerations of patient confidentiality). Wherever possible, 24-hour notice should be given of this decision.

Restriction or exclusion on security grounds

The behaviour of a particular visitor may be disruptive, or may have been disruptive in the past, to the degree that exclusion from the facility is necessary as a last resort. Examples of such behaviour include:
- smuggling of illicit drugs into the facility
- transfer of potential weapons
- unacceptable aggression.

A decision to exclude a visitor on the grounds of their behaviour should be fully documented and explained to the patient orally and in writing. Where possible and appropriate, the reason for the decision should be communicated to the person being excluded (subject to the normal considerations of patient confidentiality and any overriding security concerns).

Monitoring by Directors

Directors should regularly monitor the exclusion from the facility of visitors to admitted patients.

Restricting visitors to patients who need support for facilitated decision-making to decide whether to remain in the facility could amount to or contribute to an unlawful deprivation of liberty or a breach of the individual's human rights.

Children and young people

All facilities should have written policies and procedures regarding the arrangements for children and young people who visit patients in the facility and for visits to patients who are children or young people. Policies should be drawn up in consultation with local authorities and local safeguarding children boards.

Local policies should ensure that the best interests and safety of the children and young people concerned are always considered and that visits by children and young people are not allowed if they are not in their best interests. Within that overarching framework, and subject to risk assessments, facilities should do all they can to facilitate the maintenance of children and young people's contact with friends and family and offer privacy within which that can happen.

Information about visiting should be explained to children and young people in a way that they are able to understand. Environments that are friendly to children and young people should be provided.

Where a child or young person is being admitted, it should not be assumed, because of their age, that they would welcome all visitors, and, like adults, their views should be sought.

Chapter 12: Decision-making ability – Supported decision-making – Facilitated decision-making (Chapter 5 Part II of the Act)

The two foundations of the CRPD are: First, that people have legal capacity (which, clearly, does not mean mental ability) at all times and in all life domains. And secondly, that some people will, for some decisions, require support which is phrased as a state obligation. Legal capacity includes both the ability to hold rights and to be an actor under the law (e.g. enter into contracts, vote, marry, etc.). It is the law's recognition and validation of an individual's will and preference and is the key to accessing meaningful participation in society. Decision-making ability is distinct from legal capacity. Legal capacity is the capacity and power to create, modify or extinguish legal relationships, while decision-making ability is the mental capacity of a person as judged by someone else.

The CRPD both promotes a classic liberty model based on freedoms, and makes the point that formulistic equality is not enough for people with disabilities: some people need support to elevate them to an "equal basis with others", a level of substantive equality to which all human beings are entitled.

Supported decision-making

In making determinations about whether a person requires decision-making assistance the following should be identified:

- whether the person is able, with or without individualized assistance as (plain language, interpreters, assistance to other parties such as relative, a lose friend or a person of trust), but short of mandated supported decision-making persons/networks, to communicate his or her will and intention to others sufficient for all the parties to enter into legal arrangements and have decisions made consistent with the person's intentions;

- whether the person is able to choose a supported decision-making network of trusted support persons to assist the individual in making decisions and in communicating his/her intentions and personal identity to others.
- if the need of assistance has been determined the following kinds of questions shall be asked to determine the necessary and appropriate modifications and adjustments to provide the person in need of support:
- Is the person perceived as able to make and communicate this decision on his/her own, without support?
- if not, is the person able, with some decision-making assistance, to communicate his or her intention sufficiently for the purposes of this decision/action? If so, what type of assistance is necessary for this purpose?
- is the person able to communicate his/her intention, with accommodations that are to manage this particular decision/act or enter this legal arrangement – like an interpreter, translator, communication assistance to other parties – but short of a mandated supported decision-making network/person?
- if not, is the person able to engage a supported decision-making network/ persons who will assist in making decisions and communicating the person’s intentions and personal identity to others? Recognition of the role of the supported decision-making network, in a fiduciary relationship with the individual, and assistance in facilitating the development and maintenance of this network is the main accommodation required in this case. Other accommodations in b(i) above may also be in this case.
- have reasonable efforts been made, to the point of undue hardship, to provide these accommodations including – where it is determined that b(ii) accommodations are required – investment in development of valuing personal relationships and personal knowledge that would help establish supported decision-making networks?

Professionals should be assessing what supports need to be put in place, and how to ensure a person’s will and preferences are given primacy. The assessment process should be designed to identify a person’s wishes and goals, the decisions a person needs and wants to make, and what supports should be put in place to enable him/her to exercise the right to make their own decisions. A person should not be labelled with ‘incapacity’ (or ‘incompetence’, or “lacking decision-making ability”), but be found instead as needing some support.

Facilitated decision-making

Where after all efforts are made, an individual’s will or preference cannot be ascertained, there should be an option for facilitated decision-making. This structure should only apply when:

- Supports have been exhausted (including creative communication techniques, building relationships, accessible information, etc.) and they have not led to a decision; and
- the individual’s will and preferences cannot be ascertained; and
- the individual has no previously-expressed will and preferences (advance directives and statements).

A person should not be labelled as being incapacitated to make decisions but as persons in need of support for facilitated decision-making when they cannot:

- understand information which is relevant to the decision to be made, and
- use that information as part of the decision-making process.

As decision-making ability relates to specific matters and can change over time, decision-making ability should be reassessed as appropriate over time and in respect of specific treatment decisions. Professionals should note that the test of decision-making ability should be used whenever assessing a patient's decision-making ability to consent for the purposes of the Act.

Professionals should ensure that where a decision-making ability assessment is undertaken, this is recorded in the individual's care and treatment record. As well as the outcome of the test, the following should be recorded:

- the specific decision for which decision-making ability was assessed.
- the salient points that the individual needs to understand and comprehend and the information that was presented to the individual in relation to the decision.
- the steps taken to promote the individual's ability to decide themselves.
- How the information was given in the most effective way to communicate with the individual.
- how the test was assessed, and how the assessor reached their conclusions.

Care planning

Professionals should seek to involve those who need support for facilitated decision-making in decisions about their care as much as they would involve those who do not. Care plans should be developed in collaboration with the patient as much as possible. Where professionals and patients disagree over elements of the care plan the emphasis should be on discussion and compromise where possible.

Care planning, including planning for discharge, should ensure participation by the patient and consideration of their wishes, feelings, beliefs and values and consultation with specified others (eg carers, legal representatives and persons of trust nominated by the patient) about the patient's best interpretation of wishes and preferences.

Persons who are assessed as persons in need of support for facilitated decision-making enjoy their right to periodic review of their admission by the relevant MHC and the AIHRC.

Chapter 13: Emergency admission and treatment

There will be situations when urgent emergency admission and/or emergency treatment may be needed. Actively suicidal patients or acutely disturbed patients who are violent or aggressive are examples.

An emergency situation is one in which there is immediate and imminent danger to the safety of the person concerned and/or others. Identification of cases in which people pose a violence risk and determination of the steps necessary to protect individual and or/public safety shall be done with the use of the internationally recognized violence risk assessment instrument HCR-20 as the official standard tool for all mental health professionals in assessing a person's dangerousness for involuntary admission and treatment purposes. Apart from facilitating uniformity (i.e. how severe does a mental illness need be? To what extent does one's "ability to understand or control" one's behaviour have to be impaired"?

What is the threshold of “dangerousness” required for a person to be hospitalized?), this tool will allow the courts to assess the quality of psychiatric opinions, as well as enable persons whose involuntary admission is at issue and their lawyers to challenge expert psychiatrists in court.

Professionals should always consider whether there are less restrictive alternatives to emergency admission under the Act, which may include management in the community – eg by a crisis and support team.

Emergency admission and/or emergency treatment should not be prolonged, but allowed only for a short period of time. During this time, if it appears that the person may require further involuntary care, the substantive procedures for involuntary admission or treatment should be undertaken. Emergency admission or emergency treatment is not permitted beyond 72 hours.

Procedure for emergency admission and treatment

The patient should be examined by a qualified practitioner to determine whether an emergency exists. In particular, the practitioner should be able to justify admission, given the nature of the emergency.

If the person requires involuntary admission and/or treatment beyond the prescribed emergency 72 hours time frame, procedures for such admission and/or treatment should be initiated and completed within 24 hours.

Admitted patients who do not fit the criteria for involuntary admission/treatment after an emergency admission, but who may still benefit from treatment, may if they want to continue be admitted as voluntary patients.

If the patient does not fit the criteria for involuntary admission/treatment, the person should be discharged immediately after the emergency has ended.
If a person is discharged from emergency admission and not granted involuntary admission and/or involuntary treatment, it would be inappropriate to reapply emergency powers immediately to readmit the person unless there is a substantive change in the nature of the emergency, requiring the use of such emergency powers. The purpose of this provision is to prevent misuse of emergency powers to indefinitely prolong involuntary admission or involuntary treatment.

Patients’ family members, and/or legal representatives should be immediately informed of the use of emergency powers, unless the patient requests otherwise (or does not have a relative). Both patients and family members have the right to appeal to the MHC and the courts against such emergency admission and treatment.

What constitutes an urgent necessity?

Articles 54, 55, 56, 57, and 59 of the Act should be used only in a genuine emergency and should never be used for administrative convenience. I cases of emergencies patients or their representatives should immediately be provided with information in accordance with Article 58 of the Act.

To be satisfied that an emergency has arisen, the person making the application and the doctor making the supporting recommendation should have evidence of an immediate and significant risk of serious danger to life or safety of the person or others.

Treatment in emergency situations

Emergency treatment can include only medication that is not standard treatment for a person's medical condition and has no therapeutic purposes but is administered to manage a person's behaviour in a way that refuses the safety risk to the person or others and to temporarily restrict the person's freedom of movement; Emergency treatment should not include ECT, depot narcoleptics and irreversible treatments such as psychosurgery or sterilization procedures. Article 59 of the Act provides detailed guidance for treatment and safeguards in emergency situations.

Chapter 14: Involuntary admission

Involuntary admission constitutes an exceptionally serious interference with a person's liberty (which in turn affects many other individual rights, e.g. bodily integrity, privacy, right to education, right to family, and the right to work). Consequently, it is an exceptional measure which can be applied only when: (1) stringent criteria related to a person's condition are met; (2) no other less restrictive measure would be adequate. It should be indeed a measure of last resort (and first and other resorts should be adequately reported) and persons subject to the Act should have effective guarantees against unjustified involuntary admission and involuntary treatment.

A mental disorder (no matter how serious) is not a sufficient ground for involuntarily admitting a person against their will. The Act makes clear that persons with mental disabilities should be assumed to have decision-making ability unless it is established that they need support for facilitated decision-making. Involuntary admission against their will, either without their consent or with the consent of a substitute decision-maker constitutes arbitrary deprivation of liberty and violates articles 12 and 14 of the CRPD.

Criteria for involuntary admission

As outlined in Article 61 of the Act, a person may be involuntarily admitted for observation to a facility pursuant to an application under article 62, or continue to be involuntarily admitted after an emergency admission or after a voluntary admission, on the grounds that he or she does not have the decision-making ability to consent to admission, and that treatment of the person concerned in a facility would be likely to benefit or alleviate the condition of that person to a material extent, and that failure of admission of the person to a facility would be likely to lead to a serious deterioration in his or her condition or would prevent the administration of appropriate treatment that could be given only by such admission.

In all cases, consideration should be given to:
- any past wishes expressed by the patient
- the patient's cultural background
- the patient's social and family circumstances

- the impact that any future deterioration or lack of improvement in the patient's condition would have on their children, other relatives or carers, especially those living with the patient, including an assessment of their ability and willingness to cope, and
- the effect on the patient, and those close to the patient, of a decision to admit or not to admit under the Act.

In deciding whether it is necessary to admit or to continue detain patients who need support for facilitated decision-making to consent to admission, professionals should always consider the alternative ways of providing the treatment or care that would be likely to benefit or alleviate the condition of that person to a material extent, i.e. in the community.

The threat of involuntary admission should not be used to coerce a patient to consent to admission (and is likely to invalidate any apparent consent).

The application process

An application for admission or continuation of involuntary admission under Article 61 may be made only by the persons referred to in Article 62 of the Act. The medical doctor is usually a more appropriate applicant than a patient's relative, given their professional training. This also removes the risk that an application by the relative might have an adverse effect on their relationship with the patient.

Objective of the assessment under Article 63

The objective of the assessment is to determine whether the criteria for involuntary admission are met and, if so, whether the person can be involuntarily admitted or continue to be involuntarily admitted.

Because a proper assessment cannot be done without considering alternative means of providing care and treatment, medical doctors should, as far as possible in the circumstances, identify and liaise with services which may potentially be able to provide alternatives to admission, such as home treatment teams.

Setting up the assessment

Local arrangements should, as far as possible, ensure that assessments are carried out by the most appropriate medical doctors in the particular circumstances.

Where a patient is known to belong to a group for which particular expertise is desirable (eg they are aged under 18 or have an intellectual disability), at least one of the professionals involved in their assessment should have expertise in working with people from that group, wherever possible.

If this is not possible, at least one of the professionals involved in the person's assessment should consult with one or more professionals who do have relevant expertise at the earliest opportunity and involve them as closely as the circumstances of the case allow.

Unless different arrangements have been agreed locally, medical doctors who assess patients for possible involuntary admission under the Act have overall responsibility for co-ordinating the process of assessment. In doing so, they should be sensitive to the patient's age, sex, gender identity, social, cultural or ethnic background, and religion or belief. They should also consider how any disability the patient has may affect the way the assessment needs to be carried out.

Given the importance of good communication, it is essential that those professionals who assess patients are able to communicate with the patient effectively and reliably to prevent potential misunderstandings. Medical doctors should establish, as far as possible, whether patients have particular communication needs or difficulties and take steps to meet these, by arranging, for example a signer or a professional interpreter. Medical doctors should also be in a position, where appropriate, to supply appropriate equipment to make communication easier with patients who have impaired hearing, but who do not have their own hearing aid.

People who have dementia

Individuals who are presenting signs and symptoms of dementia as well as those with a confirmed diagnosis of dementia can fall within the Act's definition of mental disorder. Dementia can pose particular challenges and understanding of the condition is essential to delivery of quality care.

Generally, people who have dementia present a range of behaviours:

- dementia is generally progressive, meaning symptoms gradually get worse over time. How quickly it progresses varies from person to person
- people with dementia experience memory loss, have problems recalling things that happened recently and can sometimes repeat themselves
- people with dementia often have difficulty communicating, including through speech; many have difficulty reading and understanding written material
- some people with dementia experience problems concentrating, are confused about time or place, and/or have difficulty problem solving and sequencing tasks
- some people experience sight or visual difficulties, for example judging distances or misinterpreting reflections in mirrors, and/or
- people with dementia can have problems controlling their emotions, experience mood changes and lose interest in things; they can for example become unusually sad or frightened, angry or upset or withdrawn.

People with dementia may present and behave in very different ways from those with other kinds of mental disorder. It is important that such behaviours are understood properly if the Act is to be used appropriately. Effective communication is key to supporting people to understand the assessment process, e.g. giving people time to answer questions and using non-verbal aids where appropriate.

Where possible, professionals with specialist skills and knowledge to support people who have dementia should be involved in any decision to use the Act. Professionals working in the facility or the community to support patients who have dementia should have appropriate skills, knowledge and expertise, or be able to acquire these, to support patients with dementia effectively.

Especially in times of crisis, decisions about the use of the Act for people with dementia may have to be made by professionals who are not specialists in the field. It is important that the professionals assessing the person have a sufficient understanding of signs and symptoms of dementia as well as other forms of mental disorder.

Individuals identified as having dementia may never have had a thorough clinical assessment and diagnosis. Professionals should use validated assessment tools, eg Mini Mental State Examinations, to conduct such an assessment and diagnosis.

Medical doctors undertaking assessments need to apply professional judgment and reach decisions independently of each other, but in a framework of co-operation and mutual support.

Medical doctors have to provide an independent decision about whether or not there are alternatives to provide an independent decision about whether or not there are alternatives to involuntary admission under the Act, bringing a social perspective to bear on their decision, and taking account of the least restrictive option and maximizing independence guiding principle.

If a patient wants someone else (eg a familiar person) to be present during the assessment and any subsequent action that may be taken, then ordinarily medical doctors should assist in securing that person's attendance. Patients may feel safer or more confident with a friend or other person they know well in attendance.

Patients should usually be given the opportunity of speaking to the medical doctor alone.

It is not desirable for patients to be interviewed through a closed door or window. Where patients are subject to the short-term effects of drugs (whether prescribed or self-administered) which make interviewing them difficult, the medical doctor should either wait until the effects have abated before interviewing the patient or arrange to return later. If it is not realistic to wait because of the patient's disturbed behaviour and the urgency of the case, the assessment will have to be based on whatever information can be obtained from reliable sources. This should be made clear in the medical doctor's record of the assessment.

The medical doctor and the relative

When medical doctors make an application for admission or continuation of involuntary admission under Article 62 of the Act, they should take such steps as are practicable to inform the relative, that the application is to be (or has been) made.

Before making an application for admission under Article 62 medical doctors should consult the relative, unless it is not reasonably practicable or would involve unreasonable delay.

Circumstances in which the relative need not be informed or consulted include those where:

- it is not practicable for the medical doctors to obtain sufficient information to establish the identity or location of the relative or where to do so would require an excessive amount of investigation involving unreasonable delay, and
- consultation is not possible because of the relative's own health.

There may also be cases where, although physically possible, it would not be reasonably practicable to inform or consult the relative because the detrimental impact of this on the patient would interfere with the patient's right to respect for their privacy and family life to an extent that would not be justified and proportionate in the particular circumstances of the case. Detrimental impact may include cases where patients are likely to suffer emotional distress, deterioration in their mental health, physical harm, or financial or other exploitation as a result of the consultation.

Consulting and notifying the relative is a significant safeguard for patients. Therefore decisions not to do so on these grounds should not be taken lightly. Medical doctors should consider all the circumstances of the case, including:

- the benefit to the patient of the involvement of their relative;
- the patient's wishes including taking into account whether they have the decision-making ability to decide whether they would want their relative involved and any statement of their wishes they have made in advance

- any detrimental effect that involving the relative would have on the patient's health and wellbeing, and
- whether there is any good reason to think that the patient's objection may be intended to prevent information relevant to the assessment being discovered.

If they do not consult or inform the relative, medical doctors should record their reasons. Consultation should not be avoided purely because it is thought that the relative might object to the application.

When consulting relatives medical doctors should, where possible:
- ascertain the relative's views about both the patient's needs and the relative's own needs in relation to the patient
- inform the relative of the reasons for considering an application for involuntary admission and what the effects of such an application would be, and
- inform the relative of their role and rights under the Act.

Consultation with other people

Although there are specific requirements to consult the relative, it is important to recognize the value of involving other people in the decision-making process, particularly the patient's carers, family members and persons of trust, who are often able to provide a particular perspective on the patient's circumstances and medical doctors should consider consulting with other relevant relatives, carers or friends and should take their views into account.
Where patients are under 18, medical doctors should in particular consider consulting with the patient's parents (or other people who have parental responsibility for the patient).
In deciding whether it is appropriate to consult carers and other family members, medical doctors should consider:
- the patient's wishes
- the nature of the relationship between the patient and the person in question, including how long the relationship has existed, and
- whether the patient has referred to any hostility between them and the person in question, or there is other evidence of hostility, abuse or exploitation.

Medical doctors should also consult wherever possible with other people who have been involved with the patient's care, including their care co-ordinator if they are supported on the holistic care programme This could include people working for statutory, voluntary or independent services and other service providers who do not specialize in mental health services but have contact with the patient. For example, the patient may be known to services for older people or substance misuse services.

Some patients may have an attorney or a person of trust who has authority to make decisions about their personal welfare. Where such a person is known to exist, medical doctors should take reasonable steps to contact them and seek their opinion. Where attorneys or persons of trust have the power to consent or refuse treatment for mental disorder on the patient's behalf, they should also be given the opportunity to talk directly to the doctors assessing the patient, where practicable.

Medical examination by doctors as part of the assessment

A medical examination should involve:

- direct personal examination of the patient and their mental state, and
- consideration of all available relevant clinical information, including that in the possession of others, professional or non-professional.

Where practicable, at least one of the medical recommendations should be provided by a doctor with previous acquaintance with the patient. Preferably, this should be a doctor who has personally treated the patient. It is sufficient for the doctor to have had some previous knowledge of the patient's case.

Doctors should give reasons for the opinions stated in their recommendations. When giving a clinical description of the patient's mental disorder as part of these reasons, doctors should include a description of the patient's symptoms and behaviour, not merely a diagnostic classification.

When making recommendations for involuntary admission, doctors are required to state that appropriate medical treatment is available for the patient.

If the doctors reach the opinion that the patient needs to be admitted, it is their responsibility to take the necessary steps to secure a suitable facility bed; it is not the responsibility of the applicant.

Having regard to the empowerment and involvement principle, medical doctors should ensure as far as is possible that carers are involved in the decision about where to locate an individual, and are informed of the reasons for the decision taken. Facilities should have in place a policy so that the patient and/or the patient's carers are able to challenge a decision.

When a patient's carer informs the medical doctors of difficulties in visiting the patient because of the distance that they need to travel, the medical doctors should consider whether they can provide any assistance to support the patient's carer to visit and maintain contact with the patient.

Local recording and reporting mechanisms should be in place to ensure the details of any delays in placing patients, and the impacts on patients, their carers, provider staff and other professionals are reported to the MHC.

Communicating the outcome of the assessment

Having decided whether or not to make or accept an application for admission, medical doctors should inform the patient, giving their reasons. Subject to the normal considerations of patient confidentiality, medical doctors should also give their decision and the reasons for it to:

- the patient's relative
- the doctors involved in the assessment

Where the medical doctor has considered a patient's case at the request of the relative, the reasons for not applying for the patient's admission should be given to the relative in writing. Such a letter should contain, as far as possible, sufficient details to enable the relative to understand the decision while at the same time preserving the patient's right to confidentiality.

Action when it is decided not to apply for admission

Where medical doctors decide not to apply for a patient’s involuntary admission they should record the reasons for their decision. The decision should be supported, where necessary, by an alternative framework of care or treatment (or both). Medical doctors should decide how to pursue any actions which their assessment indicates are necessary to meet the needs of the patient. That might include, for example, referring the patient to social, health or other services.

The steps to be taken to put in place any new arrangements for the patient’s care and treatment, and any plans for reviewing them, should be recorded in writing and copies made available to all those who need them (subject to the normal considerations of patient confidentiality).

Arrangements should be made to ensure that information about assessments and their outcome is passed to professional colleagues where appropriate, eg where an application for admission is not immediately necessary but might be in the future. This information will need to be available at short notice at any time of day or night.

More generally, making out-of-hours services aware of situations that are ongoing – such as when there is concern for an individual but no assessment has begun– assists out-of-hours services in responding accordingly.

Resolving disagreements

Sometimes there will be differences of opinion between professionals involved in the assessment. There is nothing wrong with disagreements: handled properly these offer an opportunity to safeguard the interests of the patient by widening the discussion about the best way of meeting their needs. In the case of discrepancy between the two assessments a third independent assessment by a psychiatrist on the staff of the facility shall be carried out and then the majority recommendation shall prevail. Doctors should be ready to consult other professionals and others involved with the patient’s current care, and to consult carers and family, while retaining for themselves the final responsibility for their decision. Where disagreements do occur, professionals should ensure that they discuss these with each other.

Where there is an unresolved dispute about an application for involuntary admission, it is essential that the professionals do not abandon the patient. Instead, they should explore and agree an alternative plan – if necessary on a temporary basis. Such a plan should include a risk assessment and identification of the arrangements for managing the risks. The alternative plan should be recorded in writing, as should the arrangements for reviewing it. Copies should be made available to all those who need it (subject to the normal considerations of patient confidentiality).

Co-operation between local agencies

Health and social care professionals should co-operate in ensuring that there are opportunities for regular communication between professionals involved in mental health assessments, in order to promote understanding and to provide a forum for clarification of their respective roles and responsibilities.

Opportunities should also be sought to involve and learn directly from people with experience of being assessed (patients and former patients), their carers, and their family.

Patients who are deaf

Doctors assessing a deaf person should, wherever possible, have had deaf awareness training, including basic training in issues relating to mental health and deafness. Where required, they should also seek assistance from specialists with appropriate expertise in mental health and deafness.

Unless different arrangements have been agreed locally, the professionals involved in the assessment should be responsible for booking and using registered qualified interpreters with expertise in mental health interpreting, bearing in mind that the interpretation of thought-disordered language requires particular expertise.

Reliance on unqualified interpreters or health professionals with only limited signing skills should be avoided. Subject to the normal considerations about patient confidentiality, family members may occasionally be able to assist a professional interpreter in understanding a patient's idiosyncratic use of language. Family members should not be relied upon in place of a professional interpreter, even if the patient is willing for them to be involved.

Pre-lingual deafness may cause delayed language acquisition, which may in turn influence social behaviour. People carrying out assessments under the Act should have an awareness and knowledge of how mental health problems present in pre-lingually deaf people.

Cultural issues need to be taken into account, for instance in people who are pre-lingually deaf, as they have a visual perspective of the world and may consider themselves to be part of a cultural and linguistic minority. This means that they may behave in ways which are misperceived as evidence of mental disorder. For example, animated signing may be misunderstood as aggression, while touching a hearing person to talk to them may be misunderstood as an assault. A deaf person's spoken or written language may be poor, giving rise to a false assumption of thought disorder.

Chapter 15: Treatment for physical conditions

The Act regulates medical treatment of mental disorder for individuals who are liable to be admitted under the Act. This may include treatment of physical conditions that is intended to alleviate or prevent a worsening of symptoms or a manifestation of the mental disorder (eg a clozapine blood test) or where the treatment is otherwise part of, or ancillary to, treatment for mental disorder.

Where individuals liable to be admitted under the Act have a physical condition unrelated to their mental disorder, consent to treat this physical condition should be sought from the individual. If the individual cannot or does not want to consent, treatment for physical conditions can be provided as long as it is likely to benefit or alleviate the condition of those individuals to a material extent.

If the individual is involuntarily admitted and the need for physical treatment is the only reason why the person needs to be admitted, then the patient is not within the scope of the Mental Health Act.

Chapter 16: Places of safety

Local policies on use of police powers and places of safety

Facilities, police forces and ambulance services should have local partnership arrangements in place to deal with people experiencing mental health crises. The objective of local partnership arrangements is to ensure that people experiencing mental health crises receive the right medical care from the most appropriate health agencies as soon as possible. The police will often, due to the nature of their role, be the first point of contact for individuals in crisis, but it is crucial that people experiencing mental health crises access appropriate health services at the earliest opportunity.

It is also important to ensure that a jointly agreed local policy is in place. Good practice depends on a number of factors. For example:

- facilities, police forces and ambulance services should ensure that they have a clear and jointly agreed policy on the powers, as well as the operation of agreed places of safety within their localities
- all professionals involved in implementation of the powers should understand them and their purpose, the roles and responsibilities of other agencies involved, and follow the local policy
- professionals involved in implementation of the powers should receive the necessary training to be able to carry out fully the role ascribed to their agency
- the parties to the local policy should meet regularly to discuss its effectiveness in the light of experience and review the policy where necessary.

The policy should define responsibilities for:

- providing sufficient and safe health-based places of safety, including for people under 18
- identifying and agreeing the most appropriate places of safety in local areas, including contingency arrangements for those cases where the preferred place of safety is not available. This should ensure that local agency boundaries are not an overriding constraint, and that there are arrangements to ensure children and young people can access a place of safety in their local area
- escalating and reviewing decisions, particularly in the event of disagreement
- providing prompt assessment and, where appropriate, admission to a facility for further assessment or treatment .
- the safe, timely and appropriate transport of the person to and between places of safety (bearing in mind that ambulance transport would be preferable to police transport, which

should only be used exceptionally, such as in cases of extreme urgency or where there is an immediate risk of violence)

- deciding whether it is appropriate to transfer the person from the place of safety to which they have been taken to another place of safety
- ensuring that people who are intoxicated can be safely managed in any place of safety or an emergency department, and receive an assessment of both their physical and mental health needs. Intoxication should not be used as a basis for excluding people from particular places of safety, except in the circumstances outlined in the policy such as where the patient’s current behaviour clearly indicates that there may be a risk to their own safety, or that of the staff, which cannot be safely managed in the health-based place of safety.
- ensuring that people who are behaving, or have behaved, violently can be safely managed in a place of safety taking into account the needs of the person and the safety of staff and others
- arranging access to an emergency department for assessment for people who need it, and having an agreed list of circumstances when this will be necessary, such as where a person is self-harming, has a high body temperature or physical injury
- record keeping and monitoring and audit of practice against policy
- the release, transport and follow-up of people assessed who are not then admitted to a facility or immediately accommodated elsewhere, and
- preparing multi-agency care plans for people who are repeatedly admitted.

Responsibilities should be allocated to those who are best placed to discharge them, bearing in mind the different purposes for which health and social services and the police service exist. Local policies should ensure that police officers know who to contact prior to the removal of a person to a place of safety in order to help secure their acceptance into a health-based place of safety.

Such policies should cover arrangements for police officers to remain in attendance when a person arrives at a health-based place of safety. Healthcare staff, including ambulance staff, should take responsibility for the person as soon as possible.

Such policies may be best maintained by the establishment of a liaison committee, which might also take responsibility for examining the processes in place for other multi-agency tasks, such as transport of persons under the Act.

Places of safety

The locally agreed policy should contain a list of identified places of safety. The process for identifying the most appropriate place of safety to which a particular person is to be removed should be clearly outlined in the local policy. This should be a hospital or other facility where mental health services are provided.

Other options which might be appropriate to the individual’s needs should be considered, for example a residential care home or the home of a relative or friend of the person who is willing to accept them temporarily. There is nothing that precludes other areas of a psychiatric hospital (such as a ward) being used as a temporary place of safety, provided that it is a suitable place and it is appropriate to use that place in the individual case.

A police station should not be used as a place of safety except in exceptional circumstances, for example it may be necessary to do so because the person's behaviour would pose an unmanageably high risk to other patients, staff or other users if the person were to be admitted in a healthcare setting. A police station should not be used as the automatic second choice if there is no local health- based place of safety immediately available.

If, exceptionally, a police station is used, the locally agreed policy should set out the place and time within which the appropriate health and social care professionals will assess the person.

If, in exceptional circumstances, a police officer needs to take a person to an emergency department after detaining that person, for example because emergency medical assessment or treatment is required, the emergency department should provide a safe and suitable place for immediate care for that person.

In identifying the most appropriate place of safety for an individual, consideration should be given to the impact that the proposed place of safety (and the journey to it) may have on the person and on their examination and interview. It should always be borne in mind that the use of a police station can give the impression that the person is suspected of having committed a crime. This may cause distress and anxiety to the person concerned and may affect their co-operation with, and therefore the effectiveness of, the assessment process. In the event that a person is taken to a police station, it should be clearly explained to them that they are not suspected of any crime or other wrongdoing, and they are being kept there until they can be assessed to see if they need any care or treatment.

Where an individual is removed to a place of safety by the police, the following apply:

- where the place of safety is a hospital, the police should make contact as soon as is practicable with the hospital before the person's arrival at the place of safety. This will allow arrangements to be made for the person to be interviewed and examined as soon as possible
- where a hospital is used as a place of safety, it is a local decision whether the person is admitted to a bed on arrival or whether that happens only after they have been interviewed and examined
- where a police station is to be used as the place of safety, the police should make contact quickly with the hospital and with an appropriate doctor.

This will enable the examination and interview to be conducted as quickly as possible, thus ensuring that the person spends no longer than necessary in police custody before being allowed to leave or taken to hospital. Early assessment will also allow consideration to be given to the possibility of a transfer to an alternative place of safety as soon as this is considered to be safe and appropriate in all of the circumstances intoxication (e.g. through drugs) should not be used as a basis for exclusion from places of safety, except in circumstances set out in the local policy, where there may be too high a risk to the safety of the individual or staff. Health-based places of safety should not be conducting tests to determine intoxication as a reason for exclusion, and a child or young person should not be taken to a place of safety in a police station unless, having regard to the best interests of the child or young person, there is no suitable alternative available.

If this occurs, consideration should also be given to using a different part of a police station or other place under the supervision of a police officer and not a police custody suite.

Assessment at a place of safety

The same care should be taken in examining and interviewing people in places of safety as in any other assessment. No assumptions should be made about them simply because the police have been involved, nor should they be assumed to be in any less need of support and assistance during the assessment.

Assessment by medical doctors should begin as soon as possible after the arrival of the individual at the place of safety. In cases where there are no clinical grounds to delay assessment, it is good practice for the medical doctor to attend within three hours;

If possible, either a consultant psychiatrist or a trainee psychiatrist or an approved clinician with knowledge and experience of working with people with intellectual disabilities should be available to make the assessment where it appears that the person has a intellectual disability.

Where the person is under the age of 18, or is known to have moved recently to adult mental health services, they should be taken to an appropriate place of safety, where either a child and adolescent mental health services consultant or a mental health professional with knowledge and experience of caring for this age group should undertake the assessment. If arranging for a child and adolescent mental health services consultant specialist to assess the person would result in a substantial delay, then those assessing the person should at least discuss the case with an appropriately qualified person. Where there is no local place of safety specifically for under 18s, the local health-based place of safety should be used.

The authority to detain a person in a place of safety ends as soon as the assessment has been completed and suitable arrangements have been made.

If the doctor sees the person first and concludes that involuntary admission to a facility is not necessary, but that they may still need treatment or care (whether in or out of a facility), the person should still be seen by a social worker or a psychologist who should consult the doctor about any arrangements that might need to be made for the person's treatment or care.

It is important to remember that the definition of mental disorder is wide and includes personality disorder. If the assessment by a doctor reveals that the person is not suffering from a mental disorder, but there are physical symptoms which require treatment, then the person should be released and appropriate steps taken to manage the physical condition.

Transfer between places of safety

A person removed to a place of safety may be moved to a different place of safety within the maximum 72-hour period for which they may be admitted. The maximum period of involuntary admission begins from the time of the person's arrival at the first place of safety to which they are taken and cannot be extended if the person is transferred to another place of safety.

A person may be transferred before their assessment has begun, while it is in progress, or after it is completed and they are waiting for any necessary arrangements for their care or treatment to be put in place. If it is unavoidable, an assessment begun by doctor may be taken over and completed by another, either in the same location or at another place to which the person is transferred.

Although it may be helpful for local policies to outline circumstances in which a person is usually to be transferred between places of safety, the decision in each case should reflect the individual circumstances, including the person's needs and the level of risk. For example, where the purpose of the transfer would be to move a person from a police station to a more appropriate health-based place of safety, the benefit of that move needs to be weighed against any delay it might cause in the person's assessment and any distress that the journey might cause them. Any delays resulting from transferring the person cannot result in an overall period of involuntary admission which exceeds 72 hours.

Unless it is an emergency, a person should not be transferred without the agreement of a doctor or another healthcare professional who is competent to assess whether the transfer would put the person's health or safety (or that of other people) at risk. Someone with the authority to effect a transfer should proceed by agreement wherever possible. It is for those professionals to decide whether they first need to see the person personally.

A person should never be moved from one place of safety to another unless it has been confirmed that the new place of safety is willing and able to accept them.

Record keeping

A record of the person's time of arrival should be made immediately when they reach the place of safety. As soon as involuntary admission in a place of safety ends, the individual should be told that they are free to leave by those who are detaining them. The organization responsible for the place of safety should ensure that proper records are kept of the end of the person's involuntary admission under these sections.

Given that the maximum period of involuntary admission at a place of safety is not affected by any subsequent transfer to a different place of safety, it is very important to ensure that the time of arrival at the first place of safety is recorded clearly. This information should be shared between the transferring and receiving place of safety in the event of a transfer.

When admitted to a place of safety in a hospital, a record of the admission, and of the outcome of the assessment, should be made by the hospital.

If a person is excluded from a place of safety in a facility and taken to a police station as a place of safety a record should be made of the decision, of who made the decision, and the reason it was made.

Rights of people in places of safety

Persons removed to a police station as a place of safety are entitled to many of the safeguards applicable to any person who is in police detention. A person should expect to be allowed to tell the police if they want access to a lawyer, if they want someone to be told that they are at the police station, and if they want medical help.

A person in a place of safety may be searched by the constable to ascertain what they have on them which could be used to harm themselves or others, or damage property. The constable can hold on to anything found in the search, including clothes and personal effects, which the constable believes the person may use to cause such harm or damage.

Where a facility is used as a place of safety, the directors should ensure that information is given to the person to be admitted. In addition, access to legal advice should be facilitated whenever it is requested. In all cases, the person should be told that the maximum period of admission is 72 hours.

Places of safety and consent to treatment

Admitting a patient in a place of safety does not confer any power under the Act to treat them without their consent. In other words, they are in exactly the same position in respect of consent to treatment as patients who are not admitted under the Act.

Making necessary arrangements following assessment

Once the assessment has been concluded, it is the responsibility of the medical doctors involved to make any necessary further arrangements for the person's treatment or care.
It is unlikely that an emergency admission would be justified in these circumstances. If there was an urgent need to secure the transfer of the patient to hospital, the power of transfer between places of safety could be used.

Chapter 17: Transport of patients

Patients may need to be transported between different locations. This chapter provides information about how patients should be conveyed in a manner that is most likely to preserve their dignity and privacy consistent with managing any risk to their health and safety or to other people, and the factors that should be taken into account. When transport between facilities is required, directors should make appropriate arrangements.

General considerations

Patients should always be transported in the manner which is most likely to preserve their dignity and privacy consistent with managing any risk to their health and safety or to other people. Patients should be informed as soon as possible of the reasons for any planned transfers and their views taken into consideration. They should also be supported, where appropriate, to discuss the planned transfer with carers (who should usually be informed if the patient is under 18, or has a intellectual disability, autistic spectrum disorder or dementia). A record of these discussions should be made in the patient's notes.

If, under exceptional circumstances, a patient is being transported out of area, directors should consider whether they can provide any additional assistance as part of the care package to support any carers to visit and contact the patient, and/or encourage the carer to have a carer's assessment. This is particularly relevant when the patient is a child or young person.
This applies in all cases where patients are compulsorily transported under the Act, including:

- taking patients to a facility to be admitted for assessment or treatment
- transferring patients between facilities
- taking patients to, and between, places of safety, and
- taking patients to and from court.

When deciding on the most appropriate method for transporting a patient, factors to be taken into account include:

- the availability of different transport options
- the distance to be travelled
- the wishes and views of the patient, including any relevant statement of those views or wishes made in advance
- the patient's age and gender
- cultural sensitivities
- any physical disability the patient has
- any risks to the health and safety of the patient – including their need for support, supervision and clinical care or monitoring during the journey. This is particularly important where sedation has been, or may be used
- the nature of the patient's mental disorder and their current state of mind
- the patient's violent or dangerous behaviour
- the health and safety of the people transporting the patient and anyone else accompanying them
- the impact that any particular method of transporting the patient will have on the patient's relationship with the community to which they will return
- the effect on the patient of who accompanies them (eg whether the presence of one of the doctors involved in the decision to involuntarily admit them may have a detrimental effect)
- the availability of transport to return those who accompany the patient.

Transporting to a facility on the basis of an application for involuntary admission

Patients who have been sedated before being transported should always be accompanied by a health professional who is knowledgeable in the care of such patients, is able to monitor the patient closely, identify and respond to any physical distress which may occur and has access to the necessary emergency equipment to do so.

A properly completed application for involuntary admission under the Act, together with the required medical recommendations, gives the applicant (the medical doctor or nearest relative) the authority to transport the patient to the facility named in the application.

Where the medical doctor is the applicant, they have a professional responsibility to ensure that all the necessary arrangements are made for the patient to be transported to hospital. All relevant agencies should co-operate fully with the medical doctor to ensure safe transport to hospital.

If the relative is the applicant, any medical doctor and other professionals involved in the assessment of the patient should give advice and assistance. However, they should not assist in a patient's involuntary admission unless they believe it is justified and lawful.

Medical doctors should make decisions on which method of transport to use in consultation with the other professionals involved, the patient and (as appropriate) their carer. The decision should be made following a risk assessment carried out on the basis of the best available information.

If the patient is likely to be unwilling to be moved, the applicant will need to provide the people who are to transport the patient (including any ambulance staff or police officers involved) with authority to transport the patient. This will give them the legal power to transport patients against their will, using reasonable force if necessary.

If the patient's behaviour is likely to be violent or dangerous, the police should be asked to assist in accordance with locally agreed arrangements. Where practicable, given the risk involved, an ambulance service (or similar) vehicle should be used even where the police are assisting.

The locally agreed arrangements should set out what assistance the police will provide to medical doctors and health services in transporting patients safely, and what support ambulance or other health services will be expected to provide where patients are, exceptionally, transported in police vehicles.

Where it is necessary to use a police vehicle because of the risk involved, it may be necessary for the highest qualified member of an ambulance crew to ride in the same vehicle with the patient, with the appropriate equipment to deal with immediate problems. In such cases, the ambulance should follow directly behind to provide any further support that is required.

Medical doctors should agree to a patient being transported by private vehicle only if they are satisfied that the patient and others will be safe from risk of harm and that it is the most appropriate way of transporting the person. In these circumstances there should be a medical escort for the patient other than the driver.

People authorized by the applicant to transport patients act in their own right and not as the agent of the applicant. They may act on their own initiative to restrain patients and prevent them absconding, if absolutely necessary. When they are the applicant, medical doctors retain a professional responsibility to ensure that the patient is transported in a lawful and humane manner and should give guidance to those asked to assist.

Patients may be accompanied by another person, provided that the medical doctor and the person in charge of the vehicle are satisfied that this will not increase the risk of harm to the patient or others.

Before patients are moved, the applicant should ensure that the receiving facility is expecting the patient and has been told the likely time of arrival. If possible, the name of the person who will be formally receiving the patient and their admission documents should be obtained in advance.

Where the applicant is not travelling in the same vehicle as the patient, the application form and medical recommendations should be given to the person authorized to transport the patient, with instructions for them to be presented to the member of facility staff receiving the patient.

Locally agreed arrangements

It is essential to have clear agreements in place so that people who need assistance in transporting patients under the Act can obtain it without delay. Local crisis care policies and transport agreements should already be in place and transport services, health providers and the police, should agree joint local policies and procedures. These should include:

- a clear statement of the respective roles and obligations of each agency and service provider (and their staff)
- the form of any authorization to be given by medical doctors (and others) when authorizing people to transport patients on their behalf
- the assistance that directors and staff of facilities will provide to medical doctors s to make necessary arrangements for the transport of patients who are to be admitted to their hospital
- guidance and training (including refresher training) on legal powers in relation to transporting patients
- a clear statement of how risk assessment and management should be conducted and how the outcomes will influence decisions in relation to the transport of patients
- agreement on the appropriate use of different methods of restraint in transporting patients and how decisions on their use will be made in any given case
- any special arrangements where patients need to be transported outside the local area, and
- processes for reviewing and monitoring the involvement of the different agencies, including standards against which delivery will be monitored.

Policies should ensure that medical doctors (in particular) are not left to negotiate arrangements with providers of transport services on an ad hoc basis, in the absence of clear expectations about the responsibilities of all those involved.
Policies should also be consistent with those agreed in relation to the use of the police powers.

Transporting patients between facilities

Where a patient requires transport between facilities, it is for the directors of the facilities concerned to make sure that appropriate arrangements are put in place. The directors of the facility from which the patient is being transferred remain responsible for the patient until the patient is admitted to the new hospital.

When making arrangements for the return of patients temporarily held in police custody, facility directors should bear in mind that police transport to return them to the facility will not normally be appropriate. Decisions about the kind of transport to be used should be taken in the same way as for patients being admitted in the facility for the first time.

Chapter 18: Holding powers of voluntary patients (Articles 50, 61 and 64 f the Act)

This chapter provides guidance about the use of ‘holding powers’ and how they should be exercised.

Psychiatrists and approved clinicians have ‘holding powers’ under the Act. This chapter provides guidance on the nature of this power, monitoring its use, the nomination of deputies if necessary, the role of facility directors, and how patients should be assessed before invoking 'holding powers'. It also provides guidance on the transfer of those subject to this power, to other facilities.

Holding powers of psychiatrists and approved clinicians

Nature of the power

The power can be used where the psychiatrists or approved clinician in charge of the treatment of a facility in-patient concludes that the status of a voluntary patient should be changed to that of an involuntary patient. It authorizes the involuntary admission of the patient in the facility for a maximum of 72 hours so that the patient can be assessed with a view to such an application being made. Professionals should always consider whether there are less restrictive alternatives to involuntary admission under the Act.
The identity of the person in charge of a patient's medical treatment at any time will depend on the particular circumstances. A professional who is treating the patient under the direction of another professional should not be considered to be in charge.

There may be more than one person who could reasonably be said to be in charge of a patient's treatment, e.g. where a patient is already receiving treatment for both a physical and a mental disorder. In a case of that kind, the psychiatrist or approved clinician in charge of the patient's treatment for the mental disorder is the preferred person to use the power, if necessary.

The period of involuntary admission starts at the moment the psychiatrist's or approved clinician's report is furnished to the facility directors (e.g. when it is handed to an officer who is authorized by the directors to receive it). In this context, a facility in-patient means any person who is receiving in-patient treatment in a facility.

The power cannot be used for an out-patient attending a hospital's accident and emergency department, or any other out-patient. Patients should not be admitted voluntarily with the sole intention of then using the holding power.

Doctors and approved clinicians should use the holding power only after having personally examined the patient.

Recording the end of involuntary admission

The time which a patient ceases to be admitted should be recorded, preferably using a standardized system established by the facility directors for the purpose. The reason why the patient is no longer involuntarily admitted under the power should be recorded, and what then happened to the patient (eg the patient remained in the facility voluntarily or was discharged).

Monitoring use

Facility directors should monitor the use of Chapter 8 of the Act, including:

- how quickly patients are assessed for involuntary admission and discharged from the holding power
- the attendance times of doctors and approved clinicians following the use of Chapter 8 of the Act

Information

Facility directors should ensure that all patients admitted under the Act are given information about their position and their rights as required by the Act.

Medical treatment of patients

Admitting patients, including involuntarily, under the Act does not confer any power under the Act to treat them without their consent.

Transfer to other facilities

It is not possible for patients involuntarily admitted under Chapter 8 of the Act to be transferred to another facility without prior approval of the MHC..

A patient who is involuntarily admitted but needs to go to another facility urgently for treatment, or other exceptional reasons, can only be taken there if they consent to the transfer. If the patient needs support for facilitated decision-making to consent to the transfer, any transfer should be carried out only with the approval of the MHC.

Additional considerations for specific patients

Certain groups of patients require consideration in addition to the general guidance that applies to all patients and is provided elsewhere in this Code. This group of chapters addresses the particular needs of children and young people under the age of 18 and the role of professionals and others responsible for their care. The key issues from the Act which are relevant to people with intellectual disabilities or autistic spectrum conditions are identified and guidance for professionals is provided to ensure independence, dignity and respect.

Chapter 19: Children and young people under the age of 18

Particular issues arise in relation to children (under 16 years of age) and young people (16 or 17 years old). This chapter provides guidance on the role of those with parental responsibility for a child or young person; confidentiality and sharing information; how children and young people should be safeguarded where admission to the facility is not appropriate and on decisions related to admission and treatment. It should be read in conjunction with other chapters in this Code.

This chapter sets out some of the key factors including:

- some of the main concepts to be considered when providing care and treatment to children and young people, such as ‘parental responsibility’ and decisions within the ‘scope of parental responsibility’
- assessing the competence of children and the decision-making ability of young people to make decisions about their admission and/or treatment
- when voluntary admission might be appropriate
- specific provisions relating to the treatment of children and young people under the Act
- the duty to provide age appropriate services
- applications and references to the MHC, and

    - general duties of local authorities in relation to children and young people in hospital.

General considerations

In addition to the Act, those responsible for the care of children and young people in the facility should be familiar with other relevant legislation, including the United Nations Convention on the Rights of the Child (UNCRC) and the United Nations Convention on the Rights of Persons with Disabilities (UNCRPD) and keep up-to-date with relevant guidance.

When making decisions in relation to the care and treatment of children and young people, practitioners should keep the following points in mind:

- the best interests of the child or young person should always be a significant consideration
- everyone who works with children has a responsibility for keeping them safe and to take prompt action if welfare needs or safeguarding concerns are identified
- all practitioners are expected to contribute to whatever actions are needed to safeguard and promote a child or young person’s welfare
- the developmental process from childhood to adulthood, particularly during adolescence, involves significant changes in a wide range of areas, such as physical, emotional and cognitive development – these factors need to be taken into account, in addition to the child and young person’s personal circumstances, when assessing whether a child or young person has a mental disorder
- children and young people should always be kept as fully informed as possible and should receive clear and detailed information concerning their care and treatment, explained in a way they can understand and in a format that is appropriate to their age
- the child or young person’s views, wishes and feelings should always be sought, their views taken seriously and professionals should work with them collaboratively in deciding on how to support that child or young person’s needs
- any intervention in the life of a child or young person that is considered necessary by reason of their mental disorder should be the least restrictive option and
- the least likely to expose them to the risk of any stigmatization, consistent with effective care and treatment, and it should also result in the least possible separation from family, carers, friends and community or interruption of their education
- where admission is necessary, the child or young person should be placed as near to their home as reasonably practicable, recognizing that placement further away from home increases the separation between the child or young person and their family, carers, friends, community and school
    - all children and young people should receive the same access to educational provision as their peers
    - children and young people have as much right to expect their dignity to be respected as anyone else, and
    - children and young people have as much right to privacy and confidentiality as anyone else.

People with parental responsibility

Those with parental responsibility have a central role in relation to decisions about the admission and treatment of their child. It is therefore essential that those proposing the admission and/or treatment identify who has parental responsibility.

Those with parental responsibility will usually, but not always, be the parents of the child or young person. Other people may also acquire parental responsibility. Those taking decisions under the Act should be clear about who has parental responsibility. When seeking to identify who has parental responsibility for the child or young person, practitioners should always check whether the child or young person's medical and/or social service files include any relevant court orders, and request copies of any such orders. These orders may include care orders, child arrangements orders, special guardianship orders, evidence of appointment as the child or young person's guardian, parental responsibility. Practitioners should always check with those caring for the child or young person whether any child arrangements orders, parental responsibility agreements or orders have been obtained.

Where the parents of a child or young person (both of whom have parental responsibility), are separated and the child or young person is living with one parent in accordance with a child arrangements order, practitioners should be aware that the parents continue to share parental responsibility and both should be involved in making decisions about their child.

Confidentiality and sharing information

As with adults, children and young people have a right to confidentiality. Where children are competent, and young people have the decision-making ability, to make decisions about the use and disclosure of information they have provided in confidence, their views should be respected. However, as with adults, in certain circumstances confidential information may be disclosed without the child or young person's consent; for example if there is reasonable cause to believe that the child or young person is suffering, or is at risk of suffering, significant harm.
The same principles of confidentiality apply if a child who is competent, or a young person who has decision-making ability, to make a decision regarding the information does not wish their parent (or others with parental responsibility) to be involved in decision-making about their care and treatment. Their decision should be respected unless the disclosure can be justified; for example, if there is cause to suspect that the child or young person is suffering or is likely to suffer, serious harm. Practitioners should encourage the child or young person to involve their parents (unless it is considered that to do so would not be the best interests of the child or young person). They should also be proactive in discussing with the child or young person the consequences of their parent(s) not being involved.

Where a child or young person does not wish their parent(s) to be involved, every effort should be made to understand the child or young person's reasons with a view to establishing whether the child or young person's concerns can be addressed.

There is no minimum age limit for involuntary admission in a facility under the Act. It may be used to involuntarily admit children or young people who need to be admitted to hospital for assessment and/or treatment of their mental disorder, when they cannot be admitted and/or treated on a voluntary basis, and where the criteria for involuntary admission under the Act are met.

Where practitioners conclude that involuntary admission is not the appropriate course of action, consideration should be given to alternative means of care and support that will meet the needs of the child or young person.

Decisions on admission and treatment of under 18s

The decision to admit a child or young person is inextricably linked to the decision to treat them once they have been admitted. They are, however, different decisions and need to be considered separately. The following concepts will be relevant to admission and treatment decisions of both children and young people:

- consent
- assessing decision-making ability (young people) or competence (children) to make decisions
- the role of those with parental responsibility and the 'scope of parental responsibility'

Children and young people and consent

The valid consent of a child or young person will be sufficient authority for their admission and/or treatment for mental disorder; additional consent by a person with parental responsibility will not be required. It is good practice to involve the child or young person's parents and/or others involved in their care in the decision-making process, if the child or young person consents to information about their care and treatment being shared.

Consent should be sought for each aspect of the child or young person's admission, care and treatment as it arises. 'Blanket' consent forms (ie forms that purport to give consent to any proposed treatment) are not acceptable and should not be used.

A young person should have the decision-making ability, or a child should have competence, to make the particular decision in question. They should have sufficient information to make that decision and not be subject to any undue influence when doing so. Unlike adults, the refusal by a competent child or young person with decision-making ability under the age of 18 may in certain circumstances, be overridden in cases where the refusal of a child or young person of treatment in circumstances will, in all probability, lead to the death of the child or young person or to severe permanent injury; or where there is a serious and imminent risk that the child or young person will suffer grave and irreversible mental or physical harm. However, the child or young person's refusal is a very important consideration when deciding whether treatment should be given, despite the child or young person's refusal, noting that its importance increases with their age and maturity.

Assessing a young person's decision-making ability and a child's competence to make decisions

Before relying on the consent of a child or young person it is necessary to ascertain whether they can give valid consent. The test for assessing whether a child under 16 can give valid consent differs from that of a young person aged 16 or 17.

The decision-making ability of a young person aged 16 or 17 to consent is assessed in accordance with articles 26-31 of the Act.

Whether or not a child under 16 is capable of giving the necessary consent will depend on the child's maturity and understanding and the nature of the consent required. The child should be capable of making a reasonable assessment of the advantages and disadvantages of the treatment proposed, so the consent, if given, can be properly and fairly described as true consent.

Practitioners with expertise in working with children and young people should be consulted in relation to these assessments. The different tests are explained in more detail below.

Practitioners should consider the following three questions which should be read in conjunction with the paragraphs below:

- has the child or young person been given the relevant information in an appropriate manner (such as age appropriate language)?
- have all practicable steps been taken to help the child or young person make the decision? The kind of support that might help the decision-making will vary, depending on the child or young person's circumstances. Examples include:
    - steps to help the child or young person feel at ease
    - ensuring that those with parental responsibility are available to support their child (if that is what the child or young person would like)
    - giving the child or young person time to absorb information at their own pace, and
    - considering whether the child or young person has any specific communication needs (and if so, adapting accordingly).
    - can the child or young person decide whether to consent, or not to consent, to the proposed intervention?

Decision-making and young people

Young people aged 16 or over should be assumed to have decision-making ability to make the decision about a proposed admission and/or treatment unless it is established that they need support for facilitated decision-making, as is the case with adults.

A person needs support for facilitated decision-making in relation to a matter if at the relevant time they cannot make a decision for themselves in relation to the matter. Article 26(2) of the Act states that a person cannot make a decision if they cannot understand the information relevant to the decision and cannot use the information to make a decision

The Act also states that a person should not be regarded as unable to understand the information relevant to the decision if they are able to understand an explanation of it given in a way that is appropriate to their circumstances. It is therefore essential that steps are taken to enable a person to understand information, such as using simple language and visual aids.

Where there are concerns that the young person cannot make the particular decision, consideration should be given to whether the decision could be delayed to a time when the young person might be able to make the decision with or without support.

If the young person cannot decide about the proposed action at the relevant time because of a mental disability, they will need support. The reason for the young person's reluctance to decide about the proposed admission or treatment may be because of their mental disorder.

Alternatively, the young person's inability to decide might arise from a temporary impairment or disturbance that does not amount to a mental disorder (eg an impairment or disturbance caused by the distress related to the proposed admission or treatment). In either case, the young person will need support to make the decision and support should be provided in the same way as it does for adults.

When assessing a young person's decision-making ability to make the decision in question and the support they might need, practitioners should be aware that in some cases a young person may be reluctant to make a decision for reasons other than an impairment or a disturbance even if that is only temporary).. For example, a young person who is informed that they need to be admitted may, in the particular circumstances of the case, be unable to make a decision. This might be because they find themselves in an unfamiliar and novel situation, having never before been asked to absorb that type and quantity of information, or they are worrying about the implications of deciding one way or the other.

In such cases (which are likely to be rare) every effort should be made to ensure that the young person is supported in making the decision (e.g. by involving those with parental responsibility). Steps should also be taken to explain fully and clearly why admission is thought necessary, what the alternatives to the admission are and why they are considered not to be the best option. Save where the case requires urgent action, the young person should be given the time that they need to think things over and ask for clarification.

If it is not clear whether the young person's reluctance to decide is because of an impairment or a disturbance or whether due to some other reason, a specialist opinion should be sought from a professional with expertise in working with children and young people.

Decision-making and children under 16

Children under 16 should be assessed to establish whether they have competence to make a particular decision at the time it needs to be made. Whether or not a child under 16 is capable of giving the necessary consent will depend on the child's maturity and understanding and the nature of the consent required. The child should be capable of making a reasonable assessment of the advantages and disadvantages of the treatment proposed, so the consent, if given, can be properly and fairly described as true consent.

A child may be competent to consent to admission to hospital, medical treatment, or any other activity that requires their consent.

The concept of competence of children under 16 reflects the child's increasing development to maturity. The understanding required to make decisions about different interventions will vary considerably. A child may have the competence to consent to some interventions but not others. The child's competence to consent should be assessed carefully in relation to each decision that needs to be made.

When considering whether a child has the competence to decide about the proposed intervention, practitioners may find it helpful to consider the following question: Does the child understand the information that is relevant to the decision that needs to be made and use this information?

A child may lack the competence to make the decision in question either because they have not as yet developed the necessary intelligence and understanding to make that particular decision; or for another reason, such as because their mental disorder adversely affects their ability to make the decision. In either case, the child will be considered to lack competence.

The role of those with parental responsibility and decisions within the scope of parental responsibility

Those who have parental responsibility for the child or young person, who may be able to provide parental consent to the proposed admission and/or treatment, should be identified. This is because, subject to the child or young person's right to confidentiality, they should be consulted about the proposed decision concerning their child. In relation to 16 and 17 year olds, if decisions are to be made on the basis that the young person needs support for facilitated decision-making those with parental responsibility should be consulted about the best interests of the young person.

Parental consent should not be relied upon when the child is competent or the young person has decision-making ability to make the particular decision. In relation to decisions about such a young person's treatment, it is inadvisable to rely on the consent of a person with parental responsibility to treat a young person who has decision-making ability to make the decision and has refused the treatment. Similarly, in relation to children, it is not advisable to rely on the consent of a parent with parental responsibility to admit or treat a child who is competent to make the decision and does not consent to it.

In some circumstances, it will be possible for children lacking competence and young people who need support to make decisions to be admitted to a facility and/or treated on the basis of parental consent. However, practitioners should be satisfied that it is appropriate to rely on parental consent. For example, when making decisions on behalf of their child, parents should act in their child's best interests.

Whether the particular intervention can be undertaken on the basis of parental consent will need to be assessed in the light of the particular circumstances of the case. Practitioners will need to consider a range of factors. These are set out below, under the two key questions that should be addressed (the term 'parent' is used to cover all people with parental responsibility):

First, is this a decision that a parent should reasonably be expected to make? If the decision goes beyond the kind of decisions parents routinely make in relation to the medical care of their child, clear reasons as to why it is acceptable to rely on parental consent to authorize this particular decision will be required.

Significant factors in determining this question are likely to include:

- the type and invasiveness of the proposed intervention – the more extreme the intervention, the greater the justification that will be required. Relying on parental consent to authorize an intrusive form of treatment might be justified because it is necessary to prevent a serious deterioration of the child or young person's health, but this would need to be balanced against other factors such as whether the child or young person is resisting the treatment;

- the age, maturity and understanding of the child or young person: the role of parents in decision-making should diminish as their child develops greater independence, with accordingly greater weight given to the views of the child or young person
- the extent to which the decision accords with the wishes of the child or young person, and whether the child or young person is resisting the decision, and
- whether the child or young person had expressed any views about the proposed intervention when they had the competence or decision-making ability to make such decisions; for example, if they had expressed a willingness to receive one form of treatment but not another, it might not be appropriate to rely on parental consent to give the treatment that they had previously refused.

Secondly are there any factors that might undermine the validity of parental consent? Irrespective of the nature of the decision being proposed, there may be reasons why relying on the consent of a person with parental responsibility may be inappropriate; for example:

- where the parent is not able to make the relevant decision; for example, this may arise, if the parent has a significant intellectual disability. In cases of doubt, the parent's decision-making ability will need to be assessed in accordance with the Act.
- where the parent is not able to focus on what course of action is in the best interests of their child; for example, where the parents have gone through a particularly acrimonious divorce, they may find it difficult to separate the decision whether to consent to their child's admission from their own hostilities
- where the poor mental health of the child or young person has led to significant distress and/or conflict between the parents, so that they feel unable to decide on what is best for their child and/or cannot agree on what action should be taken, and
- where one parent agrees with the proposed decision but the other is opposed to it. Although parental consent is usually needed from only one person with parental responsibility, it may not be appropriate to rely on parental consent if another person with parental responsibility disagrees strongly with the decision to admit and/or treat their child, and is likely to take action to prevent the intervention, such as removing the child from hospital.

If the decision is not one that a parent would reasonably be expected to make, or there are concerns about the validity of the consent of the person with parental responsibility, it will not be appropriate to rely on parental consent. In such cases, the proposed intervention should be lawfully authorized by other means. If there is doubt as to whether or not parental consent can be relied upon to authorize the particular intervention, professionals should take legal advice.

In determining the limits of parental responsibility, professionals should carefully consider and balance: (i) the child's right to liberty which should be informed by article 37 of the UNCRC, (ii) the parent's right to respect for the right to family life, which includes the concept of parental responsibility for the care and custody of minor children, and (iii) the child's right to autonomy. Professionals should seek their own legal advice in respect of cases before them.

Voluntary admission and treatment

Admission and treatment for mental disorder of young people aged 16 and 17 differ from that of children under 16. In both cases, whether they are competent (in the case of children) or have decision-making ability (in the case of young people) to decide about their admission and/or treatment is of central importance.

In all cases concerning admission and/or treatment, practitioners should determine whether the proposed intervention can be undertaken on a voluntary basis. The following paragraphs provide guidance on how to determine whether such routes to voluntary admission and/or treatment are applicable. These should be considered in the light of the particular circumstances of each case. Where the proposed admission and/or treatment cannot be authorized on a voluntary basis, the criteria for involuntary admission under the Act should be met for the child or young person to be admitted under the Act or (where the Act is not applicable), the admission can be authorized by a Court. The only exception to this is where a life-threatening emergency has arisen.

In cases where a child or young person cannot be admitted and/or treated voluntarily, and the criteria for involuntary admission under the Act are not met, legal advice should be obtained on whether to seek the assistance of a Court. The court's authorization may be sought by way of an order or declaration, under its inherent jurisdiction. Whether the court is prepared to assist will depend on the facts of the particular case.

Voluntary admission of 16 and 17 year olds with decision-making ability to consent

Where a young person aged 16 or 17 has decision-making ability to consent to being admitted for treatment for mental disorder, they may either consent, or refuse to consent, to the proposed voluntary admission. If a young person has the decision-making ability to consent to voluntary admission and gives such consent, they can be admitted, irrespective of the views of a person with parental responsibility (who cannot prevent the admission). If the young person with decision-making ability does not consent to the admission, then a person with parental responsibility cannot consent on their behalf.

In some cases, the young person may be unable to decide whether or not to agree to their admission to hospital, but not because they do not have decision-making ability. For example, this might be because, despite every effort in helping the young person to make this decision, the young person finds the decision too difficult to make. In such cases, it will not be possible for a person with parental responsibility to consent on their behalf.

Where the young person does not consent to their admission to hospital, but the admission is thought to be necessary, consideration should be given to whether the criteria for involuntary admission under the Act are met. If these criteria are not met, legal advice should be sought on the need to seek authorization from the court before further action is taken.

Involuntary admission of 16 and 17 year olds who need support for facilitated decision-making to consent

Where a young person aged 16 or 17 needs support for facilitated decision-making to consent to admission it may be possible for them to be admitted involuntarily when the criteria for involuntary admission under the Act are met. If the criteria for involuntary admission are not met, legal advice should be sought on the need to seek authorization from the court before further action is taken.

Voluntary treatment of 16 and 17 year olds with decision-making ability to consent

Young people aged 16 or 17 can consent to their medical treatment and to any ancillary procedures involved in that treatment, such as an anaesthetic. Accordingly, treatment can be given if the young person, who has decision-making ability, gives valid consent.

Where a young person has the decision-making ability to consent to proposed medical treatment but refuses to consent, it would be inadvisable to rely on the consent of a person with parental responsibility in order to treat the young person. In such cases, consideration should be given to whether admission under the Act for the purposes of treatment is necessary, and if so, whether the criteria are met. If not, legal advice should be sought on the need to seek authorization from the court before further action is taken.

Involuntary treatment of 16 and 17 year olds who need support for facilitated decision-making to consent

Different considerations apply to a decision to treat a young person aged 16 or 17 involuntarily where the young person needs support for facilitated decision-making or is otherwise not able to decide whether or not to consent to the proposed treatment.

Where the young person needs support for facilitated decision-making, the act will apply in the same way as it does to those aged 18 and over, and treatment may be given in accordance with the Act.

A person with parental responsibility may also be able to consent on behalf of the young person who needs support for facilitated decision-making about their treatment.

A person with parental responsibility may be able to consent to the treatment on behalf of a young person who although needs support for facilitated decision-making to decide about the proposed treatment, does not need support for facilitated decision-making about other things. In such cases every effort should be made to help the young person in making the decision for themselves.

If it is not possible to provide treatment relying on parental consent, consideration should be given to whether admission under the Act for the purposes of treatment is necessary, and if so, whether the criteria are met. If not, legal advice should be sought on the need to seek authorization from the court before further action is taken.

Under 16s

Informal admission and treatment of under 16s who are competent

Where a child who has the decision-making ability to decide about their admission for assessment and/or treatment of their mental disorder consents to this, they may be admitted as a voluntary patient. A child who has the decision-making ability and has consented to being admitted voluntarily, may also be given treatment if they have the decision-making ability to consent to the proposed treatment, and do consent. Consent will be required for each aspect of the child's care and treatment as it arises. This will involve an assessment of the child's decision-making ability to make the particular decision and, where the child has the decision-making ability to do so, confirmation that they have given their consent.

Where a child who has decision-making ability refuses to be admitted for treatment it should be inadvisable to rely on the consent of a person with parental responsibility. In such cases, consideration should be given to whether admission under the Act is necessary, and if so, whether the criteria are met. If not, legal advice should be sought on the need to seek authorization from the court before further action is taken.

Voluntary admission and treatment of under 16s who are not competent

Where a child is not competent then it may be possible for a person with parental responsibility to consent, on their behalf. If parental consent can be relied upon and consent is given by a person with parental responsibility, then the child may be admitted and treated as an involuntary patient.

Consent will be required for each aspect of the child's care and treatment as it arises. This will involve consideration as to whether the child is competent to make decisions about their treatment, and if not whether such treatment can be authorized by parental consent.

If it is not considered appropriate to rely on parental consent for the proposed admission and/or treatment, for example because the consent of a person with parental responsibility is not given, consideration should be given to whether involuntary admission is necessary, and if so, whether the criteria are met. If not, legal advice should be sought on the need to seek authorization from the court before further action is taken.

Emergency treatment of children and young people

A life-threatening emergency may arise when treatment needs to be given but it is not possible to rely on the consent of the child, young person or person with parental responsibility and there is no time to seek authorization from a court. If the failure to treat the child or young person would be likely to lead to their death or to severe permanent injury, treatment may be given without their consent, even if this means overriding their refusal when they have the competence (children) or the decision-making ability (young people and those with parental responsibility), to make this treatment decision. In such cases, doubt should be resolved in favor of the preservation of life, and it will be acceptable to undertake treatment to preserve life or prevent irreversible serious deterioration of the child or young person's condition.

The treatment given should be no more than necessary and in the best interests of the child or young person. Once the child or young person's condition is stabilized, legal authority for on-going treatment should be established; this might be in accordance with a decision by the MHC or in accordance with a court order.

Assessing whether to make an application under the Act

At least one of the people involved in assessing whether a child or young person should be involuntarily admitted under the Act (ie one of the two medical practitioners), should be a child and adolescent mental health services professional. Where this is not possible, the medical practitioners should consult a child and adolescent mental health services professional as soon as possible and involve them as closely as the circumstances of the case allow. In cases where the child or young person has complex or multiple needs, other clinicians may need to be involved, for example, a intellectual disability consultant where the child or young person has a intellectual disability.

Information to under 18s admitted under the Act

Facility directors should ensure that staff providing children and young people with information about their rights in accordance the Act have sufficient knowledge and experience to be able to provide information to children and young people and determine whether the information has been understood. Written information should always be made available. Such information should be age appropriate.

Treatments for under 18s regulated by the Act

Although in some cases the Act provides that treatment can be given to a child or young person without their consent, their consent should still be sought, wherever practicable. This will necessitate an assessment of the child's competence or young person's decision-making ability to decide about the treatment proposed.

Special treatments

The Act prohibits psychosurgery to patients who are under 18.
The Act prohibits the administration of ECT to patients who are under 18.

Age-appropriate services

The Act says that children and young people admitted for the treatment of mental disorder should be accommodated in an environment that is suitable for their age (subject to their needs). This duty applies to the admission of all under 18s.
This means that children and young people should have:

- appropriate physical facilities
- staff with the right training, skills and knowledge to understand and address their specific needs
- a facility routine that will allow their personal, social and educational development to continue as normally as possible, and
- equal access to educational opportunities as their peers, in so far as that is consistent with their ability to make use of them, considering their mental state.

The duty requires facility directors to ensure that the environment in the facility is suitable. When determining the suitability of the environment, they should consult a person whom they consider to have knowledge or experience in working with children and young people receiving in-patient mental healthcare and who are able to make this assessment. The duty applies to all in-patient facilities.

Article 75 of the Act prohibits admission of persons aged under 18 in adult wards.

In all cases, to be lawful, the admission of a person aged under 18 to an adult ward should be suitable for that particular individual at the time that the admission is being considered.

In a small number of cases the child or young person's need to be accommodated in a safe environment could, in the short term, take precedence over the suitability of that environment for their age (referred to as an 'emergency situation'). Such situations will arise where the child or young person needs to be admitted urgently and accordingly waiting for a bed to become available on a unit for persons aged under 18 is not considered to be an acceptable option. An 'emergency situation' should be a rare and unusual case. It is not unusual for children or young people to require unplanned admissions and accordingly local policies should be in place to ensure that such admissions are to age appropriate environments.

Once the initial emergency situation is over, facility directors should ensure that action is taken to transfer the child or young person to more appropriate accommodation. In determining whether the environment is suitable beyond the initial crisis, in addition to the appropriateness of the mental healthcare that can be provided on the adult ward, the facility directors would need to consider issues such as whether the child or young person can mix with individuals of their own age, can receive visitors of all ages, and has access to education.

An atypical case describes a situation where those arranging a young person's admission conclude that the best option for that young person is to be admitted to an adult ward. While likely to be rare, such cases may arise from time to time when a young mother requires admission for post-natal depression, and admission to an adult mother and baby unit would allow the young mother to remain with her child.

Where, whether owing to an emergency or because the admission is an atypical case, it is considered appropriate for the child or young person to be admitted to an adult ward, it will still be necessary to ensure that appropriate steps have been taken to safeguard the young person. Discrete accommodation in an adult ward, with staffing appropriate to the needs of that young person, might provide the most satisfactory solution; for example, young female patients should be placed in single sex accommodation.

Where the placement of a child or young person on a children and young persons unit might have detrimental effect on the other children and young people, facility directors need to ensure that the interests of other patients are protected. However, the needs of other children and young people should not override the need to provide accommodation in an environment that is suitable for the patient's age (subject to their needs) for an individual patient aged under 18. This means that the detrimental impact on other young patients is not an acceptable reason for transferring a child or young person to an adult ward.

Children and young people aged under 18 should also have access to age-appropriate leisure activities and space for visits from parents, guardians, siblings, or carers.

Under 18s involuntary admission in a place of safety

The process for identifying the most appropriate place of safety to which a particular person is to be removed should be clearly outlined in the local place of safety policy. This applies to children and young people as much as adults. Unless there are specific arrangements in place, the healthcare setting identified by local policies as the place of safety should be used, and the fact that this is attached to an adult ward should not preclude its use for this purpose. In addition, the policies should make clear that a person under 18 should not be removed to a police station as a place of safety unless there are exceptional circumstances, and clear reasons (which should be recorded according to the local policy and shared with relevant local authority children's services).

The MHC

Children and young people who are admitted under the Act have the same rights as other patients to apply to the MHC. It is important that children and young people are informed of their right to apply to the MHC and are assisted in obtaining legal representation at an early stage.

At least one member of the MHC panel considering a child or young person's case will have experience of working with under 18s.

After-care

Prior to their discharge from the facility all children and young people should have an assessment of their needs, on which a care plan for their after-care is based, and which should reflect the child or young people educational, health and social care needs.

Examples

The following examples should be read in conjunction with the above text.

Example A:

A 13 year old child is assessed as not being competent. The primary purpose of the intervention is to provide medical treatment for mental disorder. The child has been in hospital before and is happy to return there. However, neither of the parents (both of whom have parental responsibility) consents. Given that it is not possible to rely on the child's consent (the child is not competent) or parental consent (the parents do not consent and no other person has parental responsibility) the child cannot be admitted voluntarily in accordance with the Act. If the child meets the relevant criteria, the child could be admitted to hospital for assessment or for treatment under the Act. If the criteria for involuntary admission under the Act are not met, legal advice should be sought on the need to seek authorization from the court before further action is taken.

Example B:

A 14 year old girl is assessed as not being competent. The primary purpose of the intervention is to provide medical treatment for mental disorder. She is severely anorexic and the proposed treatment is that she is fed by naso-gastric tube. The naso-gastric tube may need to be in place for several weeks in order to restore the child to a safe BMI (body mass index). The care team conclude that as this is a particularly invasive form of treatment and the girl is likely to resist the insertion of the tube, it would not be appropriate to rely on parental consent to authorize this intervention. Accordingly, even though a person with parental responsibility consents, the child is not admitted and treated voluntarily under the Act. If the child meets the relevant criteria, she could be admitted to hospital for assessment. If the criteria for involuntary admission under the

Act are not met, legal advice should be sought on the need to seek authorization from the court before further action is taken.

Example C:

A 15 year old child is assessed as being competent. The primary purpose of the intervention is to provide medical treatment for mental disorder. The child does not consent to treatment in hospital. The child's parents are keen for the child to be admitted to hospital and give their consent. However, it is not considered safe to rely on the parent's consent where a competent child is refusing. Accordingly, the child cannot be admitted voluntarily under the Act as the child is competent to consent but does not do so. If the child meets the relevant criteria, the child could be admitted to hospital for assessment. If the criteria for involuntary admission under the Act are not met, legal advice should be sought on the need to seek authorization from the court before further action is taken.

Example D:

A 16 year old young person is assessed as needing a period of in-patient treatment. He should be presumed to have legal capacity to make decisions. There is no evidence to show that he needs support for facilitated decision-making. The primary purpose of the intervention is to provide medical treatment for mental disorder. The young person consents to admission and treatment in hospital. The young person can be admitted to hospital and treated as a voluntary patient in accordance with the Act.

Chapter 20: People with intellectual disabilities or autistic spectrum disorders

This chapter deals with issues of particular relevance to people with intellectual disabilities, autistic spectrum conditions (autism) or both, including patients who are children or young people. People with intellectual disabilities or autism have the same rights and protections as other people under the Act and this Code.

Intellectual disabilities

For the purposes of the Act, a 'intellectual disability' is defined as 'a state of arrested or incomplete development of mind of a person which includes significant impairment of intelligence and social functioning and abnormally aggressive or seriously irresponsible conduct on the part of the person'.

The vast majority of people with intellectual disability or autism will never come into contact with the Act. Intellectual disability and autism both cover a wide spectrum of people with diverse needs and other possible co-morbidities and evidence-based good practice is that most of their needs can best be met at home or in community settings.

The identification of an individual with an intellectual disability is a matter for clinical judgment, guided by current professional practice. It is important to assess the person holistically, as well as to consider their behaviour in light of the person’s current and past circumstances. Where an intellectual disability is identified, further issues have to be considered:

- how reasonable adjustments would benefit the person with intellectual disabilities, and
- how to ensure the inclusion and promotion of the person’s human rights adds to the wellbeing of the person.

Abnormally aggressive or seriously irresponsible behaviour

A person with a intellectual disability can only be considered for admission under the Act, where the intellectual disability is associated with a co-morbid condition of such a severity to meet the threshold for mental disorder (e.g. when the person has abnormally aggressive behaviour, and/or seriously irresponsible conduct).

This means that, for the purposes of those provisions, which include applications for involuntary admission for treatment, a person should not be considered to be suffering from a mental disorder solely because they have a intellectual disability: the disability should be associated with a co-morbid condition of such a severity to meet the threshold for mental disorder.

Neither term is defined in the Act, and it is not possible to define exactly what kind of behaviour would fall into either category. Inevitably, it will depend on the nature of the behaviour and the circumstances in which it is exhibited.

It is important to establish whether a person’s intellectual disability is associated with conduct that could be categorized as abnormally aggressive, not simply aggressive. Relevant factors when assessing this include:

- when such aggressive behaviour has been observed, and how persistent and severe it has been
- whether it has occurred without a specific trigger or seemed disproportionate to the circumstances that triggered it
- whether, and to what degree, it has resulted in harm or distress to other people, or actual damage to property
- how likely it is to recur, and
- how common similar behaviour is in the population generally.

Similarly, in assessing whether a person’s intellectual disability is associated with conduct that is not only irresponsible but seriously irresponsible, relevant factors may include:

- whether behaviour has been observed that suggests a disregard or an inadequate regard for its serious or dangerous consequences
- how recently such behaviour has been observed and, when it has been observed, how persistent it has been
- how seriously detrimental to the individual, or to other people, the consequences of the behaviour were or might have been
- whether, and to what degree, the behaviour has actually resulted in harm to the person or the person’s interests, or in harm to other people or to damage to property, and
- how likely it is to recur.

Bizarre or unusual behaviour is not the same as abnormally aggressive or seriously irresponsible behaviour.

When assessing whether a person with a intellectual disability should be involuntarily admitted for treatment under the Act, it is important to establish whether any abnormally aggressive or seriously irresponsible behaviour identified stems from difficulties in communication or an underlying condition or syndrome or unmet need. Challenging behaviour may be due to an unmet support need, unmet social or emotional need, or an unmet physical health need (including untreated pain), rather than to a mental disorder. This area is often referred to as functional assessment. Challenging behaviour due to these factors should be addressed by addressing the underlying condition or unmet need.

Unless very urgent action is required, it would not be good practice to diagnose a person as having a intellectual disability associated with co-morbid mental disorder without an assessment by a consultant psychiatrist in intellectual disabilities and a formal specialist psychological assessment. This should be part of a holistic appraisal by medical, nursing, social work, speech and language and occupational therapy and psychology clinicians with experience in intellectual disabilities, in consultation with a relative, advocate or supporter of the person. A practitioner who assesses someone with a intellectual disability under the Act should have training and experience in working with people with intellectual disabilities.

Recent reviews of serious cases have shown that people’s life experiences and life stories are important in helping to understand some aggressive behaviour. People with intellectual disabilities experience disproportionate harassment, ‘hate crime’ and ‘mate crime’, and they are disproportionately the victims of violence. These are all factors that may make aggressive behaviour sometimes a learned protective behaviour rather than a sign of a mental disorder.
Professionals should record on the relevant form their reasons for concluding that the individual’s conduct is abnormally aggressive or seriously irresponsible, and why it relates to the person’s intellectual disability and is not attributable to others factors such as an unmet physical health, social or emotional need.

For children or young people aged under the age of 18 (and for many people up until the age of 25), the fact that they are at an age where they are intellectual to manage their emotions should be taken into consideration. Children and young people with and without intellectual disabilities often experience and express their emotions more strongly than other people, and they need support to understand what might be happening to them.

In any case, if the person has the decision-making ability to make decisions about treatment, treatment can be given only with this person’s consent.

Autistic spectrum conditions

Autistic spectrum conditions (autism) have been defined as a lifelong developmental disability that affects the way a person communicates with, and relates to, other people. It also affects how they make sense of the world around them. It is a spectrum condition meaning each individual will have different needs.

The Act’s definition of mental disorder does not include autistic spectrum conditions.
Compulsory treatment in a hospital setting is rarely likely to be helpful for a person with autism, who may be very distressed by even minor changes in routine and is likely to find admission in

hospital anxiety provoking. Sensitive, person-centred support in a familiar setting will usually be more helpful. Wherever possible, less restrictive alternative ways of providing the treatment or supporting a person should be found. The specialist expertise and skills of staff should be regularly audited, particularly the ability to recognize social and health needs, and specialist communication skills.

Autistic spectrum conditions are disorders occurring from early stages in development where a person shows marked difficulties with social communication, social interaction and social imagination. They may be preoccupied with a particular subject of interest. This spectrum includes high functioning people who need person-centred care as well as those with little or no verbal communication.

Autism is developmental in nature and is not a mental illness. People with autism may have additional or related problems, which frequently include anxiety. These may be related to social factors associated with frustration or communication problems or rigid or literal patterns of thought and behaviour. As with people with intellectual disabilities, people with autism may also have co-morbid mental disorders, including mood disorders and, occasionally, personality disorders and this should be kept in mind.

A person with autism may have additional sensory and motor difficulties, which make them behave in an unusual manner which might be interpreted as a mental illness but are, in fact, a coping mechanism. These include sensitivity to light, sound, touch and balance and may result in a range of regulatory behaviours, including rocking, self-injury and avoidance, such as running away.

A person with autism is likely to behave in ways that seem odd to other people. Mere eccentricity, in anyone, does not however justify the use of the Act.

There can also be a repetitive or compulsive element to much of the behaviour of people with autism. The person may appear to be choosing to act in a particular way, but their behaviour may be distressing even to themselves. It may be driven or made worse by anxiety and could lead to harm to self or others. Repetitive behaviour does not in itself constitute a mental disorder.

A person with autism may show a marked difference between their intellectual and their emotional development. Their behaviour may occasionally seem aggressive or seriously irresponsible. They may be able to discuss an act intellectually and express a desire to do or not do it, but they may not have the instinctive social empathy to keep to their intentions. This should be understood and responded to by professionals, who should recognize that specialist structured approaches to communication may be required. When a person is unable to prevent themselves from causing severe harm to themselves or others, compulsory measures under the Act may be needed.

If people with autism do need to be admitted under the Act, it is important that they are treated in a setting appropriate to their social and communication needs as well as being able to treat their mental condition. Practitioners working with or detaining people with autism should have relevant specialist training and experience.

People with autism should be admitted for as short a period as possible. Many people with autism who have been admitted will require, and be entitled to, after-care. Discharge planning for people with autism should begin when the person is admitted and involve health and local authorities to work together in the interests of an individual to ensure appropriate community-based support is in place before discharge. This will require assessment by a practitioner with expertise in autism, as set out by the statutory adult autism guidance.

Further considerations

In addition to the above information for individuals with a intellectual disability or autism the following should be taken into consideration where a person with intellectual disabilities or autism who is admitted under the Act has a physical illness or condition which is unrelated to their mental disorder for which they need treatment (eg cancer treatment or pregnancy), an assessment should take place to define whether they have the decision-making ability to give consent to that treatment. If the person has the decision-making ability to make decisions about treatment, treatment can be given only with this person's consent.

A person with a intellectual disability or autism cannot be involuntarily admitted if they can consent to or refuse that admission and treatment.

If a person with a intellectual disability or autism is admitted under the Act, a comprehensive assessment of their needs should be undertaken to ensure that reasonable adjustments are made. As well as the following points, reasonable adjustments relate to many other areas of the Code, such as access to the MHC and information giving. Reasonable adjustments should include:

- communication support
- information in an accessible format. This could include, for example, easy read leaflets or simple videos, although this does not replace the need for clear and simple verbal explanation by professionals
- sufficient time for the person and any others supporting them for preparation before meetings
- accessible information explaining rights and how to raise safeguarding concerns or complaints
- treatment goals and support plans in an accessible format
- adapted treatment programmes including psychological therapies
- adapted therapeutic environment
- ensuring that meetings are held in an environment which is not intimidating risk assessment of personal safety (due to increased vulnerability), and prioritized access to and involvement of carers and/or advocates, unless the individual had indicated that they do not want this.

The examination or assessment of someone with intellectual disabilities or autism requires special consideration of how to communicate effectively with the person being assessed. Carers will often be able to assist clinicians with this and should be consulted where appropriate. Whenever possible the people carrying out assessments should have experience and training in working with people with intellectual disabilities or autism. If this is not possible they should seek assistance from specialists with appropriate expertise, but this should not be allowed to delay action that is immediately necessary. Assessment should ideally be part of a complete appraisal – a multi-disciplinary process involving medical, nursing, social work, occupational therapy, speech and language therapy and psychology professionals (as necessary) with relevant specialist experience.

In addition, the following should be taken into consideration:

- where some people with intellectual disabilities or autism find it difficult to manage ‘queuing’ at meal times, a hospital or assessment or treatment centre should make different arrangements for meal times in a hospital or assessment and treatment setting where social activities are provided on a ‘first come first served’ basis, positive action should be used to enable people with reduced ability or confidence due to their intellectual disability or autism, to access these activities in an institutional setting where aggressive behaviour can occur, institutions should take extra steps to protect those who are vulnerable staff should be aware, and if a patient with a intellectual disability or autism is being harassed or victimized by other people using the service, and carefully considered ‘adjustments’ to the care regime may be needed to prevent this, and
- if it can reasonably be foreseen that restrictive interventions may need to be used, the patient’s individualized care and treatment plan should include primary preventative strategies, secondary preventative strategies and tertiary strategies including the types of restrictive interventions that may be used. People with intellectual disabilities need individualized care and support plans to be carefully targeted to their understanding, their needs and their history and to be assisted to understand when restrictive interventions may be used and for what purpose.

Practice considerations

An application under Chapters 13 and 14 of the Act to involuntarily admit a person with an intellectual disability or autism cannot be made unless the criteria in these Chapters are met. Intellectual disabilities and autism share few features with the serious mental illnesses that are the most common reason for using the Act, and so consideration should be given to whether admission of a person with intellectual disability or autism is appropriate. Behaviour may be due to an underlying condition, syndrome or unmet need and may not be best treated in hospital. Facilities are not homes, and most support for people with a intellectual disability or autism should be provided in a local community setting. The following practice considerations should also be kept in mind:

- Consideration should be given to whether there are alternative means of providing the care and treatment which the patient requires before it is decided that admission to hospital is necessary. Alternatives to admission under the Act should always be considered.
- Detaining a person with intellectual disabilities or autism under the Act because there is no treatment available for them in the community is not a substitute for appropriate commissioning of care.
- The purpose of treatment under the Act is to alleviate or prevent a worsening of the mental disorder or its symptoms. A person’s underlying intellectual disability or autism cannot be ‘treated’.

Risks relating to people with intellectual disabilities or autism

All those involved in examining, assessing, treating or taking other decisions in relation to people with intellectual disabilities or autism should bear particular risks in mind in relation to people with intellectual disabilities or autism including:

- incorrect assumptions that they do not have decision-making ability to make decisions for themselves and a tendency to be over-protective.

- incorrect assumptions that a tendency to acquiesce is the same as informed consent
- in providing relevant information about the person’s past, or about effective communication methods
- over-reliance on carers, both for support and for decision-making. The considerable expertise of carers should be acknowledged, and appropriately used in partnership with the clinical team. This should not mean that clinicians rely on carers to take decisions inappropriately and on their own on behalf of the person
- a lack of appreciation of the potential abilities of people with intellectual disabilities or autism, including their potential to make decisions for themselves
- the risk the person may be denied access to decision-making processes, meetings about them or information
- the person’s limited life experiences to draw on when making choices, and
- attributing the person’s symptoms and behaviours to their intellectual disability or autism rather than underlying undiagnosed and/or unmet physical or mental health needs or to something traumatic that happened to them in their past.

Those working under the Act with people with intellectual disabilities or autism should bear in mind the following general points:

- practitioners require to assist people to make decisions for themselves where possible;
- the need to respect a decision by a person who has decision-making ability which may be seen as unwise; and to offer care that is the least restrictive of people’s rights.
- people with intellectual disabilities or some autistic spectrum conditions may use non-verbal communication rather than spoken language. This non-verbal communication may include behaviour, gestures, posture and body language, ways of moving, signing, noises and pointing. It is important to recognize people’s communication in all its forms and to avoid assuming that people’s behaviour is a symptom of a mental disorder, when it may be their way to communicate feelings or physical pain or discomfort
- people with intellectual disabilities or autism may find new environments, such as a medical setting, frightening. All ‘reasonable adjustments’ need to be made to adapt and respond to each individual’s needs. This may mean offering a quiet space, for example, or having a key worker with specialist training or a communication book.
- the least restrictive way of achieving the proposed assessment or treatment should be identified and for people with intellectual disabilities or autism, this means they should usually be treated in the community. Inappropriate care in a hospital can lead to a worsening of challenging behaviour, which can cause a negative cycle of feelings of frustration leading to challenging behaviour and increased restriction of liberty. The most appropriate method of communication for each person with intellectual disabilities or autism should be identified as soon as possible, and the help of a speech and language therapist should be sought wherever appropriate. It is helpful to identify a specific person who will undertake this task
- some people with intellectual disabilities or autism may prefer to have written material in simple language with images or symbols to assist, or in pictures without written words, and this could be reinforced orally. It can be helpful to repeat information and leave a record of the information that has been shared so that the person can consult it later and ask others to clarify anything that is difficult to understand
- it is important to set aside sufficient time for preparation of suitable information and for preparation before meetings. Meetings should be held in an environment which is not intimidating in order to allow the person every chance to understand the information given,

and individualized care and support plans may help people with intellectual disabilities or autism.

The role of providers

It is good practice for facilities providing treatment and care for people with intellectual disabilities or autism to have policies and practices which specifically address:

- staff training and supervision in how to effectively communicate with people with intellectual disabilities or autism, particularly in understanding their wishes and feelings
- specialist staff who create communication books for individual in-patients and who teach how to develop personalized care for people who have intellectual disabilities or autism
- training of staff to ensure sufficient awareness and knowledge of intellectual disability, autism, behaviour that challenges, and mental health, and training in positive behavioural support
- training in the safe and effective management of commonly associated physical health conditions, such as epilepsy
- ensuring physical health needs are met (eg annual health check and associated action plan)
- reasonable adjustments and capable environments, and
- regular audits of incidents involving restrictive practices to see whether less restrictive methods could be used.

Providers should ensure that their care and treatment of people with intellectual disabilities or autism is compliant with the law. People with intellectual disabilities and their families and carers should be helped to access information and (if necessary) legal advice on how to access the MHC and the Courts.

Promoting human rights such as the right to private life, may mean reviewing policies on: access to the person’s sleeping area; mobile phones, visits from family and friends; and how to maintain family life (eg through contact with family members, such as sharing meals and celebrations, and performing roles such as being parents or grandchildren). The person’s right to liberty should also be protected by developing and applying the least restrictive option and maximizing independent principle in care and treatment regimes.

Providers cannot assume that people with intellectual disabilities or autism necessarily understand how to access information and advice about their rights, for example in relation to consent to admission and treatment, applications for discharge and accommodation decisions on discharge. Providers should take such steps as are practicable to ensure people with intellectual disabilities or autism can access information and advice. Facility directors should ensure that those responsible for explaining the way the Act works and their rights to people who are subject to the Act, are adequately trained in understanding the Act.

Seeking advice from specialists and carers

Where information relates to the right of the individual to have their case reviewed by the MHC, adjustments may need to be made to ensure people with intellectual disabilities or autism understand MHC’s role. An individual (and carers supporting them) may well need support to make an informed decision about whether and when and how to make an application.

Where professionals taking decisions under the Act have limited expertise in promoting the rights of people with intellectual disabilities or autism, it is good practice to seek advice from a specialist or specialist service (perhaps within the local authority or a voluntary organization), which can suggest alternatives to using the Act and give advice on decision-making ability issues and on communication.

Where appropriate, it is desirable that someone who knows the person with a intellectual disability or autism is present at an initial examination and assessment, provided that this does not breach the person's confidentiality. Knowledge of the person's early developmental history, usual pattern of behaviour, communication needs and any particular needs will help prevent someone with a intellectual disability or autism wrongly being made subject to the Act or treated inappropriately.

The potential of co-morbidity with personality disorder should also be kept in mind so professionals with appropriate expertise can be involved in the person's assessment, treatment and care. The possibility of physical health problems underlying the presentation of abnormally aggressive or seriously irresponsible behaviour should always be kept in mind, including the impact of inadequately treated epilepsy or side effects of medication.

For children and young people under the age of 18, a children and adolescent mental health services consultant with relevant experience of intellectual disability or autism should be involved.

Chapter 21: People with personality disorders

The Act applies equally to all people with mental disorders, including those with either primary or secondary diagnosis of personality disorder. This chapter is particularly helpful for professionals and practitioners working with people with personality disorders. Guidance is given on assessment and appropriate medical treatment.

Personality disorders – general points

Generally, people who have personality disorders present a complex range of mental health and other problems:

- many people may have a diagnosis of more than one personality disorder, and they may also have other mental health problems such as depression, anxiety or post-traumatic stress syndrome
- suicidality, self-harm, substance misuse problems and eating disorders are also common in people with personality disorders
- some individuals experience very severe, periodic emotional distress in response to stressful circumstances and crisis, particularly people with borderline personality disorder
- some individuals can at times display a form of psychosis that is qualitatively different from that displayed by people with a diagnosis of mental illness
- people with personality disorders usually have long-standing and recurrent relationship difficulties
- people with personality disorders are more likely than other population groups to experience housing problems and long-term unemployment

- a very small subgroup of people with personality disorder may be anti-social and dangerous, and/or
- anti-social personality disorder is strongly associated with offending, and it is estimated that personality disorders have a high prevalence within offender populations.

Personality disorders and mental health legislation

People with personality disorders who are subject to compulsory measures under the Act may include individuals who:

- have a primary diagnosis of personality disorder
- have complex mental disorders, including personality disorder
- have primary diagnoses of personality disorder or complex disorders including personality disorder

Practice considerations

<u>Assessment</u>

People with personality disorders may present and behave in very different ways from those with other mental disorders. It is important that such behaviours and presentations are properly understood if the Act is to be used appropriately.

Especially in times of crisis, decisions about the use of the Act for people with personality disorders will often have to be made by professionals who are not specialists in the field. It is therefore important that doctors carrying out initial assessments have a sufficient understanding of personality disorder as well as other forms of mental disorder.

Individuals who have historically been labeled by various local agencies as having a personality disorder may never, in fact, have had a thorough clinical assessment and formulation. A number of validated assessment tools enable a more precise identification to be made. Professionals will need to ensure that any treatment and after-care plans are shaped by appropriate clinical assessments conducted by suitably trained practitioners.

In emergency or very high-risk situations, where such an assessment has not already been carried out and an application for involuntary admission under the Act is being considered, the first priority is responding to the immediate risk to the health or safety of the patient or to other people. Achieving an appropriate clinical assessment and formulation should be an immediate aim of involuntary admission.

<u>Appropriate medical treatment</u>

What constitutes appropriate medical treatment for a particular patient with personality disorder will depend on their individual circumstances. First and foremost that calls for a clinical judgment by the clinicians responsible for their assessment or treatment.

A proposed care plan will not meet the Act's definition of appropriate medical treatment unless it is for the purpose of alleviating or preventing a worsening of the patient's mental disorder, its symptoms or manifestations.

Generally, treatment approaches for personality disorder need to be relatively intense and long-term, structured and coherent. Sustainable long-term change is more likely to be achieved with the voluntary engagement of the patient.

People with personality disorders may take time to engage and develop motivation for such longer-term treatment. But even patients who are not engaged in that kind of treatment may need other forms of treatment, including nurse and specialist, to manage the continuing risks posed by their disorders, and this may constitute appropriate medical treatment.

In the majority of cases the primary model of intervention for personality disorder is rooted in a psycho-social model.

In deciding whether treatment under the Act can safely be delivered, account should be taken of:

- where the specific model of treatment intervention can be most effectively and safely delivered
- if management of personal and social relationships is a factor in the intervention, how the appropriate day-to-day support and monitoring for the patient's social as well as psychological needs can be provided
- to what degree the psycho-social model of intervention requires the active participation of the patient for an effective and safe outcome
- the degree to which the patient has the ability to take part in a psycho-social intervention that protects their own and others' safety
- the degree to which 24-hour access to support will be required, and the need for the intervention plan to be supervised by a professional who is appropriately qualified in the model of intervention and in risk assessment and management in the community.

Chapter 22: Patients concerned with criminal proceedings

This chapter provides guidance on the use of the Act for people who come into contact with the criminal justice system.

Psychiatric Assessment

People who are subject to criminal proceedings have the same rights to psychiatric assessment and treatment as everyone else. Any person who is in prison or police custody or before the courts charged with a criminal offence and who is in need of medical treatment for mental disorder is entitled to receive the required treatment. Wherever possible, alternatives to custody for vulnerable individuals should be considered taking into account all information about the persons health needs.

Wherever possible, people who appear to police custody officers or the court to have a mental disorder should have their assessment and/or treatment needs being considered at the earliest possible opportunity. Vulnerable people may be at greatest risk of self-harm while in custody.

Prompt access to specialist treatment may prevent significant deterioration in their condition and is likely to assist in a speedier justice process, helping to avoid longer-term harm.

Article 96 facilities

Article 96 facilities aim to identify and assess individuals of all ages who have mental health problems, intellectual disabilities and other needs, such as autistic disorder, when they come into contact with the youth and adult justice systems and help support the most appropriate criminal justice system outcome. Article 96 facilities ensure youth and adult justice practitioners are notified of specific health requirements and vulnerabilities of an individual which can be taken into account when decisions about charging and sentencing are made. Article 96 services will aim to identify these individuals as early as possible after they come into contact with the police and criminal justice system. For many people, contact with criminal justice agencies will be the first time they will have been assessed and diagnosed.

Article 96 facilities should ensure that prompt medical assessment of defendants is provided to assist in the speedy completion of the trial process, meeting individual needs and fulfilling the rights of the person and the most suitable disposal for the offender.

A doctor who is asked to provide evidence in relation to Article 97 should bear in mind that the request is for a general report on the defendant’s condition.

Doctors should identify themselves to the person being assessed, explain who has requested the report and make clear the limits of confidentiality in relation to the report. They should explain that any information disclosed, and the medical opinion, could be relevant not only to medical disposal by the court but also to the imposition of a punitive sentence, or to its length, and request relevant pre-sentence reports, the inmate medical record and previous psychiatric reports, as well as relevant documentation regarding the alleged offence. If any of this information is not available, the doctor’s report should say so clearly.

The doctor should, identify and access other independent sources of information about the person’s previous history (including convictions). This should include information on previous psychiatric treatment and patterns of behaviour.

Mental health treatment requirement

Article 96 facilities can provide only short-term admission and treatment services (up to 7 days) based on medical evidence that the person needs treatment, to individual with mental disabilities who become involved with the criminal justice. Mental health treatment services are required to be administered under the direction of a psychiatrist.

Assessments

A patient who is remanded to hospital for a report is entitled to have in accordance with article 98 of the Act their condition assessed in accordance with internationally accepted medical standards and the internationally recognized violence risk assessment instrument HCR-20, and their decision-making ability assessed in accordance with the provisions stipulated in Article 25-33 of the Act. Patients can obtain, at their own expense, or where applicable through legal aid, an independent report on their mental condition from a doctor or other clinician of their choosing, for the purpose of applying to court for the termination of the remand. Facility directors should help in the exercise of this right by enabling the patient to contact a suitably qualified and experienced lawyers or other legal adviser.

Reports to the court

Clinical opinion is particularly important in helping courts to determine the sentence to be passed. Clinicians providing their assessment should have had experience (forensic) in working with mentally disordered offenders.

A medical report for the court should set out:

- the material on which the report is based
- how that material relates to the opinion given
- where relevant, how the opinion may relate to any other trial issue
- factors relating to the presence of mental disorder that may affect the risk that the patient poses to themselves or to others.

Reports should not include an assessment of the patient's fitness to plead nor speculate about guilt or innocence. In any case, patients should always be given the opportunity to actively participate in the hearings and have a lawyer who performs adequately and is paid by the state (where the patient cannot afford one).

Recommendations on disposal

The court is required to obtain a medical report before passing a custodial sentence other than one fixed by law. Before passing such a sentence, the court should consider any information before it which relates to the offender's mental condition and the likely effect of such a sentence on that condition and on any treatment which may be available for it.

It may, therefore, be appropriate to include recommendations on the disposal of the case. In making recommendations for disposal the doctor should consider the longer-term, as well as immediate, consequences. Factors to be taken into account include whether, the offender should initially be admitted to hospital.

Consideration of longer-term implications is especially important where the court considers the offender to be dangerous under the Criminal Procedure Code. The medical reports especially with respect to the offender's level of responsibility for the offence, will form an important element in the court's consideration.

A prison healthcare centre is not a facility within the meaning of the Act.

Transporting patients

Patients transported between courts or prison are the responsibility of the prison sending the patient unless other arrangements negotiated. In certain circumstances (eg an emergency situation) police officers may be required to transport the patient. All agencies involved in the transportation of patients should be mindful of the need to implement reasonable adjustments in arrangements to cater for the individual needs of the patient.

A child or young person should be transferred under local escort and bed watch policies. They should be transported in ‘usual transport’ (eg a car) unless in an emergency or otherwise agreed when an ambulance should be used.

It may be necessary for patients to be subject to mechanical restraint for the purposes of ensuring a safe transfer.

Transport to and from court

For patients remanded to police stations or to hospital, responsible for transporting the defendant from the court to the receiving hospital or the local police department are police officers of the local police department.

When a patient has been admitted to a hospital on remand, it is the responsibility of the local police department to return the patient to court as required. Where needed, the hospital will be responsible for providing a suitable escort for the patient when travelling from the hospital to the court and should plan for the provision of appropriately qualified staff to do this taking into account the age of the patient and any disability. If possible, and having regard to the needs of the patient, medical or nursing staff should remain with the patient on court premises, even though legal accountability while the patient is admitted for hearings, remains with the court.

Treatment

Article 101 of the Act stipulates the following four basic principles concerning the treatment of forensic patients:

1) When forensic patients lack decision-making ability to make mental health care decisions, their treatment without consent shall be justified on the same basis with civil patients who lack decision-making ability to make decisions about their treatment.
2) When forensic patients lack decision-making ability to consent to treatment, involuntary treatment shall be authorized. If they regain decision-making ability, treatment may continue only with their consent.
3) In the case of those found unfit to stand trial, who cannot be sent to prison, their involuntary treatment shall be lawful even if they retained decision-making ability, on the following conditions: they have been shown, on reliable evidence, to have committed the acts or omissions necessary to constitute a serious offence; they have a mental disorder that contributed significantly to that conduct, and an effective treatment can be offered that could reasonably be expected to reduce the risk of recurrence.
4) Serious criminal offenders who were found to lack decision-making ability to consent to treatment shall receive involuntary treatment. If they regain decision-making ability and refuse treatment, however, they shall continue their sentence without mental health care. At the end of their sentence, if decision-making ability was not regained, their involuntary treatment shall continue as civil patients.

Children and young people

It is recognized that the treatment of children and young people under the Act should be provided by specialist professionals; be appropriate for their age and clinical need and be planned and implemented effectively with minimum delay and disruption.

Medical assessment

Medical assessments in the case of a defendant under the age of 18, should be undertaken by a professional with current clinical expertise, including specialist knowledge of child and adolescent mental health services. If this is not possible, professionals with the appropriate expertise and experience, including defendants under the age of 18 and those with an intellectual disability should be consulted. A mental health assessment should be undertaken within three days of admission to a custodial setting.

Guidance on assessing the competence (of children under the age of 16) and the decision-making ability (of young people aged 16 or 17) to make decisions about their admission treatment is provided in Chapter V of the Act and Chapter 19 of this Code.

Chapter 23: The appropriate medical treatment test

This chapter provides guidance on the application of the appropriate medical treatment test and the criteria for admission under the Act. It includes guidance on appropriate treatment for people with dementia.

Purpose of treatment for mental disorder

For the purposes of the Act, treatment includes nursing, psychosocial intervention, occupational therapy services and specialist mental health habilitation, rehabilitation (including habilitation) and care. For the purposes of the Act Emergency Treatment is not considered as treatment. Habilitation means equipping someone with skills and abilities they have never had, whereas rehabilitation means helping them recover skills and abilities they have lost.

In the Act, treatment means medical treatment which is for the purpose of safeguarding, ameliorating the condition, restoring health or relieving suffering, and improving the social dimension of a person’s life.

Symptoms and manifestations include the way a disorder is experienced by the individual concerned and the way in which the disorder manifests itself in the person’s thoughts, emotions, communication, behaviour and actions. It should be remembered that not every thought or emotion or every aspect of the behaviour, of a patient suffering from mental disorder will be a manifestation of that disorder.

Even if particular mental disorders are likely to persist or get worse despite treatment, there may well be a range of interventions which would represent appropriate medical treatment. It should never be assumed that any disorders, or any patients, are inherently or inevitably untreatable. Nor should it be assumed that likely difficulties in achieving long-term and sustainable change in a person’s underlying disorder make medical treatment to help manage their condition and the behaviours arising from it either inappropriate or unnecessary.

Appropriate medical treatment test

The Act requires appropriate medical treatment to be available to a patient in order to meet the criteria for admission under the Act. Where the appropriate medical treatment test forms part of the criteria for admission, the medical treatment in question is treatment for mental disorder in the facility in which the patient is to be admitted of administered the treatment.

The appropriate medical treatment test should be applied to ensure that no one is admitted (or remains admitted) for treatment, unless medical treatment for their mental disorder is both appropriate and available.

In order to be deemed appropriate, medical treatment should be for the purpose of safeguarding, ameliorating the condition, restoring health or relieving suffering, and improving the social dimension of a person's life. It should also be appropriate, having taken account of the nature and degree of the patient's mental disorder and all their particular circumstances, including cultural, ethnic and religious or belief considerations.

The appropriate medical treatment test requires a judgment about whether an appropriate treatment or package of treatment for mental disorder is available for the individual in question. It is not consistent with the least 'restrictive option and maximizing independence' and 'purpose and effectiveness' guiding principles' to detain someone for treatment that is not actually available or may not become available until some future point in time.

Applying the appropriate medical treatment test

The test requires a balanced and holistic judgment as to whether, medical treatment available to the patient is appropriate, given:

- the nature and degree of the patient's mental disorder, and
- all the other circumstances of the patient's case. In other words, both the clinical appropriateness of the treatment and its appropriateness more generally should be considered.

The other circumstances of a patient's case might, for example, include factors such as:

- the patient's physical health – how this might impact on the effectiveness of the available medical treatment for the patient's mental disorder and the impact that the treatment might have in return
- the patient's age
- any physical disabilities or sensory impairments the patient has
- the patient's culture and ethnicity
- the patient's gender
- the patient's religion or beliefs
- the location of the available treatment
- the implications of the treatment for the patient's family and social relationships, including their role as a parent (where applicable)
- its implications for the patient's education or work

- the consequences for the patient, and other people, if the patient does not receive the treatment available (for mentally disordered offenders about to be sentenced for an offence, the consequence will sometimes be a prison sentence), and
- the patient's views and wishes about what treatment works for them and what doesn't.

Medical treatment should always be an appropriate response to the patient's condition and situation and indeed wherever possible should be the most appropriate treatment available. It may be that a single medical treatment does not address every aspect of a patient's mental disorder.

Medical treatment should actually be available to the patient. It is not sufficient that appropriate treatment could theoretically be provided.

What is appropriate will vary greatly between patients. It will depend, in part, on what might reasonably be expected to be achieved given the nature and degree of the patient's disorder.

Medical treatment which aims merely to prevent a disorder worsening is unlikely, in general, to be appropriate in cases where normal treatment approaches would aim (and be expected) to alleviate the patient's condition significantly. However, for some patients with persistent and severe mental disorders, management of the undesirable effects of their disorder may be the most that can realistically be hoped for.

Appropriate medical treatment does not have to involve medication or psychological therapy – although it very often will. There may be patients whose particular circumstances mean that treatment may be appropriate even though it consists only of nursing and specialist day-to-day care under the clinical supervision of an approved clinician in a safe therapeutic environment with a structured regime.

Simply detaining someone, even in a hospital, does not constitute medical treatment.

A patient's attitude towards the proposed treatment may be relevant in determining whether the appropriate medical treatment test is met. An indication of unwillingness to co-operate with treatment generally, or with a specific aspect of treatment, does not make such treatment inappropriate.

In particular, psychosocial services and other forms of medical treatments which, to be effective, require the patient's co-operation are not automatically inappropriate simply because a patient does not currently wish to engage with them. Such treatments can potentially remain appropriate and available as long as it continues to be clinically suitable to offer them and they would be provided if the patient agreed to engage.

In determining whether the appropriate medical treatment test is met, those making the judgment should satisfy themselves that appropriate medical treatment is available for the time being, given the patient's condition and circumstances as they are currently understood. Determinations are time specific and may need to be reconsidered as the patient's condition changes or clinicians obtain a greater understanding of the patient's case.

Patients with dementia

Generally, treatment approaches for dementia differ according to the type of dementia the person has. People with dementia may take time to engage and develop motivation for treatment. People with dementia can benefit from approaches that do not involve drugs, eg reminiscence therapy or cognitive stimulation therapy. People with dementia may experience depression or anxiety and it may be appropriate to offer them antidepressant drugs and/or offered talking therapies.

Some people with dementia may display challenging behaviour because they are distressed, confused or in pain. The use of sedation or antipsychotic medication may not be appropriate in these circumstances and alternative intervention or treatment could be deemed more appropriate.

Chapter 24: Medical treatment

This chapter gives guidance on medical treatment for mental disorder under the Act, especially treatment given without patients' consent. It also gives guidance on promoting good physical healthcare for patients subject to the Act. The Act regulates treatment of voluntary, involuntary and non-protesting patients.

Definitions

In the Act, treatment means an intervention (physical or psychological) on a person that, taking into account the person's social dimension, may include measures required for the purposes of safeguarding, ameliorating the condition, restoring health or relieving suffering, and improving the social dimension of a person's life, such as medications, occupational therapy services, psychosocial services, rehabilitation services; ECT; and ancillary tests and treatment. For the purposes of the Act Emergency Treatment is not considered as treatment;

This includes treatment of physical health problems only to the extent that such treatment is part of, or ancillary to, treatment for mental disorder (eg treating wounds self-inflicted as a result of mental disorder). Otherwise, the Act does not regulate medical treatment for physical health problems.

Appropriate treatment

All treatment provided should be appropriate to the patient's mental health condition and take account of any advance decisions made by the person and any wishes or feelings they have expressed in advance of treatment. The practicalities of how the treatment is to be delivered, and how outcomes will be monitored should be considered.

Where reasonably practicable, treatment should be based on a strong evidence-base. Professionals should ensure that any treatment is compliant with the current WHO guidelines for treatment of mental and neurological disorders.

In the case of medications that are used to treat mental disorder, particular care is required when prescribing medications that exceed the maximum dosage or where multiple medications are used to treat a patient.

Treatments to which special rules and procedures apply

The Act prohibits ECT and psychosurgery to children and young people.

Decision-making ability and consent

The Act frequently requires healthcare professionals to determine:

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

The rules for answering these questions are the same as for any other patients.

Decision-making ability to consent: people aged 16 or over

<u>People aged 16 or over:</u>

- should be assumed to have decision-making ability unless it is established that they need support for facilitated decision-making
- are not to be treated as unable to make a decision unless all practicable steps to help them do so have been taken without success
- are not to be treated as unable to make a decision merely because they make an unwise decision.

When taking decisions about patients under the Act, it should be remembered that:

- mental disorder does not necessarily mean that a patient lacks decision-making ability to give or refuse consent, or to take any other decision
- any assessment of an individual's decision-making ability has to be made in relation to the particular decision being made – a person may, for example, have the decision-making ability to consent to or refuse one form of treatment but not to another decision-making ability in an individual with a mental disorder can vary over time and should be assessed at the time the decision in question needs to be taken where a patient's decision-making ability fluctuates in this way, consideration should be given, if a decision is not urgently required, to delaying the decision until the patient has decision-making ability again to make it for themselves not everyone is equally capable of understanding the same explanation –explanations should be appropriate to the level of the patient's assessed ability, and all assessments of an individual's decision-making ability should be fully recorded in the patient's notes.

Competence to consent to treatment – children under 16

Children who have sufficient understanding and intelligence to fully to understand what is involved in a proposed treatment are considered to be competent to consent to it. Further information on assessing a child's competence to make treatment decisions is provided above in Chapter 19.

Consent

In accordance with the definition provided in Article 5 of the Act Consent is the consent obtained freely, without threat, or incentives, and after appropriate disclosure to the person of sufficient information in a manner and language understood by the person on diagnosis, purpose, method, duration, expected benefits, and side effects of prescribed treatment as well as alternative treatment methods. Informed consent can be given only by persons who have the decision-making ability to give consent to the treatment proposed;

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

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

Patients should be invited to ask questions and professionals should answer fully, frankly and truthfully. If a patient asks about a risk, they should always be given an honest answer. There may sometimes be a compelling reason for not disclosing certain information. A professional who chooses not to disclose information should be prepared to justify the decision. A professional who chooses not to answer a patient’s question should make this clear to the patient so that the patient knows where they stand. A record should be kept of any decision not to disclose information, and the reasons for that decision.

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

Treatment without consent – general points

On admission, the patient’s consent should be sought before any medication is administered, wherever practicable. The patient’s consent or refusal to consent should be recorded in the case notes. If a person has decision-making ability to consent, but such consent is not forthcoming or is withdrawn during this period, the clinician in charge of the treatment should consider carefully whether to proceed in the absence of consent, to give alternative treatment or stop treatment.

Clinicians authorizing or administering treatment without consent under the Act are performing a function of a public nature and should therefore comply with certain rights and freedoms guaranteed to patients under international conventions and treaties to which Afghanistan is a signatory.

In particular, the following should be noted:

- compulsory administration of treatment which would otherwise require consent is invariably an infringement of patient's human rights unless it is proportionate to a legitimate aim (i.e. the improvement of their health)
- compulsory treatment is capable of being inhuman treatment (or in extreme cases even torture), if its effect on the person concerned reaches a sufficient level of severity and it is not convincingly shown to be of medical necessity from the point of view of established principles of medicine.
- Scrupulous adherence to the requirements of the legislation and good clinical practice should ensure that there is no such incompatibility. If clinicians have concerns about a potential breach of a person's human rights they should seek legal advice.

Treatment plans

Treatment plans are essential for patients being treated for mental disorder under the Act. A treatment plan should include a description of the immediate and long-term goals for the patient and should give a clear indication of the treatments proposed and the methods of treatment.

The treatment plan should form part of a coherent care plan, and be recorded in the patient's notes.

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

Wherever possible, the whole treatment plan should be discussed with the patient. Patients should be encouraged and assisted to make use of advocacy support, if it they want it. Where patients cannot (or do not wish to) participate in discussion about their treatment plan, any views they have expressed previously should be taken into consideration.

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

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

For children and young people, subject to the normal considerations of patient confidentiality, the plan should similarly be discussed with the people who have parental responsibility for them. Treatment plans should be regularly reviewed and the results of reviews recorded in the patient's notes.

Promoting good physical health for adults, children and young people

Providers should ensure that patients with a mental disorder receive physical healthcare that is equivalent to that received by people without a mental disorder. The physical needs of patients should be assessed routinely alongside their psychological needs. Providers need to ensure that long term physical health conditions are not undiagnosed or untreated, and that patients receive regular oral health and sensory assessments and, as required, referral.

Patients admitted under the Act are at particular risk of co-morbidities. Directors should build into their procurement outcomes the requirement for physical health checks, physical healthcare planning and reporting arrangements that include evidence that physical health issues have been routinely considered for every individual patient. Providers should deliver services that consider and address the physical health needs of their population. This would include practices in place to routinely screen for and provide interventions for high risk health conditions such as heart disease and diabetes and attention to care planning that had a focus on reducing common risk factors (e.g. smoking, poor diet and physical inactivity).

Good nutrition and access to dietary advice is essential for healthy outcomes. Providers should ensure that they are compliant with current requirements on food, diet and nutrition. Every provider should have a food and drink strategy that covers the nutrition and hydration needs of patients.

Patients should have their nutritional state assessed on admission and at regular intervals thereafter, using an accredited screening tool. Providers should offer food and drink that meets the needs of all their patients (e.g. high density food for frail and underweight patients, and healthier food for those whose needs are more akin to the general population). Where necessary, support should be given to patients who need help to eat, or who wish to take action to improve their diet.

Providers should ensure that all patients have sufficient opportunities to undertake sufficient physical and other meaningful activity to support their physical and mental health.

Chapter 25: Treatments subject to special rules and procedures

This chapter gives guidance on the special rules and procedures in the Act for certain types of medical treatment for mental disorder, such as ECT.

Clinician in charge of treatment

This chapter frequently refers to the ‘clinician in charge of treatment’. This means the clinician in charge of the particular treatment in question for a patient, who need not be the same as the responsible clinician who is in charge of a patient’s case overall.

In any such case these clinicians in charge of treatment should:

- seek to understand the patient’s views on the proposed treatment, and the reasons for them. This includes involving an advocate, carers or making any reasonable adjustments, as appropriate
- give due weight to the patient’s views, including any objection to the proposed treatment and any preference for an alternative
- consider the appropriateness of alternative forms of treatment, not just that proposed
- balance the potential therapeutic efficacy of the proposed treatment against the side effects and any other potential disadvantages to the patient;
- take into account any previous experience of comparable treatment for a similar episode of disorder, and
- give due weight to the opinions, knowledge, experience and skills of those consulted.

Clinicians in charge of treatment should provide written reasons in support of their decisions to approve specific treatments for patients. Clinicians in charge of treatment do not have to give an exhaustive explanation, but should provide their reasons for what they consider to be the substantive points on which they made their clinical judgment, and why they believe that it is an appropriate treatment in the circumstances.

Original signed certificates should be kept with the documents which authorize the patient’s involuntary admission and copies should be kept in the patient’s notes. As a matter of good practice, a copy of the certificate relating to medication should be kept with the patient’s medicine chart (if there is one) to minimize the risk of the patient being given treatment in contravention of the provisions of the Act.

Chapter 26: Safe and therapeutic responses to disturbed behaviour

A safe and therapeutic culture should be provided for all people receiving treatment for a mental disorder including those who may present with behavioural disturbance.

Restrictive intervention reduction programmes

Providers who treat people who are liable to present with behavioural disturbances should focus primarily on providing a positive and therapeutic culture. This culture should aim at preventing behavioural disturbances, early recognition, and de-escalation.

Providers should have governance arrangements in place that enable them to demonstrate that they have taken all reasonable steps to prevent the misuse and misapplication of restrictive interventions. When restrictive interventions are unavoidable, providers should have a robust approach to ensuring that they are used in the safest possible manner. All mental health providers therefore should have in place a regularly reviewed and updated restrictive intervention reduction programme.

Restrictive intervention reduction programmes are overarching, multi-component action plans which aim to reduce the use of restrictive interventions. They should demonstrate organizational commitment to restrictive intervention reduction at a senior level, how the use of data relating to restrictive interventions will inform service developments, continuing professional development for staff, how models of service which are known to be effective in reducing restrictive interventions are embedded into care pathways, how service users are engaged in service planning and evaluation and how lessons are learned following the use of restrictive interventions. They should ensure accountability for continual improvements in service quality through the delivery of positive and proactive care. They should also include improvement goals and identify who is responsible for progressing the different parts of the plan. A key indicator that a plan is being delivered well will be a reduction in the use of restrictive interventions. Other indicators include reduction of injuries as a result of restrictive interventions, improved patient satisfaction and reduced complaints.

Provider policies

Restrictive interventions may be required in health and social care settings. When they are required, they should be planned, evidence based, lawful, proportionate and dignified. In order to ensure that this is the case, each provider should have one or more policies that guide the day-to-day operation of services (‘provider policies’), which should include guidance on:

- assessments of risks and support needs
- the use of positive behaviour support plans (or equivalent)
- how the risks associated with restrictive interventions can be minimized; in particular, an assessment of their potential to cause harm to the physical, emotional and psychological wellbeing of patients and how providers will take account of a patient’s individual vulnerabilities to harm (such as unique needs associated with physical/emotional immaturity, older age, disability, poor physical health, pregnancy, past history of traumatic abuse etc)
- how restrictive interventions which are used by the provider, should be authorized, initiated, applied, reviewed and discontinued, as well as how the patient should be supported throughout the duration of the application of the restrictive intervention
- local recording and reporting mechanisms around the use of restrictive interventions
- post-incident analysis/debrief, and
- workforce development, including training requirements relating to the application of restrictive interventions, which are underpinned by their therapeutic intent.

Individualized assessments

People suffering from a mental disorder should, on admission to hospital, be assessed for immediate and potential risks of behavioural disturbance. Staff should be alert to risks that may not be immediately apparent, such as self-neglect. Assessments should take account of the person’s history of such behaviours, their history of experiencing personal trauma, their presenting mental and physical state and their current social circumstances.

While previous history is an important factor in assessing current risk, staff should not assume that a previous history of behavioural disturbance means that a person will necessarily behave in the same way in the future.

Care should be taken to ensure that negative and stigmatizing judgments about certain diagnoses, behaviours or personal characteristics do not obscure a rigorous assessment of the degree of risk which may be presented, or the potential benefits of appropriate treatment to people who are assessed as liable to present with behavioural disturbance. Providers should consider the accuracy of assessments of risks as part of routine audit arrangements and put training in place to learn from any inappropriate risk judgments.

Assessments of behavioural presentation are important in understanding an individual's needs. These should take account of the individual's social and physical environment and the broader context against which behavioural disturbance occurs. There may be times where an individual feels angry for reasons not associated with their mental disorder and this may be expressed as behavioural disturbance. Assessments should seek to understand behaviour in its broader context and not presume it to be a manifestation of a mental disorder.

Assessments should consider the views of patients and their families and carers about why an individual might be behaving in a particular way, including any historical accounts of behaviour and possible reasons for that behaviour. This is particularly important because they can provide useful insights regarding individual responses to behavioural that have been tried in the past.

The results of the assessment should guide the development and implementation of effective, personalized and enduring systems of support that meet an individual's needs, promote recovery and enhance quality of life outcomes for the individual and others who care and support them.

When concluded, assessments should describe behaviours of concern, identify factors which predict their occurrence, and describe the functions that behaviours serve or the outcomes they achieve for the individual. These assessments should inform the patient's care plan and/or positive behaviour support plans (or equivalent).

- Factors which may contribute to behavioural disturbance and which should be considered within assessments include:
- poorly treated symptoms of mental disorder
- unmet social, emotional or health needs
- excessive stimulation, noise and general disruption
- excessive heating, overcrowding and restricted access to external space
- boredom, lack of constructive things to do, insufficient environmental stimulation
- lack of clear communication by staff with patients
- the excessive or unreasonable application of demands and rules
- lack of positive social interaction
- restricted or unpredictable access to preferred items and activities
- patients feeling that others (whether staff, friends and/or families) are not
- concerned with their subjective anxieties and concerns
- exposure to situations that mirror past traumatic experiences
- a sense of personal disempowerment
- emotional distress, e.g. following bereavement
- frustrations associated with being in a restricted and controlling environment
- antagonism, aggression or provocation on the part of others
- inconsistent care
- difficulties with communication
- the influence of drugs
- a state of confusion, and
- physical illness.

Primary, secondary and tertiary strategies

Staff should ensure that patients who are assessed as being liable to present with behavioural disturbance have a care or treatment plan which includes primary preventative strategies, secondary preventative strategies and tertiary strategies. In some services such a care or treatment plan is referred to as a positive behaviour support plan. These individualized care plans, should be available and kept up to date, and include the following elements:

primary preventative strategies aim to enhance a patient's quality of life and meet their unique needs, thereby reducing the likelihood of behavioural disturbances.

secondary preventative strategies focus on recognition of early signs of impending behavioural disturbance and how to respond to them in order to encourage the patient to be calm (including on de-escalation), and

tertiary strategies guide the responses of staff and carers when there is a behavioural disturbance. Responses should be individualized and wide ranging, if appropriate, possibly including continued attempts to de-escalate the situation, summoning assistance, removing sources of environmental stress or removing potential targets for aggression from the area. Where it can reasonably be predicted on the basis of risk assessment, that the use of restrictive interventions may be a necessary and proportionate response to behavioural disturbance, there should be clear instruction on their pre-planned use. Instructions should ensure that any proposed restrictive interventions are used in such a way as to minimize distress and risk of harm to the patient.

Patients and their families should be as fully involved as possible in developing and reviewing positive behaviour support plans (or equivalents). The preparation of positive behaviour support plans (or equivalents) also provides an important opportunity to record the wishes and preferences of families and carers and the involvement they may wish to have in the management of behavioural disturbances. For example, on occasion, family members may wish to be notified if the patient is becoming anxious and to contribute to efforts to de-escalate the situation by speaking to the individual on the phone. People should consent to the involvement of families if they have decision-making ability to give or refuse such consent.

Positive behaviour support plans (or equivalent) should take account of disabilities, a patient's level of cognitive functioning, the impact of age in terms of physiological and emotional maturity, the patient's ethnicity, culture, religion, and gender. They should maximize privacy and dignity.

Primary preventative strategies

Behavioural disturbance can be minimized by promoting a supportive and therapeutic culture within the care environment. Primary preventative strategies should typically include the following, depending on the individual's assessed needs:

A: The care environment:

providing predictable access to preferred items and activities

avoiding excessive levels of environmental stimulation
organizing environments to provide for different needs, for example, recreation rooms, single-sex areas and access to open spaces and fresh air
giving each patient a defined personal space and a safe place to keep their possessions
ensuring an appropriate number and mix of staff to meet the needs of the patient population
ensuring that reasonable adjustments can be made to the care environment to support people whose needs are not routinely catered for, for example, sensory impairments, and
avoiding demands associated with compliance with service-based routines and adherence to ‘blanket rules’.

B: Engaging with individuals and their families:

- ensuring that individuals are able to meet visitors safely in private and convivial environments, as well as to maintain private communication by telephone, post and electronic media, respecting the wishes of patients and their visitors
- engaging individuals, supporting them to make choices about their care and treatment and keeping them fully informed, and communicating in a manner that ensures the individual can understand what is happening and why.
- involving individuals in the identification of their own trigger factors and early warning signs of behavioural disturbance and in how staff should respond to them.
- engaging individuals in all aspects of care and support planning.
- ensuring that meetings to discuss an individual’s care occur in a format, location and at a time of day that promotes engagement of patients, families, carers and advocates.
- with the individual’s consent (if they have the decision-making ability to give or refuse such consent), involving their relative, family, carers, and others who know them and their preferences in all aspects of care and treatment planning, and
- promptly informing patients, families, and carers of any significant developments in relation to the individual’s care and treatment, wherever practicable and subject to the patient’s wishes and confidentiality issues.

C: Care and support:

- opportunity for individuals to be involved in decisions about an activity and therapy programme that is relevant to their identified needs, including evening and weekend activities
- delivering individualized patient-centred care which takes account of each person’s unique circumstances, their background, priorities, aspirations and preferences
- supporting individuals to develop or learn new skills and abilities by which to better meet their own needs
- developing a therapeutic relationship between each patient and care workers, including a named key worker or nurse identified as the patient’s primary contact at the service
- providing training for staff in the management of behavioural disturbance, including alternatives to restrictive interventions, desirable staff attitudes and values, and training in the implementation of models of care including positive behavioural support plans
- ensuring that individuals’ complaints procedures are accessible and available and that concerns are dealt with quickly and fairly
- ensuring that physical and mental health needs are holistically assessed and that the person is supported to access the appropriate treatments, and

- developing alternative coping strategies in response to known predictors of behavioural disturbance.
- People who are identified as being at risk of presenting with behavioural disturbance should be given the opportunity to have their wishes and feelings recorded in an advance statement, if they have the decision-making ability to do so.
- Whilst some psychological treatments or programmes may impose restrictions on normal day-to-day activities, such restrictions should not be imposed across the service, or be used to punish or humiliate. This means that service providers should avoid blanket restrictions that apply to all patients; interventions should always be individualized, and subject to discussion and review by the whole clinical team. The individual's consent to the intervention should always be sought where the individual has decision-making ability to consent or refuse the intervention, even if a refusal may be overridden (e.g. because it is part of the compulsory treatment the individual may be given under the Act).
- Access to leave, food and drink, fresh air, shelter, warmth, a comfortable environment, exercise, confidentiality or reasonable privacy should never be restricted or used as a 'reward' or 'privil..e' dependant on 'desired' behaviours.
- Provider policies should encourage patients to avoid staying in their bedrooms for prolonged periods during the daytime. Therapeutic interventions and a range of engaging activities should be available and people should not be locked out of their bedrooms in an attempt to restrict their freedom of movement.

Secondary preventative strategies

De-escalation is a secondary preventative strategy. It involves the gradual resolution of a potentially violent or aggressive situation where an individual begins to show signs of agitation and/or arousal that may indicate an impending episode of behavioural disturbance.

De-escalation strategies promote relaxation, eg through the use of verbal and physical expressions of empathy and alliance. They should be tailored to individual needs and should typically involve establishing rapport and the need for mutual co-operation, demonstrating compassion, negotiating realistic options, asking open questions, demonstrating concern and attentiveness, using empathic and non-judgmental listening, distracting, redirecting the individual into alternate pleasurable activities, removing sources of excessive environmental stimulation and being sensitive to non-verbal communication.

Staff should liaise with individuals and those who know them well, and take into account clinical assessments, to identify individualized de-escalation approaches which should be recorded as secondary preventative strategies in the individual's positive behaviour support plan (or equivalent). In some instances it may be feasible for families to contribute to de-escalation approaches.

Staff should ensure that they do not exacerbate behavioural disturbance, eg by dismissing genuine concerns or failing to act as agreed in response to requests, or through the individual experiencing unreasonable or repeated delays in having their needs met. Where such failures are unavoidable, every effort should be made to explain the circumstances of the failure to the individual and to involve them in any plans to redress the failure.

Enhanced observation

Staff should know the location of all patients for whom they are responsible in a facility ward or service. It is not necessary to routinely keep patients who are not considered to present a serious risk of harm to themselves or others within sight.

Research suggests that most attempted suicides are discovered and prevented by staff checking on patients, particularly in the more private areas of wards. For individuals assessed as being at risk of suicide or serious self-harm, a significant preventive mechanism is for nursing staff to be caringly vigilant and inquisitive. For such individuals, staff should have a thorough knowledge of the patient and have a clear plan in relation to monitoring and supervision. Unusual circumstances and noises should be investigated.

There may be times when enhanced levels of observation are required for the short-term management of behavioural disturbance or during periods of distress to prevent suicide or serious self-harm. Enhanced observation is a therapeutic intervention with the aim of reducing the factors which contribute to increased risk and promoting recovery. It should focus on engaging the person therapeutically and enabling them to address their difficulties constructively (e.g. through sitting, chatting, encouraging/supporting people to participate in activities, to relax, to talk about any concerns etc).

Enhanced observation may be provided on an intermittent basis with staff engaging with patients and observing their condition at irregular and unpredictable intervals of between 15 and 30 minutes. High use of intermittent observation on wards has been shown to be associated with low levels of self-harm and has been shown to be tolerated by most patients.

Alternatively enhanced observation may be provided on a continuous basis with the individual remaining either within eyesight of staff or, for the most serious degrees of risk, within arm's length. Continuous observation should be carried out when intermittent observation is seen as insufficient to safely manage risks.

Provider policies should cover the use of enhanced observation and include:

- which staff (profession and grade) are best placed to carry out enhanced observation and under what circumstances it might be appropriate to delegate this duty to another member of the team
- how the selection of a staff member to undertake enhanced observation should take account of the individual's characteristics and circumstances (including factors such age and gender)
- how enhanced observation can be undertaken in a way which minimizes the likelihood of individuals perceiving the intervention to be coercive, and
- how observation can be carried out in a way that respects the individual's privacy as far as practicable and minimizes any distress. In particular, provider policies should outline how an individual's dignity can be maximized without compromising safety when individuals are in a state of undress, such as when using the toilet, bathing, showering, dressing etc.

Staff should balance the potentially distressing effect on the individual of increased levels of observation, particularly if these are proposed for many hours or days, against the identified risk of self-injury or behavioural disturbance. Levels of observation and risk should be regularly reviewed and a record made of decisions agreed in relation to increasing or decreasing the observation.

Restrictive interventions

Restrictive interventions are deliberate acts on the part of other person(s) that restrict a patient's movement, liberty and/or freedom to act independently in order to:
- take immediate control of a dangerous situation where there is a real possibility of harm to the person or others if no action is undertaken, and
- end or reduce significantly the danger to the patient or others.

Restrictive interventions should not be used to punish or for the sole intention of inflicting pain, suffering or humiliation.
Where a person restricts a patient's movement, or uses (or threatens to use) force then that should:
- be used for no longer than necessary to prevent harm to the person or to others
- be a proportionate response to that harm, and
- be the least restrictive option.

Where risk assessments identify that restrictive interventions may be needed, their implementation should be planned in advance and recorded as tertiary strategies within the positive behaviour support plans (or equivalent).

On other occasions, behavioural disturbance may not have been predicted by risk assessments. In such cases emergency management of the situation and the use of restrictive interventions should be based on clinical judgment which take account of relevant best practice.

The most common reasons for needing to consider the use of restrictive interventions are:
- physical assault by the patient
- dangerous, threatening or destructive behaviour
- self-harm or risk of physical injury by accident
- extreme and prolonged over-activity that is likely to lead to physical exhaustion.

Restrictive interventions should be used in a way that minimizes any risk to the patient's health and safety and that causes the minimum interference to their autonomy, privacy and dignity, while being sufficient to protect the patient and other people. The patient's freedom should be contained or limited for no longer than is necessary. Unless there are cogent reasons for doing so, staff should not cause deliberate pain to a patient in an attempt to force compliance with their instructions (for example, to mitigate an immediate risk to life).

The choice and nature of restrictive intervention will depend on various factors, but should be guided by:
- the patient's wishes and feelings, if known (eg by an advance statement)
- what is necessary to meet the needs of the individual based on a current assessment and their history
- the patient's age and any individual physical or emotional vulnerabilities that increase the risk of trauma arising from specific forms of restrictive intervention

- whether a particular form of restrictive intervention would be likely to cause distress, humiliation or fear
- obligations to others affected by the behavioural disturbance
- responsibilities to protect other patients, visitors and staff, and
- the availability of resources in the environment of care.

Where an individual has a history of abuse, restrictive interventions of any nature can trigger responses to previous traumatic experiences. Responses may be extreme and may include symptoms such as flashbacks, hallucinations, dissociation, aggression, self-injury and depression. Where patients have an identified history of trauma it will be particularly useful to obtain their recorded wishes about restrictive interventions. Patients' preferences in terms of the gender of staff carrying out such interventions should be sought and respected. Health staff should be alert to the risk of any respiratory or cardiac distress and continue to monitor the patient's physical and psychological wellbeing.

Respecting human rights

Services and their staff should help all patients to understand the legal authority for any proposed action and their rights.

No restrictive intervention should be used unless it is medically necessary to do so in all the circumstances of the case. Action that is not medically necessary may well breach a patient's right to be free from inhuman or degrading treatment.

Restrictions that alone, or in combination, deprive a patient of their liberty without lawful authority.

Examples of restrictions that could indicate there is a deprivation of liberty include:
- voluntary capacitated patients being prevented from leaving a facility
- voluntary capacitated patients being told that they will be involuntarily admitted under the Act if they do not comply with requests of staff, or
- voluntary capacitated patients being kept in circumstances amounting to seclusion without their consent.

(the list of examples is not exhaustive).

Children and young people under 18

In accordance with Article 91 of the act children under the age of 16 should never be mechanically restrained or secluded

In the case of young people, the use of restrictive interventions may require modification to take account of their developmental status.

Service providers should ensure that staff involved in the care of children and young people who exhibit behavioural disturbance are able to employ a variety of skills and strategies that enable them to provide appropriate help and support. In most cases restrictive interventions will only be used if they form part of the positive behaviour support plan (or equivalent) and have therefore been developed with input from the child or young person and their family.

Staff should always ensure that restrictive interventions are used only after having due regard to the individual’s age and having taken full account of their physical, emotional and psychological maturity.

When antipsychotic medication is used to sedate a child or young person, special consideration should be given to risks relating to their developing central nervous system, especially when the medication is given to children or adolescents who do not have a diagnosed psychosis.

Article 92(8) of the Act stipulates that mechanical restraint and/or seclusion must never be imposed onto minors below 16 years of age.

The size and physical vulnerability of young people aged 16-17 should be taken into account when considering mechanical restraint. Mechanical restraint should be used with caution when it involves young people because in most cases their musculoskeletal systems are immature which elevates the risk of injury.

Seclusion can be a traumatic experience for any individual but can have particularly adverse implications for the emotional development of a young person. This should be taken into consideration in any decision to seclude a young person (seclusion of children under the age of 16 is prohibited). Careful assessment of the potential effects of seclusion by a trained child and adolescent clinician is required, especially for those adolescents with histories of trauma and abuse, where other strategies to de-escalate behaviours may be more appropriate than the use of seclusion.

In children and young people’s services where ‘time-out’ processes are used, provider policies should differentiate between time-out and seclusion. Time-out is a specific behaviour change strategy which should be delivered as part of a behavioural programme. Time-out might include: preventing a young person from being involved in activities which reinforce a behaviour of concern until the behaviour stops; asking them to leave an activity and return when they feel ready to be involved and stop the behaviour; or accompanying the young person to another setting and preventing them from engaging in the activity they were participating in for a set period of time. If time-out processes have the features of seclusion, this should be treated as seclusion and comply with the requirements of the Code.

Staff having care of children and young people should be aware that they may do ‘what is reasonable in all the circumstances of the case for the purpose of safeguarding or promoting the child’s welfare’. Whether an intervention is reasonable or not will depend, among other things, upon the urgency and gravity of what is required. This might allow action to be taken to prevent a child from harming him/herself, however it would not allow restrictive interventions that are not proportionate.

Procedures for the safe use of restrictive interventions

Facility policies concerning the use of restrictive interventions and their implementation should be kept under ongoing review in order to ensure consistency with current national policy, best practice guidance and evidence. Restrictive interventions should never be employed to deliberately punish or humiliate, and staff should not cause deliberate pain to a person in an attempt to force compliance with their instructions except in the most exceptional circumstances to mitigate an immediate risk to life.

Any initial attempt to manage an acute behavioural disturbance should, as far as the situation allows, be non-restrictive. For example, assistance might be sought using an emergency alarm system or by verbally summoning assistance. A single member of staff should assume control of the incident. Where possible, the patient should be asked to stop the behaviour. An individual's communication needs should be taken into account including those arising from sensory impairments, intellectual disability, autism spectrum disorders. Where possible, an explanation should be given of the consequences of refusing the request from staff to stop the behaviour. The explanation should be provided calmly and every attempt should be made to avoid the explanation being perceived by the patient as a threat.

The nature and manner of application of any restrictive intervention, the reason(s) for its use and the consequences or outcome, should be recorded in an open and transparent manner.

Staff should only use methods of restrictive interventions for which they have received training. Training records should record precisely the techniques for which a member of staff has received training.

Verbal de-escalation should continue throughout a restrictive intervention. Negotiations should focus on establishing rapport, demonstrating concern, helping the patient to relax, and reducing the patient's level of agitation.

Whenever restrictive interventions are being used, provider's policies should make provision for the timely attendance of a doctor in response to staff requests concerning a psychiatric emergency whether in relation to medication, restraint or seclusion.

Where a behavioural disturbance occurs and a restrictive intervention has been used, family members should be informed.

Physical restraint

Physical restraint refers to any direct physical contact where the intention is to prevent, restrict, or subdue movement of the body (or part of the body) of another person.

Patients should not be deliberately restrained in a way that impacts on their airway, breathing or circulation. The mouth and/or nose should never be covered and there should be no pressure to the neck region, rib cage and/or abdomen. Unless there are cogent reasons for doing so, there should be no planned or intentional restraint of a person in a prone position (whereby they are forcibly laid on their front) on any surface, not just the floor.

Full account should be taken of the individual's age, physical and emotional maturity, health status, cognitive functioning and any disability or sensory impairment, which may confer additional risks to the individual's health, safety and wellbeing in the face of exposure to physical restraint. Throughout any period of physical restraint:

- a member of staff should monitor the individual's airway and physical condition to minimize the potential of harm or injury. Observations, including vital clinical indicators such as pulse,

respiration and complexion (with special attention for pallor/discoloration), should be conducted and recorded. Staff should be trained so that they are competent to interpret these vital signs
- emergency resuscitation devices should be readily available in the area where restraint is taking place, and
- a member of staff should take the lead in caring for other patients and moving them away from the area of disturbance.

Where physical restraint has been used, staff should record the decision and the reasons for it, including details about how the intervention was implemented and the patient's response.

Provider policies concerning the use of physical restraint should be kept under ongoing review in order to ensure consistency with national policy and best practice.

Mechanical restraint

Mechanical restraint is a form of restrictive intervention that refers to the use of a device to prevent, restrict or subdue movement of a person's body, or part of the body, for the primary purpose of behavioural control.

Mechanical restraint should only be used exceptionally, where other forms of restriction cannot be safely employed. It should be used in line with the principle of least restrictive option and should not be an unplanned response to an emergency situation. Mechanical restraint should never be used instead of adequate staffing.

The use of mechanical restraint should be approved following multi-disciplinary consultation. The nature of the multi-disciplinary team should be defined in a provider's policies. Provision for the use of mechanical restraint should be recorded as a tertiary strategy in the positive behaviour support plan (or equivalent). This plan should detail the circumstances which might warrant mechanical restraint, the type of device to be applied, how continued attempts should be made to de-escalate the situation and any special measures that are required to reduce the likelihood of physical or emotional trauma resulting.

Where the agreed provisions for the use of mechanical restraint in positive behaviour support plans (or equivalent) allow a nurse or other professional to authorize the actual use of mechanical restraint, then that professional should notify, without delay, the responsible clinician or duty doctor (or equivalent).

Staff applying mechanical restraint devices should have appropriate training in their application and use.

The individual should be reviewed by a nurse every fifteen minutes for the duration of the period of mechanical restraint.

The individual should have a medical review by a registered medical practitioner at least one hour after the beginning of mechanical restraint. Subsequently there should be ongoing medical reviews at least every four hours by a registered medical practitioner. Local policies should determine which of their registered medical practitioners should undertake medical reviews.

Reviews should be undertaken more frequently if requested by nursing staff. Reviews should ensure that the individual is as comfortable as possible and should include a full evaluation of the patient's physical and mental health condition.

Procedures should be in place to enable nursing staff to summon a doctor to conduct a medical review ahead of the next scheduled review if they have concerns about the patient's condition.

The patient's clinical record should provide details of the rationale for the decision to mechanically restrain them, the medical and psychiatric assessment, the patient's condition at the beginning of mechanical restraint, the response to mechanical restraint and the outcomes of the medical reviews.

Mechanical restraint which involves tying an individual to some part of a building or its fixtures, as well as police handcuffs, metal chains, net- and cage-beds, locking devices, rope or cord, rubber bands and sheets, should never be used.

If, exceptionally, a belt (or similar device) is applied to an individual's body to secure their arms or wrists and the resulting degree of immobility prevents their ability to leave an area (such as where they are unable to reach or operate door handles), this will amount to either seclusion or long-term segregation. The individual should be afforded safeguards regarding associated observation and monitoring, review procedures and care plans to ensure that their privacy and dignity are preserved. Such devices should never be used as an alternative to (or in addition to) seclusion because a suitable safe environment in which to undertake seclusion is not available.

There may be circumstances where mechanical restraint devices need to be used on a long-term basis (maximum 24 hours), such as to limit self-injurious frequent and intense behaviour. This will be rare and encountered with small numbers of patients who have severe cognitive impairments, where devices such as arm splints or cushioned helmets may be required to safeguard an individual from the hazardous consequences of their behaviour. In such cases, tertiary strategies within positive behaviour support plans (or equivalent) should aim to provide brief recurrent periods when restraints can be removed. The positive behaviour support plan (or equivalent) may also allow for less frequent medical and nursing reviews provided that the whole clinical team, the patient's family, carers and advocates are in agreement.

Mechanical restraint must never be imposed onto minors below 16 years of age.

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Patients subject to the Ministry of Justice

There may be occasions when the use of mechanical restraint (including police handcuffs) is required for security purposes when transferring prisoners or suspects. Guidance for prison and health staff to develop local procedures for the safe management of patients subject to the Ministry of Justice during transfer needs to be developed.

The use of mechanical restraint in these circumstances should be informed by an assessment of the risks posed by the patient, as well as their presenting physical and mental condition and the need to maximize their dignity.

Rapid tranquillization

Rapid tranquillization refers to the use of medication to calm or lightly sedate an individual to reduce the risk of harm to self or others and to reduce agitation and aggression. This may provide an important opportunity for a thorough psychiatric examination to take place. Prescribers should aim to ensure that the degree of sedation arising from rapid tranquillization does not compromise the person's decision-making ability to understand and respond to what is said to them.
Rapid tranquillization may also be used to manage acute behavioural disturbance, though this should be a very short-term strategy designed solely to reduce immediate risk and is distinct from treating any underlying mental illness.

Rapid tranquillization should only be used where a patient is highly aroused, agitated, overactive and aggressive, or is making serious threats or gestures towards others, or is being destructive to their surroundings, when other therapeutic interventions have failed to contain the behaviour.

Rapid tranquillization includes the use of both intra-muscular injections and oral medication. Oral medication should always be considered before any injections.

Rapid tranquillization should be prescribed in accordance with evidence-based practice guidelines.

Staff prescribing rapid tranquillization should note any physical observations and monitoring needed following administration and make that clear to staff caring for the patient.

Where a prescription indicates a choice of administration routes for rapid tranquillization (eg oral or intramuscular injection), the person prescribing the medication should list factors which should be considered in deciding which route to use under any reasonably foreseeable circumstances.

Where rapid tranquillization in the form of an intramuscular injection is needed, the person prescribing the injection should state the preferred injection site, having taken full account of the need to avoid prone restraint (ie where the person is forcibly laid on their front).

The use of restraint to administer treatment in non-emergency circumstances should be avoided wherever possible, but may sometimes be necessary, especially if an emergency situation would be likely to occur if the treatment were not administered. The decision to use restraint should be discussed first with the clinical team and should be properly documented and justified in the patient's notes.

Following the administration of rapid tranquillization, the patient's condition and progress should be closely monitored. Subsequent records should indicate the reason for the use of rapid tranquillization and provide a full account of both its efficacy and any adverse effects observed or reported by the patient.

Rapid tranquillization should never be used to manage patients as a substitute for adequate staffing.

Seclusion

Seclusion refers to the supervised confinement and isolation of a patient, away from other patients, in an area from which the patient is prevented from leaving, where it is of immediate necessity for the purpose of the containment of severe behavioural disturbance which is likely to cause harm to others.

If a patient is confined in any way that meets the definition above, even if they have agreed to or requested such confinement, they have been secluded and the use of any local or alternative terms (such as ‘therapeutic isolation’) or the conditions of the immediate environment do not change the fact that the patient has been secluded. It is essential that patients are afforded the procedural safeguards of Article 92 of the Act.

Seclusion should only be undertaken in a room that have been specifically designed and designated for the purposes of seclusion and which serves no other function on the ward.

Seclusion should not be used as a punishment or a threat, or because of a shortage of staff. It should not form part of a treatment programme.

Seclusion should never be used solely as a means of managing self-harming behaviour. Where the patient poses a risk of self-harm as well as harm to others, seclusion may be used only when the professionals involved are satisfied that the need to protect other people outweighs any increased risk to the patient’s health or safety arising from their own self-harm and that any such risk can be properly managed.

The following factors should be taken into account in the design of rooms or areas where seclusion is to be carried out:

- the room should allow for communication with the patient when the patient is in the room and the door is locked
- rooms should include limited furnishings which should include a bed, pillow, mattress and blanket or covering
- there should be no apparent safety hazards
- rooms should have robust, reinforced window(s) that provide natural light (where possible the window should be positioned to enable a view outside)
- rooms should have externally controlled lighting, including a main light and subdued lighting for night time
- rooms should have externally controlled heating and/or air conditioning, which enables those observing the patient to monitor the room temperature
- rooms should not have blind spots and alternate viewing panels should be available where required
- a clock should always be visible to the patient from within the room, and
- rooms should have access to toilet and washing facilities.

Provider policies should include detailed guidance on the use of seclusion and should be consistent with the guiding principles of the Code.

The policy should:

- ensure the physical and emotional safety and wellbeing of the patient

- ensure that the patient receives the care and support rendered necessary by their seclusion both during and after it has taken place
- designate a suitable environment that takes account of the patient’s dignity and physical wellbeing
- set out the roles and responsibilities of staff, and
- set requirements for recording, monitoring and reviewing the use of seclusion and any follow-up action.

In order to ensure that seclusion measures have a minimal impact on a patient’s autonomy, seclusion should be applied flexibly and in the least restrictive manner possible, considering the patient’s circumstances.

Commencing seclusion

Staff may decide what a patient can take into the seclusion area. The patient should never be deprived of clothing when in seclusion

The person authorizing seclusion should have seen the patient immediately prior to the commencement of seclusion.

When a patient is placed in seclusion, the start time of the seclusion should be recorded in the seclusion record.

Where seclusion has been authorized by a psychiatrist, whether or not they are the patient’s responsible clinician, the first medical review will be the review that they undertook immediately before authorizing seclusion.

Observation during seclusion

A suitably skilled professional should as a minimum be readily available within sight and sound of the seclusion area at all times throughout the patient’s period of seclusion.

The professional should have the means to summon urgent assistance from other staff at any point.

Consideration should be given to whether a male or female person should carry out ongoing observations; this may be informed by consideration of a patient’s trauma history.

The aim of observation is to safeguard the patient, monitor their condition and behaviour and to identify the earliest time at which seclusion can end.

For patients who have received sedation, a skilled professional will need to be outside the door at all times.

A record of the patient’s behaviour should be made at least every 15 minutes. The record made should include, where applicable: the patient’s appearance, what they are doing and saying, their mood, their level of awareness and any evidence of physical ill health especially with regard to their breathing, pallor or cyanosis.

Where a patient appears to be asleep in seclusion, the person observing the patient should be alert to and assess the level of consciousness and respirations of the patient as appropriate.

Seclusion reviews

A series of review processes should be instigated when a patient is secluded. These include the multi-disciplinary team (MDT), nursing, and medical reviews. All reviews provide an opportunity to determine whether seclusion needs to continue or should be stopped, as well as to review the patient's mental and physical state. Family members should be advised of the outcomes of reviews.

Medical reviews

For the purposes of medical reviews, where the responsible clinician is not immediately available, e.g. outside of normal working hours, local policies should make provision for a 'duty doctor' to deputise for the responsible clinician. The policy should also identify which of their doctors are competent to carry out a medical review.

The first medical review should:

- if seclusion was authorized either by a clinician, who is not a doctor or the professional in charge of the ward, be undertaken by the responsible clinician or duty doctor (or equivalent) within one hour of the commencement of seclusion, or
- if seclusion was authorized by a consultant psychiatrist (whether or not they are the patient's responsible clinician or an approved clinician), be the review that they undertook immediately before seclusion was authorized.

If it is agreed that seclusion needs to continue more than 6 hours (but not exceeding 24 hours) as provided in Article 92 of the Act, a seclusion care plan should be agreed and prepared, which should identify how the patient's presenting and ongoing needs whilst in seclusion can continue to be met.

Subsequent medical reviews should be undertaken by either the responsible clinician, a doctor who is an approved clinician, or a duty doctor.

Continuing four-hourly medical reviews of secluded patients should be carried out until the first (internal) multidisciplinary team meeting has taken place including in the evenings, night time, on weekends and official holidays. A provider's policy may allow different review arrangements to be applied when patients in seclusion are asleep.

Medical reviews provide the opportunity to evaluate and amend seclusion care plans, as appropriate. They should be carried out in person and should include, where appropriate:

- a review of the patient's physical and mental health
- an assessment of adverse effects of medication
- a review of the observations required
- a reassessment of medication prescribed

- an assessment of the risk posed by the patient to others
- an assessment of any risk to the patient from deliberate or accidental self-harm, and
- an assessment of the need for continuing seclusion, and whether it is possible for seclusion measures to be applied more flexibly or in a less restrictive manner.

Nursing reviews

Nursing reviews of the secluded patient should take place at least every two hours following the commencement of seclusion. These should be undertaken by two individuals who are registered nurses, and at least one of whom should not have been involved directly in the decision to seclude.

In the event of concerns regarding the patient’s condition, this should be immediately brought to the attention of the patient’s responsible clinician or duty doctor.
When patients in seclusion are asleep, provider policies may allow reviews to be undertaken in accordance with a revised schedule which should be recorded in the seclusion care plan in order to avoid waking the patient.

Multidisciplinary team reviews

The first internal multidisciplinary team seclusion review should be held as soon as is practicable.
Appropriate membership of the multidisciplinary team review meetings should be determined by provider policies. Membership would likely include the responsible clinician, a doctor who is an approved clinician, or an approved clinician who is not a doctor but who has appropriate expertise, the senior nurse on the ward, and staff from other disciplines who would normally be involved in patient reviews.

At weekends and overnight, membership of the initial multidisciplinary team review may be limited to medical and nursing staff.

Ending seclusion

Seclusion should immediately end when a multidisciplinary team review or a medical review determines it is no longer warranted. Alternatively where the professional in charge of the ward feels that seclusion is no longer warranted, seclusion may end following consultation with the patient’s responsible clinician or duty doctor.

Seclusion ends when a patient is allowed free and unrestricted access to the normal ward environment

Opening a door for toilet and food breaks or medical review does not constitute the end of a period of seclusion.

Further guidance on seclusion

A seclusion care plan should set out how the individual care needs of the patient will be met whilst the patient is in seclusion and record the steps that should be taken in order to bring the need for seclusion to an end as quickly as possible. As a minimum the seclusion care plan should include:

- a statement of clinical needs (including any physical or mental health problems), risks and treatment objectives
- a plan as to how needs are to be met, how de-escalation attempts will continue and how risks will be managed
- details of bedding and clothing to be provided
- details as to how the patient's dietary needs are to be provided for, and
- details of any family or carer contact/communication which will maintained during the period of seclusion

Wherever possible, the patient should be supported to contribute to the seclusion care plan and steps should be taken to ensure that the patient is aware of what they need to do for the seclusion to come to an end. In view of the potentially traumatizing effect of seclusion, care plans should provide details of the support that will be provided when the seclusion comes to an end.

The seclusion record format should be determined by providers' policies on seclusion. Different providers may use different systems, which may be electronic or paper-based (or a combination of both); in any case they should meet recognized professional record keeping standards. The seclusion record should provide the following details:

- who authorized the seclusion
- the date and time of commencement of seclusion
- the reason(s) for seclusion
- what the patient took into the seclusion room
- if and when a family member, carer was informed of the use of seclusion
- 15 minute recordings by the person undertaking continuous direct observation
- details of who undertook scheduled nursing reviews, their assessment, and a record of the patient's condition and recommendations
- details of who undertook scheduled medical reviews, their assessment and a record of the patient's condition and recommendations
- details of who undertook the scheduled multidisciplinary team reviews, their assessment and a record of the patient's condition and recommendations
- the date and time seclusion ended, and
- details of who determined that seclusion should come to an end.

Deprivation of access to normal daytime clothing

Individuals should never be deprived of appropriate clothing with the intention of restricting their freedom of movement, neither should they be deprived of other aids necessary for their daily living.

Following acute behavioural disturbance

Following any episode of acute behavioural disturbance that has led to the use of a restrictive intervention, a post-incident review or debrief should be undertaken so that involved parties, including patients, have appropriate support and there is opportunity for organizational intellectual. It is important that patients are helped to understand what has happened and why. Patients with limited verbal communication skills may need support to participate in the post incident review or de-briefing.

Where a patient is not able to participate in debriefing, methods for assessing the effects of any intervention on their behaviour, emotions and clinical presentation should be fully explored as part of their assessment(s) and recorded in their positive behaviour support plan (or equivalent).

If the patient is able and agrees to discuss the incident which led to the use of a restrictive intervention, their understanding and experience of the incident should be explored. The patient should be given a choice as to who they would like to discuss their experience with, wherever possible. Attempts by staff to simply justify decisions to use a restrictive intervention may be counterproductive; the aim is to use empathic therapeutic relationships to explore what aspects of the intervention helped, didn't help and might be done differently in future.

Patients' accounts of the incident and their feelings, anxieties or concerns following the restrictive intervention should be recorded in their notes. Positive behaviour support plans (or equivalent) should be reviewed and updated as necessary. Patients should be reminded that they can record their future wishes and feelings about which restrictive interventions (or any other aspect of treatment and care that has been raised by the incident) they would or would not like to be used in an advance statement.

If patients wish to formally raise a concern they should be reminded of how to access the local complaints system. Patients should also be made aware of how and where to find an accessible version of the facility policy on restrictive interventions. The hospital's safeguarding lead should be informed whenever a patient raises concerns about restrictive interventions. Patients who need alternative support (eg alternative format, additional explanation) should be offered this support to access and use the complaints procedure.

There should be arrangements to support patients (and others) who have suffered serious assaults in the facility including, where appropriate, the involvement of the police.

Training

All facilities should have a policy on workforce development and training for staff who may be exposed to aggression or violence in their work or who may need to become involved in the application of restrictive interventions. The policy should specify who will receive what level of training (based on training needs analysis) and how often they will be trained. The policy should require training to be delivered during the induction period of new staff members or as soon as is practicably possible.

All staff members who support people who are liable to present with behavioural disturbance should be competent in physical monitoring and emergency resuscitation techniques to ensure the safety of patients following administration of rapid tranquillization and during periods of physical restraint or seclusion.

All clinical staff who undertake training in the recognition, prevention and management of violence and aggression and associated physical restraint should attend periodic refresher or update education and training programmes.

Chapter: 27 Leave of absence

Only the patient's responsible clinician can grant leave of absence to a patient involuntarily admitted under the Act. Responsible clinicians cannot delegate the decision to grant leave of absence to anyone else. In the absence of the usual responsible clinician (eg if they are on leave), permission can be granted only by the approved clinician who is for the time being acting as the patient's responsible clinician.

Responsible clinicians may grant leave for specific occasions or for specific or indefinite periods of time. They may make leave subject to any conditions which they consider necessary in the interests of the patient or for the protection of other people.

Leave of absence can be an important part of an involuntary admitted patient's care plan. When considering and planning leave of absence, responsible clinicians should:

- consider the benefits and any risks to the patient's health and safety of granting or refusing leave
- consider the benefits of granting leave for facilitating the patient's recovery
- balance these benefits against any risks that the leave may pose for the protection of other people (either generally or particular people)
- consider any conditions which should be attached to the leave, eg requiring the patient not to visit particular places or persons
- be aware of any child protection and child welfare issues in granting leave
- take account of the patient's wishes, and those of carers, friends and others who may be involved in any planned leave of absence
- consider what support the patient would require during their leave of absence and whether it can be provided.

Leave should normally be of short duration and not normally more than seven days. Leave for more than seven days may be used to assess a patient's suitability for discharge from involuntary admission

Short-term leave

Patients may be given leave for a shopping trip of two hours every week to a specific destination, with the decision on which particular two hours to be left to the discretion of the responsible nursing staff.

Responsible clinicians should regularly review any short-term leave they authorize on this basis and amend it as necessary.

Recording leave

Facility directors should establish a standardized system by which responsible clinicians can record the leave they authorize and specify the conditions attached to it. Copies of the authorization should be given to the patient and to any carers, professionals and other people in the community who need to know.

The outcome of leave – whether or not it went well, particular problems encountered, concerns raised or benefits achieved – should be recorded in patients' notes to inform future decision-making. Patients should be encouraged to contribute by giving their own views on their leave; some facilities provide leave records specifically for this purpose.

Care and treatment while on leave

Responsible clinicians' responsibilities for their patients remain the same while the patients are on leave.

Escorted leave

A responsible clinician may direct that their patient remains in custody while on leave of absence, either in the patient's own interests or for the protection of other people

Voluntary patients

Voluntary patients and patients who are not legally admitted in a facility have the right to leave at any time. They cannot be required to ask permission to do so, but may be asked to inform staff when they wish to leave the ward.

Chapter 28: Absence without leave

Local policies

Facility directors should ensure that there is a clear written policy about the action to be taken when an involuntarily admitted patient, goes missing. All relevant staff should be familiar with this policy. Facility directors should agree their policy with other agencies – such as the police and ambulance services – as necessary.

Policies in relation to involuntary patients should include guidance about:

- the immediate action to be taken by any member of staff who becomes aware that a patient has gone missing, including a requirement that they immediately inform the professional in charge of the patient's ward (where applicable), who should in turn ensure that the patient's responsible clinician is informed

- the circumstances in which a search of a facility and its grounds should be made
- the circumstances in which other local agencies with an interest, including the local authority, should be notified
- the circumstances in which the police should be informed, who is responsible for informing the police and the information they should be given (this should be in line with local arrangements agreed with the police)
- how and when other people, including the patient's relative, should be informed (this should include guidance on informing people if there is good reason to think that they might be at risk as a result of the patient's absence)
- how (and by whom) patients are to be returned to the place where they ought to be, and who is responsible for organizing any necessary transport.

The police should always be informed immediately if a patient is missing who is:

- considered to be particularly vulnerable
- considered to be dangerous

Where the police have been informed about a missing patient, they should be told immediately if the patient is found or returns.

Although every case should be considered on its merits, patient confidentiality will not usually be a barrier to providing basic information about a patient's absence to people – such as those the patient normally lives with or is likely to contact – who may be able to help with finding the patient.

It is good practice when a patient returns after a substantial period of absence without leave always to re-examine the patient to establish whether they still meet the criteria for involuntary admission.

All instances of absence without leave should be recorded in the individual patient's notes.

Chapter 29: Renewal order and discharge

Before it expires, responsible clinicians should decide whether patients' current period of involuntary admission should be renewed. A 3-member (Article 67 of the Act) or 4-member (Article 69 of the Act) multidisciplinary team of clinicians should examine the patient and decide whether the criteria for renewing involuntary admission are met or whether discharge is appropriate. The responsible clinician should discuss their decision with the patient. They should consult one or more other people who have been professionally concerned with the patient's medical treatment. The multidisciplinary team should make this decision on the basis of clinical factors only and should fully document the reasons for this decision in the report to the facility directors.

Where responsible clinicians are satisfied that the criteria for renewing the patient's involuntary admission are met, they should submit a report to that effect to the facility directors, who in their turn should submit it to the MHC for approval. Extensions of involuntary admission cannot take place without approval by the MHC.

Involuntary admission should not continue if the authority for involuntary admission is not renewed following approval by the MHC because any such involuntary admission would be an unlawful deprivation of liberty. Such cases are sometimes referred to as 'de-facto' involuntary admission. If, in exceptional cases, authority for involuntary admission is not renewed and the patient continues to be kept in circumstances which amount to a deprivation of liberty, the responsible clinician should notify the facility directors immediately. The patient should then be immediately discharged or there should be lawful authority to continue to detain the patient, for example, in exercise of the holding powers in the Act.

The responsible clinician's power of discharge

As responsible clinicians have the power to discharge patients, they should keep under review the appropriateness of using that power. If, at any time, responsible clinicians conclude that the criteria which would justify renewing a patient's involuntary admission are not met, they should exercise their power of discharge. They should not wait until the patient's involuntary admission is due to expire (i.e. when an admission order for 21 days has been issues but clinicians conclude that the patient should be discharged before the expiration of such period).

Chapter 30: Mental health after-care

Article 12 of the Act requires the provision of aftercare and rehabilitation services to patients who have been discharged.

After-care services mean services which have the purposes of meeting a need arising from or related to the patient's mental disorder and reducing the risk of a deterioration of the patient's mental condition (and, accordingly, reducing the risk of the patient requiring admission to a facility again for treatment for mental disorder. Their ultimate aim is to maintain patients in the community, with as few restrictions as are necessary, wherever possible.

The definition of after-care services should be interpreted broadly. For example, after-care can encompass healthcare, social care and employment services, supported accommodation and services to meet the person's wider social, cultural and spiritual needs, if these services meet a need that arises directly from or is related to the particular patient's mental disorder, and help to reduce the risk of a deterioration in the patient's mental condition. After-care is a vital component in patients' overall treatment and care. As well as meeting their immediate needs for health and social care, after-care should aim to support them in regaining or enhancing their skills, or intellectual new skills, in order to cope with life outside hospital.

The duty to provide after-care services continues as long as the patient is in need of such services.

Where eligible patients have remained in the facility voluntarily after ceasing to be involuntarily admitted under the Act, they are still entitled to after-care once they leave the facility.

After-care planning

Although the duty to provide after-care begins when the patient leaves hospital, the planning of after-care needs to start as soon as the patient is admitted to hospital.

When considering relevant patients' cases, facility directors will expect to be provided with information from the professionals concerned on what after-care arrangements might be made if they were to be discharged.

Before deciding to discharge a patient, the responsible clinician should ensure that the patient's needs for after-care have been fully assessed, discussed with the patient (and their carers, where appropriate) and addressed in their care plan.

After-care for all patients admitted to a facility for treatment for mental disorder should be planned within the framework of the holistic care programme. In order to ensure that the after-care plan reflects the full range of needs of each patient, it is important to consider who needs to be involved, in addition to patients themselves. This may involve carers and a wide range of professionals.

Ending after-care services

The most clear-cut circumstance in which after-care would end is where the person's mental health improved to a point where they no longer needed services to meet needs arising from or related to their mental disorder. Fully involving the patient and their carer in the decision-making process will play an important part in the successful ending of after-care.

After-care services may be reinstated if it becomes obvious that they have been withdrawn prematurely, eg where a patient's mental condition begins to deteriorate immediately after services are withdrawn.

Even when the provision of after-care has been successful in that the patient is now well-settled in the community, the patient may still continue to need after-care services, eg to prevent a relapse or further deterioration in their condition.

Patients are under no obligation to accept the after-care services they are offered, but any decisions they may make to decline them should be fully informed. An unwillingness to accept services does not mean that patients have no need to receive services, nor should it preclude them from receiving them should they change their minds. .

Chapter 31: Holistic care programme

The holistic care programme is an overarching system for co-ordinating the care of people with mental disorders. It requires close engagement with service users and their carers and includes arrangements for assessing, planning and reviewing care.

Central to holistic care programme is the holistic care programme care plan which aims to ensure a transparent and coordinated approach to meeting wide ranging physical, psychological, emotional and social needs which are associated with a person's mental disorder. Included with the holistic care programme care plan are:

- a treatment plan which details medical, nursing, psychological and other therapeutic support for the purpose of meeting individual needs promoting recovery and/or preventing deterioration.
- details regarding any prescribed medications
- details of any actions to address physical health problems or reduce the likelihood of health inequalities
- details of how the person will be supported to achieve their personal goals
- support provided in relation to social needs such as housing, occupation, finances etc
- support provided to carers
- actions to be taken in the event of a deterioration of a person's presentation, and
- guidance on actions to be taken in the event of a crisis.

holistic care programme care plans should include details of any areas of need which are critical to preventing behavioural disturbance. These should be met through primary and secondary preventative strategies. Care plans should also provide guidance on how staff and carers should respond if behavioural disturbance does arise (tertiary strategies). The holistic care programme also requires the clear identification of a named individual who has responsibility for co-ordinating the preparation, implementation and evaluation of the holistic care programme care plan.

When to use the holistic care programme

The holistic care programme should be used in secondary and tertiary mental healthcare to assess, plan, review and coordinate the range of treatment, care and support needs of those people in contact with secondary mental health services who have COMPLEX NEEDS. ACTIVE INVOLVEMENT OF AND ENGAGEMENT WITH THE PATIENT ARE AT THE HEART OF THE HOLISTIC CARE PROGRAMME, which focuses on reducing distress and promoting social inclusion and recovery.

The holistic care programme should be used for individuals who are at high risk of suffering a deterioration in their mental condition and who need:

- active engagement
- intense intervention, and/or
- support with dual diagnoses.

This would include most people who are entitled to after-care, including voluntary in-patients whenever they meet the criteria.

Who should be involved

Most importantly, the care plan should be prepared in close partnership with the patient from the outset, particularly where it is necessary to manage the process of discharge from the facility and reintegration into the community. It is also essential that a suitable care co-ordinator is identified

In order to ensure that the after-care plan reflects the needs of each patient, it is important to consider who needs to be involved, in addition to patients themselves. Subject to the patient's views, this may include:

- the patient’s responsible clinician
- nurses and other professionals involved in caring for the patient in hospital
- a practitioner psychologist
- general health practitioners
- any carer who will be involved in looking after them outside the facility (including, in the case of children and young people, those with parental responsibility)
- a representative of any relevant voluntary organizations
- an employment expert, if employment is an issue
- the patient’s attorney, if the patient has one
- any another representative nominated by the patient.

The care plan

The care plan should set out the practicalities of how the patient will receive treatment, care and support from day-to-day, and should not place undue reliance on the patient’s carers.

The care plan should be recorded in writing and a copy given to the patient. Once plans are agreed, it is essential that any changes are discussed with the patient as well as others involved with the patient before they are implemented.

The care plan should be regularly reviewed. It will be the responsibility of the care co-ordinator (or other officer responsible for its review) to arrange reviews of the plan until it is agreed between all parties, including the patient, that it is no longer necessary.

In particular, the care plan will need to be reviewed if the patient moves to another area. The care co-ordinator in the original area will be responsible for making transfer arrangements if commissioning responsibility consequently passes to authorities in the new area.

Care planning

The planning of after-care needs to start as soon as the patient is admitted to hospital. The professionals concerned should, in discussion with the patient, establish an agreed outline of the patient’s needs and agree a timescale for the implementation of the various aspects of the plan. All key people with specific responsibilities with regard to the patient should be properly identified.

Care planning requires a thorough assessment of the patient’s needs and wishes. It is likely to involve consideration of:

- continuing mental healthcare, whether in the community or on an outpatient basis
- the psychological needs of the patient and, where appropriate, of their carers
- physical healthcare
- daytime activities or employment
- appropriate accommodation
- identified risks and safety issues
- any specific needs arising from, eg co-existing physical disability, sensory impairment, intellectual disability or autistic spectrum disorder

- any specific needs arising from drug, or substance misuse (if relevant)
- any parenting or caring needs
- social, cultural or spiritual needs
- counselling and personal support
- assistance in welfare rights

Care planning should take particular account of the patient's age.

Where the patient is under the age of 18 the responsible clinician and the care co-ordinator should bear in mind that the most age-appropriate treatment should be that provided by a child and adolescent mental health service. It may also be necessary to involve the patient's parent, or whoever will be responsible for looking after the patient, to ensure that they will be ready and able to provide the assistance and support which the patient may need.

Similarly, specialist services for older people may have a role in the delivery of services for older patients. Particular care should be taken to ensure that the concepts of participation and proportionality are applied to older patients.

Professionals with specialist expertise should also be involved in care planning for people with autistic spectrum disorders or intellectual disabilities.

It is important that those who are involved are able to take decisions regarding their own involvement and, as far as possible, that of their organization. If approval for plans needs to be obtained from more senior levels, it is important that this causes no delay to the implementation of the care plan.

Chapter 32: Documents

Applications for involuntary admission in a facility and supporting medical recommendations

People who sign applications and make the supporting medical recommendations should take care to comply with the requirements of the Act. People who act on the authority of these documents should also make sure that they are in the proper form, as an incorrectly completed or indecipherable form may not constitute authority for a patient's involuntary admission.

This chapter distinguishes between receiving admission documents and scrutinizing them. For these purposes, receipt involves physically receiving documents and checking that they appear to amount to an application that has been duly made. Scrutiny involves more detailed checking for omissions, errors and other defects and, where permitted, taking action to have the documents rectified after they have already been acted on.

Facility directors should formally delegate their duties to receive and scrutinize admission documents to a limited number of officers, who may include clinical staff on wards. Someone with the authority to receive admission documents should be available at all times at which patients may be admitted to the hospital. A manager of appropriate seniority should take overall responsibility on behalf of the facility directors for the proper receipt and scrutiny of documents.

Facilities should have a checklist for the guidance of people delegated to receive documents (‘receiving officers’), to help them detect those errors which fundamentally invalidate an application and which cannot be corrected at a later stage in the procedure.

Documents should be scrutinized for accuracy and completeness and to check that they do not reveal any failure to comply with the procedural requirements of the Act in respect of applications for involuntary admission. Medical recommendations should also be scrutinized by someone with appropriate clinical expertise to check that the reasons given appear sufficient to support the conclusions stated in them.

If admission documents reveal a defect which fundamentally invalidates the application, the patient can no longer be involuntarily admitted on the basis of the application. The patient should be informed both orally and in writing, and in an accessible format for the patient.

Audit

Facility directors are responsible for ensuring that patients are lawfully admitted.

Facility directors and local authorities should ensure that the people they authorize to receive and scrutinize statutory documents on their behalf are competent to perform these duties, understand the requirements of the Act and receive suitable training.

Chapter 33: Allocating or changing a responsible clinician

The responsible clinician is the approved clinician who will have overall responsibility for the patient’s case.

Facility directors should have local protocols in place for allocating responsible clinicians to patients. This is particularly important when patients move between facilities or from the facility to the community and vice versa. The protocols should:

- ensure that 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
- ensure that it can be easily determined who a particular patient’s responsible clinician is
- ensure that cover arrangements are in place when the responsible clinician is not available (eg during non-working hours, annual leave etc), and
- include a system for keeping the appropriateness of the responsible clinician under review.

To ensure that the most appropriate available approved clinician is allocated as the patient’s responsible clinician, facility directors should keep a register of approved clinicians to treat patients for whom they are responsible.

The selection of the appropriate responsible clinician should be based on the individual needs of the patient concerned. For example, where psychological therapies are central to the patient’s treatment, it may be appropriate for a professional with particular expertise in this area to act as the responsible clinician.

Wherever possible, the clinician responsible for the care and treatment of children and young people should be a child and adolescent mental health services.

Even if the patient's main treatment needs are not immediately clear, it will be necessary to allocate a responsible clinician promptly upon the patient's involuntary admission in hospital.

Change of responsible clinician

As the needs of the patient may change over time, it is important that the appropriateness of the responsible clinician is kept under review throughout the care planning process. It may be appropriate for the patient's responsible clinician to change during a period of care and treatment, if such a change enables the needs of the patient to be met more effectively. If the patient requests a change their reasons should be established to inform an appropriate response. In considering such a change it is also important to take account of the need for continuity and continuing engagement with, and knowledge of, the patient.

Where a patient's treatment and rehabilitation require movement between different facilities or to the community, successive responsible clinicians need to be identified in good time to enable movement to take place. The existing responsible clinician is responsible for overseeing the patient's progress through the system.

If movement to another facility is indicated, responsible clinicians should take the lead in identifying their successors, and facility directors should respond promptly to requests to assist in this process.

There may be circumstances where the responsible clinician is qualified with respect to the patient's main assessment and treatment needs but is not appropriately qualified to be in charge of a subsidiary treatment needed by the patient (eg medication which the responsible clinician is not qualified to prescribe). In such situations, the responsible clinician will maintain their overarching responsibility for the patient's case, but another appropriately qualified professional will take responsibility for a specific treatment or intervention.

Where the person in charge of a particular treatment is not the patient's responsible clinician, the person in charge of the treatment should ensure that the responsible clinician is kept informed about the treatment and that treatment decisions are discussed with the responsible clinician in the context of the patient's overall case. Guidance should be available locally on the procedures to follow, including when to seek a second opinion, if there are unresolved differences of opinion.

Chapter 34: Functions of facility directors

Identification of facility directors

In practice, most of the decisions of the facility directors are actually taken by individuals (or groups of individuals) on their behalf. In particular, decisions about discharge from involuntary admission are taken by panels of people (Boards) specifically selected for the role.

In this chapter, unless otherwise stated, ‘facility directors’ includes anyone authorized to take decisions on their behalf, except Boards.

Exercise of facility directors’ functions

Special rules apply to the exercise of facility directors’ power to discharge patients from involuntary admission. In broad terms, this power can be delegated only to Boards made up of people appointed specifically for the purpose who are not officers or employees of the organization concerned.

Otherwise, facility directors (meaning the organization, or individual, in charge of the facility) may arrange for their functions to be carried out, day-to-day, by particular people on their behalf. In some cases, regulations say they should do so.

The arrangements for who is authorized to take which decisions should be set out in a scheme of delegation. If the facility directors are an organization, that scheme of delegation should be approved by a resolution of the body itself.

Organizations (or individuals) in charge of facilities retain responsibility for the performance of all facility directors’ functions exercised on their behalf and should ensure that the people acting on their behalf are competent to do so.

The organization (or individual) concerned should put in place appropriate governance arrangements to monitor and review the way that functions under the Act are exercised on its behalf.

Specific powers and duties of facility directors

Admission

It is the facility directors’ responsibility to ensure that the authority for detaining patients is valid and that any relevant admission documents are in order. Facility directors should have a clear system in place for notifying local authorities when the patient is a child or young person.

Transfer between facilities

The Act allows facility directors to authorize the transfer of involuntarily admitted patients from one facility to another. A facility director does not have the power to insist that another facility accepts a patient.

People authorizing transfers on the facility directors’ behalf should ensure that there are good reasons for the transfer and that the needs and interests of the patient have been considered. Transfers are potentially an interference with a patient’s right to respect for privacy and family life.

Valid reasons for transfer might be clinical – for example, the need for the patient to be in a more suitable environment or in a specialist facility, or to move the patient closer to home. In some cases, a transfer may be unavoidable, because the facility is no longer able to offer the care that the patient needs.

Wherever practicable, patients should be involved in the process leading to any decision to transfer them to another hospital. It is important to explain the reasons for a proposed transfer to the patient and, where appropriate, their relative and carers. The reasons should be recorded.

Among the factors that need to be considered when deciding whether to transfer a patient are:

- whether the transfer would give the patient greater access to carers, or have the opposite effect
- what effect a transfer is likely to have on the course of the patient's disorder or their recovery
- whether a transfer would be appropriate to enable the patient to be in a more culturally suitable or compatible environment, or whether it would have the opposite effect.

Involuntary patients may themselves want a transfer to another facility for example, to be nearer their family or friends. Or they may have a reasonable wish to be treated by a different clinical team, which could only be met by a transfer.

The professionals involved in their care should always be prepared to discuss the possibility of a transfer, and should raise the issue themselves with the patient if they think the patient might be interested in, or benefit from, a transfer.

Requests made by, or on behalf of, patients should be recorded and given careful consideration. Every effort should be made to meet the patient's wishes. If that cannot be done, the patient (or the person who made the request on the patient's behalf) should be given a written statement of the decision and the reasons for it.

It is not a statutory requirement to have a relative's consent to transfer. However unless the patient objects, the patient's relative should normally be consulted before a patient is transferred to another hospital, and, in accordance with the regulations, they should normally be notified of the transfer as soon as practicable after the decision is made.

When a patient is transferred care plans and other relevant information should be sent to the facility to which the patient is transferred. The transferring facility should retain copies of these documents.

Information for patients and carers

The Act requires facility directors to arrange for involuntary patients, and their relatives, to be given important information about the way the Act works and about their rights.

Facility accommodation for children and young people

The Act puts a duty on facility directors to ensure that any children or young people aged under 18 receiving in-patient care for mental disorder in their facilities are accommodated in an environment which is suitable for their age (subject to their needs). The duty applies to children and young people admitted voluntarily, as well as those involuntarily admitted.

Exercise of power of discharge

The facility directors – meaning the organization or individual in charge of the facility – should either consider discharge themselves or arrange for their power to be exercised on their behalf by a Board.

A Board may consist of three or more people who are:

- members of the organization in charge of the provider (eg the chair), or
- members of a committee or sub-committee which is authorized for the purpose.

In all cases, the board (or the equivalent) of the organization concerned should ensure that the people appointed properly understand their role and the working of the Act. The organization should ensure that people appointed to a Board receive suitable training to understand the law, work with patients and professionals, to be able to reach sound judgments and properly record their decisions. This should include training or development in understanding risk assessment and risk management reports, and the need to consider the views of patients, and if the patient agrees, their relative, and if different, carer.

Facility directors should ensure that they and the facility Board understand equality issues and that there are sufficient numbers of panel members with a specialized understanding of the specific needs of particular groups including those listed below, and that panel members can communicate effectively with them:

- patients from minority cultural or ethnic backgrounds
- patients with physical impairments and/or sensory impairments, and/or
- patients with intellectual disabilities and/or autistic spectrum disorders.

Reviewing involuntary admission

Facility directors should ensure that all relevant patients, and their relative and, if different carer, are aware that the patient may ask to be discharged by the facility directors and of the distinction between this and their right to apply for a MHC hearing. Facility directors should ensure that the appropriate level of support is provided to help the patient understand this right and distinction. This is particularly important if the patient is a child or young person or an individual who has communication difficulties.

Facility directors:

- may undertake a review of whether or not a patient should be discharged at any time at their discretion
- should undertake a review if the patient's responsible clinician submits a report to them renewing involuntary admission, and should consider holding a review when the responsible clinician makes a report to them barring an order by the relative to discharge a patient.

The decision should be recorded in writing and if the decision is taken not to consider the case the reasons documented.

Criteria to be applied for discharge

The Act does not define specific criteria to be used by facility directors when considering discharge. The essential consideration is whether the grounds for continued involuntary admission under the Act are satisfied.

Procedures for reviewing involuntary admission

Facility directors' conduct of reviews should satisfy the fundamental legal requirements of fairness, reasonableness and lawfulness. Facility Boards should:

- adopt and apply a procedure which is fair and reasonable.
- not make irrational decisions – that is, decisions which no Board, properly directing itself as to the law and on the available information, could have made, and
- not act unlawfully – that is, contrary to the provisions of the Act and any other legislation.

Facility directors should have a process in place that seeks to involve the patient, their relative and, if different, carer, including at the hearing, and in doing so, should have regard to the empowerment and involvement principle. This should include offering the patient information and advice on the review process, supporting them to fully participate and ensuring that, wherever practicable, hearings are scheduled in consultation with the patient so that any representative of the patient and others supporting them may attend. Patients and their representatives should be given reasonable notice of when a hearing will take place and arrangements put in place to enable them to be fully involved.

Decisions

Facility directors have a duty to give reasons for their decisions. The decisions of the Board, and the reasons for them, should be fully recorded at the end of each review. The decision should be communicated as soon as practicable, both orally and in writing, to the patient and their representative, to the relative and, if different, carer (where relevant), and to the professionals concerned.

If the patient is not to be discharged, where practicable at least one member of the panel should offer to see the patient (or their representative) to explain in person the reasons for the decision. The formal record of the decision and reasons should be shared with the patient, and copies of the papers relating to the review should be kept in the patient's notes.

Annex A: Key words and phrases used in the Code

Advance decision

A decision specified to refuse treatment made in advance by a person who has decision-making ability to do so. This decision will then apply at a future time when that person may need support for facilitated decision-making to consent to, or refuse the specified treatment.

Advance statement

A statement made by a person, when they have decision-making ability, setting out the person's wishes about medical treatment. The statement should be taken into account at a future time when that person may need support for facilitated decision-making 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.

The Act

Unless otherwise stated, the Mental Health Act 2014

Advocacy

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

After-care

Health, care and support services in the community following discharge from hospital; especially the duty of the responsible health services and local authority to provide after-care under section 117 of the Act, following the discharge of a patient from involuntary admission for treatment under the Act. The duty applies to community patients, transferred prisoners returned to prison from hospital and conditionally discharged restricted patients, as well as those who have been fully discharged.

Application for involuntary admission

An application made by a medical doctor, or a relative, under Part 2 of Chapter 8 of the Act for a patient to be involuntarily admitted in a facility either for assessment or for medical treatment.

Approved clinician

An approved clinician is a healthcare professional who received special training in mental health issues and who is competent to become responsible for the treatment of persons with mental disabilities.

Approved mental health professionals

Approved mental health professionals are practitioners with specialized training and experience in working with persons with mental disabilities. They may include nurses, social workers, occupational therapists, psychologists and counsellors.

Holistic care programme

A system of care and support for individuals with complex needs which includes an assessment, a care plan and a care coordinator.

Children and adolescents specialist mental health services

Mental health services covering all types of provision and intervention from mental health promotion and primary prevention, specialist community-based services through to very specialist care as provided by in-patient units for children and young people.

Competent

This term refers to a child under the age of 16 who is considered to have sufficient understanding and intelligence to enable them to understand fully what is involved in a proposed intervention that requires consent, including admission to a facility and medical treatment, and who is therefore competent to consent to that intervention. See also competence to consent.

Criteria for involuntary admission

A set of criteria that should be met before a person can be involuntarily admitted, or remain involuntarily admitted, under the Act.

Dementia

The term ‘dementia’ describes a set of symptoms that include loss of memory, mood changes and problems with communicating and reasoning. These symptoms occur when the brain is damaged by certain diseases, such as Alzheimer’s disease or a series of small strokes.

Electro-convulsive therapy

A form of medical treatment for mental disorder in which a small, (ECT) carefully controlled electric current is introduced into the brain. It is administered in conjunction with a general anaesthetic and muscle relaxant medications and is occasionally used to treat very severe depression.

Leave of absence

Permission for a patient who is involuntarily admitted in a facility to be absent for short periods eg to go to the shops or spend a weekend at home, or for much longer periods.

Rapid tranquilization

Rapid tranquillization refers to the use of medication to calm and/or lightly sedate an individual to reduce agitation and aggression.

Responsible clinician

A responsible clinician is the approved clinician with overall responsibility for a patient’s case.

Annex B: List of policies and procedures

This annex contains a summary of the policies, procedures and guidance which the Code says should be put in place locally by facility directors and others.

Relatives/carers and day/overnight stay policy

Providers should have in place a Policy about the role, rights and duties of relatives or carers accompanying patients during their involuntary admission.

Human rights and equality policy

Providers should have in place an ‘Equality and Human Rights Policy’ for service provision and practice in relation to the Act, which should be reviewed at Board (or equivalent) level at least annually.

Information policy

Providers should have in place policies to ensure that all admitted patients and their relatives are given information about their legal situation and rights in accordance with the legislation.

Complaints policies

All providers should have clear complaints policies and procedures for patients and those supporting them (including relatives, carers and advocates) in formats that these individuals can understand.

Blanket locked door policy

The impact of a locked door policy on each patient should be considered and documented in the patient’s records. The policy should conform to the ‘empowerment and involvement’ guiding principle.

Mobile phones

Providers should have a policy on the use of mobile phones by patients and their relatives.

Searching

Providers should ensure that there is an operational policy on searching involuntary patients, their belongings and surroundings and their visitors.

Accommodation with enhanced levels of security

Facilities offering accommodation with enhanced levels of security should have written guidelines, setting out the categories of patients for whom it is appropriate to use physically secure conditions and those for whom it is not appropriate.

Entry and exit from hospital wards and facilities

Hospital wards and facilities should have a written policy that sets out precisely what the arrangements are for entry to and exit from the hospital ward or facility.

Recording disclosure without consent

Any decision to disclose confidential information about patients – for any reason – should be fully documented. The relevant facts should be recorded, along with the reasons for the decision and the identity of all those involved in the decision-making. Reasons should be given by reference to the grounds on which the disclosure is to be justified.

Visits by and to children and young people

Providers should have written policies and procedures regarding the arrangements for children and young people who visit patients in a facility and for visits to patients who are children or young people.

Visits to patients in facilities

Providers should have a policy on the circumstances in which visits to patients may be restricted.

Police assistance

Providers and police forces should have locally agreed arrangements for the circumstances in which the police should be asked to provide assistance.

Joint local policies for admission to hospital

Providers, police forces and ambulance services should ensure that they have in place a clear joint.

policy for the safe and appropriate admission of people in their local area agreed at Board or Board-equivalent level by each party and each party should appoint a named senior lead (‘senior lead’).

Local partnership arrangements to deal with people experiencing mental health crises

Providers, police forces and ambulance services should have local partnership arrangements in place to deal with people experiencing mental health crises.

Police powers and places of safety

Providers, police forces and ambulance services should have an agreed local policy in place governing all aspects of police powers and places of safety.

Transporting of patients under the Act

Relevant authorities, including providers, ambulance and transport services, and the police should agree joint local policies and procedures for transporting patients under the Act, setting out clearly the respective responsibilities of the different agencies and service providers.

Intellectual disabilities or autism

Policies and practices should be in place to specifically address issues such as staff awareness and training, communication with patients, the meeting of physical health needs and regular audits of incidents involving restrictive practices.

Food and drink strategy

Every provider should have a food and drink strategy that covers nutrition and hydration needs of patients

Restrictive intervention reduction programmes

All providers should have in place a regularly reviewed and updated restrictive intervention reduction programme, which are overarching, multi-component action plans which aim to reduce the use of restrictive intervention. They should demonstrate organizational commitment to restrictive intervention reduction at a senior level, how the use of data relating to restrictive interventions will inform service developments, continuing professional development for staff, how models of service which are known to be effective in reducing restrictive interventions are embedded into care pathways, how service users are engaged in service planning and evaluation and how lessons are learned following the use of restrictive interventions. They should ensure accountability for continual improvements in service quality through the delivery of positive and proactive care. They should also include improvement goals and identify who is responsible for progressing the different parts of the plan.

Provider policies on restrictive interventions

Provider policies on restrictive interventions should include guidance on assessments of risk and support needs; use of positive behaviour support plans; minimisation of risks associated with restrictive interventions; authorization and application of restrictive interventions; recording and reporting; post-incident reviews and workforce training.

Provider policies on use of enhanced observation

Provider policies on the use of enhanced observation should cover selection of appropriate staff taking into account the individual’s characteristics and circumstances, minimisation of perception of coercive intent and respect for the individual’s dignity and privacy.

Guidance on use of seclusion

Provider policies should include detailed guidance on the use of seclusion and should be consistent with the guiding principles of the Code.

Medical reviews of seclusion

Local policies should make provision for a ‘duty doctor’ to deputise. The policy should also identify which practitioners are competent to carry out a medical review.

Training for staff exposed to aggression or violence

Providers should have a policy for training staff who work in areas where they may be exposed to aggression or violence or who may need to become involved in the application of restrictive interventions.

Missing patients

Providers should ensure that there is a clear written policy about the action to be taken when an admitted patient goes missing. This policy should be agreed with other agencies such as the police, the relatives and carers.

Renewal of involuntary admission

Providers should determine local policies on the renewal of a patient’s involuntary admission.

Receipt of applications for involuntary admission

Providers should have a checklist for the guidance of people delegated to receive documents (‘receiving officers’), to help them detect those errors which fundamentally invalidate an application and which cannot be corrected at a later stage in the procedure.

Allocation of responsible clinicians

Providers should have local protocols in place for allocating responsible clinicians to patients.

Scheme of delegation

Providers should set out the arrangements for who is authorized to take which decisions in a scheme of delegation. If the providers are an organization, that scheme of delegation should be approved by a resolution of the body itself.

Authority for involuntarily admitting and/or keeping patients

It is the providers’ responsibility to ensure that the authority for involuntarily admitting and/or keeping patients is valid and that any relevant admission documents are in order. Providers should have a clear system in place for notifying MHCs when the patient is a child or young person.

Providers and MHCs

Providers and MHCs should have locally agreed arrangements on the implementation of the Act.