MENTAL HEALTH CAPACITY LEGISLATION COMMITTEE
10am - 12pm – 26th JUNE 2018
CORPORATE MEETING ROOM, HEADQUARTERS
UNIVERSITY HOSPITAL OF WALES

CARING FOR PEOPLE
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GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol Caerdydd a'r Fro
Cardiff and Vale University Health Board

MENTAL HEALTH AND CAPACITY LEGISLATION COMMITTEE
Tuesday June 26th at 10.00hrs
Corporate Meeting Room, Headquarters, UHW

AGENDA

PATIENT STORY – Mental Health Act		
PART 1: ITEMS FOR ACTION		
1	Welcome and Introductions	Oral *Chair*
2	Apologies for Absence	Oral *Chair*
3	Declarations of Interest	Oral *Chair*
4	Minutes of the Mental Health and Capacity Legislation meeting held on 6th February 2018	*Chair*
5	Action Log Review	*Chair*
6	Any Other Urgent Business Agreed with the Chair	*Chair*
MENTAL CAPACITY ACT		
7 (10 min)	Deprivation of Liberty Safeguard Monitoring Report a) Cardiff & Vale DoLS Report April b) DoLS CSSIW Report	*Medical Director*
8 (10 min)	Mental Capacity Act Monitoring Report a) MCA Supporting Info May 2018 b) IMCA Report	*Medical Director*
MENTAL HEALTH ACT		
9 (10 min)	Mental Health Act Exception Report • Section 117 Compliance • Section 136 Compliance	*I Wile*
MENTAL HEALTH MEASURE		
10 (10 min)	Mental Health Measure Monitoring Report	*Ian Wile*

11 (15 min)	Presentation – Primary Care CAMHS	*Steve Curry*
COMMITTEE GOVERNANCE		
12 (5 min)	Mental Health Operational Group - Update	*Ian Wile*
13 (15min)	Committee Work Plan	*Board Secretary*
14	**Documents for Committee Approval** 14.1 Approval of Community Treatment Order Policy 14.1a Community Treatment Order Policy 14.1b Community Treatment Order Procedure 14.2 Approval of Hospital managers' Scheme of Delegation Policy 14.2a Hospital Managers' Scheme of Delegation Policy 14.2b Hospital Managers' Scheme of Delegation Procedure 14.3 Approval of Section 5(2) Doctor's Holding Power Policy and Procedure 14.3a Section 5(2) Doctors' Holding Power Policy 14.3b Section 5(2) Doctors' Holding Power Procedure 14.4 Approval of Section 5(4) Nurses Holding Power 14.4a Section 5(4) Nurses' Holding Power Policy 14.4b Section 5(4) Nurses' Holding Power Procedure	
PART 2:	**ITEMS TO BE RECORDED AS RECEIVED AND NOTED FOR INFORMATION BY THE COMMITTEE** **Papers are available on the Health Board website**	
15	a)Hospital Managers Power of Discharge sub-Committee Minutes b) Hospital Managers Power of Discharge Handbook PoD recommendations	*Chair, PoD sub-Committee*
16	Review of the Meeting	*Oral Chair*
17	To note the date, time and venue of the next meeting:- 23rd October 2018	

UNCONFIRMED MINUTES OF THE
MENTAL HEALTH AND CAPACITY LEGISLATION COMMITTEE
(MHCLC)
HELD AT 09.30AM ON TUESDAY 6TH FEBRUARY 2018
CORPORATE MEETING ROOM, HEADQUARTERS, UHW

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Present:

Charles Janczewski	**MHCLC Chair and Vice Chair, Cardiff and Vale UHB**
Eileen Brandreth	Independent Member and MHCLC Vice Chair
Sara Moseley	Independent Member

In attendance:

Steve Curry	Chief Operating Officer (Lead Executive for Mental Health)
Ian Wile	Director of Operations, Mental Health
Sunni Webb	Mental Health Act Manager
Dr Jenny Hunt	Clinical Psychologist
Julia Barrell	Mental Capacity Act Manager
Lucy Phelps	Service User Representative
Amanda Morgan	Service User Representative
Kay Jeynes	Director of Nursing, PCIC

Apologies

Jeff Champney Smith	Chair, Hospital Managers Power of Discharge Sub-Committee
Jayne Tottle	Mental Health Clinical Board Nurse
Peter Welsh	Director of Corporate Governance
Dr Graham Shortland	Medical Director (Lead Executive for Mental Capacity)

Secretariat: Helen Bricknell

MHCLC 16/123 WELCOME AND INTRODUCTIONS

The Chair welcomed everyone to the meeting.

MHCLC 16/124 APOLOGIES FOR ABSENCE

Apologies for absence were noted.

MHCLC 16/125 DECLARATIONS OF INTEREST

The Chair invited Members to declare any interests in the proceedings on the Agenda. None were declared.

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MHCLC 16/126 MINUTES OF THE PREVIOUS MEETING OF THE MENTAL HEALTH AND CAPACITY LEGISLATION COMMITTEE HELD ON 29TH NOVEMBER 2017

The minutes were **RECEIVED** and **CONFIRMED** as a true and accurate record for 29th November 2017 subject to the following the amendments:

MHCLC 16/115: The Chair asked when would the CAMHS service reach their target of 80%, this was delivered in October 2017.

MHCLC 16/117: The measure relates to timely assessment for children and young people to enable early intervention. Fluctuations in demand together with small capacity losses (eg sickness) in a small team means it is difficult to "right size" the service. Work in underway to address this.

The Chair opened up for any matters arising from the minutes:
No Matters Arising to record.

MHCLC 16/127 ACTION LOG REVIEW

MHCLC 16/028 **Section 136 Partnership Arrangements**
Item to be brought back into Current Actions for further updates.

MHCLC 16/110 **DNA CPR**
No timescales have been noted on the Action Log currently. A verbal update was given from the Mental Capacity Act Manager informing that the Medical Director has asked for this to be addressed at the next Agenda setting meeting for Quality and Safety.
The Chair agreed to speak to the Chair of Quality and Safety around DNA CPR.

MHCLC 16/046 **MCA Clinical Boards**
Recorded as Complete in the Action Log, if this item is to be monitored it needs to be incorporated within the Work-plan.

The Chair would like to review the way the Action Log captures relevant information. This would be undertaken outside of the meeting with the Director of Corporate Governance and the Secretariat.

The Committee **SUPPORTS** this request.
The Committee **RECEIVED** and **NOTED** the Action Log.

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MHCLC 16/128 ANY OTHER URGENT BUSINESS AGREED WITH THE CHAIR.

There was no other urgent business.

MHCLC 16/129 DEPRIVATION OF LIBERTY SAFEGUARDS MONITORING REPORT

The Mental Capacity Act Manager would inform the Medical Director of any queries surrounding the report. The Chair asked as a point of order, why there is no positioning SBAR paper outlining why the report has been submitted to the Committee; the status since the last report; the risks if any; what needs to be considered, supported, approved or any strategic issues.

It was stated that the report is delivered to the Partnership Board and therefore it is important the MHCL Committee receives a covering paper which deals with the above issues.

ACTION: At the next Committee meeting a covering paper to be submitted outlining any risks, status since last report, considerations and any strategic issues.

The Committee **RECEIVED** and **NOTED** the report.

MHCLC 16/130 MENTAL CAPACITY ACT MONITORING REPORT – SBAR

The Mental Capacity Act Manager delivered a brief overview of the report on how the Health Board is complying with the Mental Capacity Act (the legal framework within which treatment and care can be given to patients).

The training figures, provided by Learning, Education and Development Department were broken down by Clinical Board, and they currently showed a lack of training uptake by clinical staff. Without training, staff will not be able to use the Mental Capacity Act within their clinical practice. The Mental Capacity Act has been in force for over 10 years and needs to be used correctly. The

Independent Mental Capacity Advocacy Service (IMCA) has highlighted that a majority of clinicians do not understand how to assess a patient's capacity nor how to work out a patient's best interests in relation to treatment and care.

The Chair opened up for discussion and the following points were noted:

The Director of Nursing PCIC services, questioned the validity of the data, as the Clinical Board has a record of high compliance with mandatory training. There may be an issue with how the figures have been recorded. It was suggested that monitoring the use of the Act in practice could be difficult as recording of the necessary information is often poor.

The report highlighted the serious potential adverse impact that non-compliance with the Mental Capacity Act can have on the safety and effective treatment of patients. Not following the requirements of the Act can lead to Ombudsman involvement and clinicians being reported to their professional bodies.

The Chair asked about the apparent lack of information provided by the Clinical Boards. The Mental Capacity Act Manager has asked for compliance with training to be built into the Performance reporting.

The Chair expressed his concern that whilst there is training available, policies and procedures in place and plenty of information readily accessible there still seems to be evidence that suggests staff are not completing the training and are not following the Act.

The Chair mentioned that perhaps the paper could be shaped differently to allow the Committee to monitor more effectively and to give assurance for the Board.

It was highlighted that even though training is available the application of this knowledge is paramount for assurance to the Board.

The chief Operating officer revisits earlier points and informs the committee that it is not a regular feature (standing item) of the performance review data sheet.

The Chair has suggested a meeting with the Medical Director and the Chief Executive to attend the next meeting, so the Committee can discuss how it can support and give assurance that this is dealt with in the Performance Reviews and reach optimum targets.

The Committee **NOTED** the report

MHCLC 16/131 MENTAL HEALTH ACT EXCEPTION REPORT

The Director of Operations, Mr. Ian Wile gave a brief overview of the report, during the fourth quarter the Mental Health Act department have no exceptions to report.

On the figures relating to the use of Section 136, a question was raised regarding the follow up of individuals who are assessed under this power of arrest but where there are no further follow up action by mental health services. Particularly inlight of the low rate of admission from 136 assessments which is currently 10%. Ian Wile conformed that the crisis services report that follow up rates by mental health services is low, but there is little comprehensive information on the outcomes for those individuals.

Cardiff and Vale Health Board, the police and two adjacent Health Boards are considering the collaborative development of a public service call center. This will be based in ABMU and professionally supported by Cwm Taff along with Cardiff and Vale UHB supporting operational functions. The idea is that there will be a mental health resource at the end of the phone, for front line police officers in South Wales to contact for any assistance or advice needed.

The funding, staffing and operational needs are currently being discussed with the intention of adopting a similar model to Gwent services.

Meeting is being held on the 26th February with the Care and Management Team to discuss the layout the Agenda, working alongside the practitioners in Mental Health, completing reviews and interviews with service users, encouraging staff to complete the audits alongside them so knowledge can be obtained in the completion of Care and Treatment Plans.

The Committee **NOTED** the report.
The Committee **RECOGNISED** the good performance.

MHCLC 16/132 HEALTHCARE INSPECTORATE WALES ANNUAL REPORT

The Director of Operations, Mr. Ian Wile gave a brief overview of the report explaining this was published last November. The paper supporting this item outlined the areas of concern and the actions followed. The main concern is Section 17 leave, how it is accommodated and applied. Staff, are to refresh on the understanding and raise the awareness within the service following the report.

It was discussed whether there has been more difficulty in accommodating the Section 17 leave since transferring to University Hospital Llandough (UHL), and how has this been overcome. The Director of Operations

mentioned that the staff has accommodated the Section 17 leave, which can include enough time to visit the local shops or the patients themselves can decide to take the time in blocks. It has been reported through Hospital Managers hearings around the time allowances.

It was brought to the Committee's attention that on page 76 there is mention of an Action Plan which has not been submitted. The Director of Operations has mentioned this is an oversight and there is some confusion around the wording.

The Chief Operating Officer suggests that many of the actions, including to raise awareness should be within the Performance Reviews as opposed to a wider Action Plan.

The Committee has **NOTED** the report.
The Committee has **CONSIDERED** and **APPROVED** the approach taken by the Mental Health Clinical Board.

MHCLC 16/133 MENTAL HEALTH ACT INSPECTION REPORTS

The Director of Operations, Mr. Ian Wile gave a verbal update stating there is not a completed written report at this time, upon receipt it will be submitted to the next Committee meeting. However, there have been two unannounced ward inspections in UHL both were carried out this month. Verbal updates given from the inspections have been supportive and positive.

The Committee **NOTED** the verbal report.

MHCLC 16/134 MENTAL HEALTH MEASURE MONITORING REPORT Progress on Care and Treatment Plans

The Director of Operations, Mr. Ian Wile presented the report and notes that we are now compliant for Part 1 of the measure with the standards in line with Welsh Government.

The UHB is also compliant with Part 2 of the measure. The Committee noted that with the aspirations of professionals involved we can use the Care and Treatment plans on a therapeutic level in future planning.

The Chair opened up for comments, the following were discussed:

Under 18's assessment activity – Children & Young People service is reporting below the Welsh Government target.
CAMHS is reporting the performance is just below 40% compliant.

Part 1 of the Measure which includes Children Young People primary service missed their target in December due to operational issues and the assessments were being carried out in 29 days (just outside of the 28 day timeframe). Requests for assessments have increased over the last two years this alone stripping the demands on the service.
Sometimes intervention has to be provided before the assessment,

The Chief Operating Officer, Mr. Steve Curry mentions that discussions with Children's and Women Clinical Board in their last performance reviews indicated that delivery against Part 1 of the Measure for CAMHS had successfully reached 86%. Improvements of the service including right sizing *service capacity* and reforming of such a small team are being worked through to be sustainable and compliant and gather assurance for the Committee.

The Chief Operating Officer and Executive Director of Public Health has been successful in gaining support for resources from Central Government. This has enabled the project management of repatriating secondary care CAMHS to move forward. An update on Part 1 CAMHS Measure will be provided at the next meeting.

ACTION: Chief Operating Officer to provide a paper on repatriation of CAMHS. Staff from Children and Women Clinical Board to attend the next Committee on this topic. 20 minute presentation at the next meeting.

It was asked who will be project managing the Repatriation of the work, the lead will be Cardiff and Vale University Health Board working to an April 2019 completion schedule.

A discussion took place around the type of primary care model that may be implemented in the future in relation to the scheme of work around describing Part 1 of the Mental Health Measure and its suitability for both CAMHS and Adult Mental Health services. A primary Care Liaison Pilot in Cardiff East is supporting Mental Health services to review its service and pathways in and around primary care services.
The Chair has asked the Director of Operations to provide a presentation on the strategic intent outlining the way in which the Mental Health services are going to model the services going forward.

ACTION: Director of Operations, Mr. Ian Wile to present at the next Committee meeting (10 mins).

The Committee **AGREED** the recommendation:
The approach taken by the Mental Health Clinical Board

MHCLC 16/135 COMMITTEE WORK PLAN

The Chair has brought the Work plan to the Committee with an invitation to all Committee members to give any submissions on shaping or alterations to the current Work plan within the next fourteen days to the Secretariat of the meeting. All submissions will be discussed at a further meeting outside of the Committee, and a new Work plan to be brought for Approval at the next Committee meeting.

The Committee **SUPPORTED** the Chair.

MHCLC 16/136 TERMS OF REFERENCE

The Chair opened up for any comments or queries with the current Terms of Reference for the Committee. The following were highlighted:

- P134. Item 4.2 The list of Attendees need to be reviewed / updated and presented to the next Committee in preparation for approval at the next Board meeting.

- The Chair observed that the Terms of Reference need to be reviewed annually. It was agreed any submissions or comments within fourteen days to the Chair or the Secretariat.

The Committee **SUPPORTED** the **RECOMMENDATIONS** of the Chair.

MHCLC 16/137 HOSPITAL MANAGERS' POWER OF DISCHARGE SUB COMMITTEE MINUTES

The Committee **RECEIVED** and **NOTED** the report.

MHCLC 16/138 REVIEW OF THE MEETING

The meeting was reviewed, it was noted the Chair would like the Committee to undertake an Annual Self-Assessment of the Committee and feedback where appropriate.
The Director of Operations informed the Committee that the National Benchmarking report is currently available electronically. For consideration to be placed on the Work plan.

MHCLC 16/139 DETAILS OF NEXT MEETING

The next meeting will be held on Tuesday 26th June 2018 at 10am, Boardroom, Headquarters, University Hospital of Wales.

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ACTION LOG FOLLOWING MHCLC MAY 2017

Minute	Date of Meeting	Subject	Agreed Action	Action To	Status
MHCLC 16/129	06.02.2018	DoLs Covering report	Next meeting to receive a Lead Covering Report	G Shortland/ N Wraith	Covering paper to be presented at June 2018 meeting. COMPLETE
MHCLC 16/134	06.02.2018	Mental Health Measure Monitoring Report	Chief Operating Officer to provide a paper on repatriation of CAMHS. Staff from Children and Women Clinical Board to attend the next Committee on this topic. 20 minute presentation at the next meeting.	S Curry	In progress
MHCLC 16/110	29.11.17	DNA CPR	To ask the Resus Team to include a question about consultation where patient lacks capacity to be involved in discussions about CPR in the audit template.	J Barrell	Resus Team will include relevant question in next audit scheduled for Autumn 2018. COMPLETE
MHCLC 16/110	29.11.17	DNA CPR	The Senior Nurse, Resuscitation Service and MCA Manager will co-ordinate a Senior Medical Staff Grand Round session to cover DNACPR and the law. Guidance will be published in the Medical Directors Bulletin.	J Barrell / G Shortland	Slot for DNACPR requested at Grand Round session. COMPLETE.
MHCLC 16/110	29.11.17	DNA CPR	The Medical Director, Mental Capacity Act Manager and the Resuscitation Service will recommend, in a paper to the Quality, Safety and Patient Experience Committee, that this	G Shortland / J Barrell / Resus Team /	Assistant Director of Nursing (Patient Safety and Quality) is amending the QSE workplan to

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			issue is considered as part of the routine reports to that Committee by the Clinical Boards. The support of the Chair of the MHCLC in raising this issue with the Chair of the Quality, Safety and Patient Experience Committee is requested as an action	MHCL Committee Chair	incorporate DNACPR. COMPLETE.
ITEMS TO BE BROUGHT TO A FUTURE MEETING					
COMPLETED ACTIONS (TO BE REMOVED ONCE REPORTED TO MEETING AS COMPLETE)					

DEPRIVATION OF LIBERTY SAFEGUARDS (DoLS) **Mental Capacity Act 2005**
Name of Meeting: Mental Health and Capacity Legislation Committee **Date of Meeting:** 26th June 2018

Executive Lead : Medical Director
Author : Medical Director
Caring for People, Keeping People Well: This report underpins the Health Board's "Culture" element of the Health Board's Strategy – "Working better together…"
Financial impact: Increasing demand for DoLs places an increased financial risk to the organization in requiring the appropriate Best Interest Assessors and also Section XII payments. The failure to comply with DoLs could lead to costly complaints and litigation
Quality, Safety, Patient Experience impact: Compliance with DoLS means that vulnerable patients will not be deprived of their liberty unlawfully.
Health and Care Standard Number 4.2
CRAF Reference Number 8.1.3
Equality and Health Impact Assessment Completed: Not Applicable

ASSURANCE AND RECOMMENDATION

LIMITED ASSURANCE is provided by:

- Recent Internal Audit Report
- Regular three monthly review of Performance with Local Authority Partners
- Staff Training
- Benchmarking data for Wales CSSIW report

The Board is asked to:

- **NOTE the report and AGREE actions to be taken in light of the Internal Audit Limited Assurance.**

SITUATION

The Mental Health and Capacity Legislation Committee had agreed that regular reports, providing information about the UHB's compliance with DoLS should be tabled.

Depriving a patient of their liberty where there is no court order or DoLS authorization in place (and the patient cannot be detained under the Mental Health Act 1983) is unlawful and the UHB could be sued for this.

As of 1st April 2009, the UHB and Cardiff and Vale of Glamorgan Local Authorities formed a partnership to provide a DoLS service across the three organizations. Senior teams from each organization meet on a three monthly basis (UHB Medical Director) to consider the operational and strategic nature of the Partnership including resource issues.

The Cardiff and Vale DoLS Partnership Board Report April 2018 prepared by the Cardiff and Vale of Glamorgan Deprivation of Liberty Safeguards and Mental Capacity Act Team is shown in Appendix One.

The main issues being considered from the annual summary include;

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Best Interest Assessors capacity/resource

- Ongoing risk associated with the number of outstanding DoLS Authorisation requests.

DoLS Team Funding

- The UHB is being asked by the two Local Authoriites to consider increasing funding to the DoLs Team to ensure continued compliance with the safeguards.
- Renegotiating the DoLS funding equation or revising funding arrangements.

Partnership Agreement

- Letter of Understanding confirming Vale of Glamorgan as Lead Provider – to be agreed and signed off
- Information Sharing Protocol - to be agreed and signed of

BACKGROUND

The Deprivation of Liberty Safeguards, an amendment to the Mental Capacity Act 2005, came into force on 1st April 2009. DoLS provide a means by which a mentally disordered, incapacitated, adult can lawfully be deprived of their liberty in hospital, if it is in the best interests of the person and there is no less restrictive way of caring for them.

Since the “Cheshire West” Supreme Court ruling in 2014, the number of applications for DoLS authorization has increased very considerably, although now appear to be stabilizing.

The DoLS Team co-ordinates the 6 assessments that have to be undertaken in order to establish whether a deprivation of liberty is occurring and whether the patient meets the criteria for a DoLS authorization to be granted.

ASSESSMENT AND ASSURANCE

Recently and Internal Audit report gave Limited assurance (appendix two). The Medical Director reported to the Audit Committee. At that meeting the Medical Director reflected on the challenges facing the DoLs team and also the relative performance of the UHB performance with that across Wales using the recent report prepared by Care and Social Services Inspectorate Wales (CSSIW), “Deprivation of Liberty Safeguards Annual Monitoring Report for Health and Social Care 2015-16 (see appendix three)”.

One of the outcomes from the audit was to ensure that training figures are made available. The following figures represent a low uptake of training:

In the last 6 months (1st November to 31st May), 28 people have received DoLS training, according to the figures logged by LED –

3 from CD&T
7 from Medicine
14 from Mental Health
4 from PCIC

The Medical Director will be agreeing with the Internal Audit team an approach to re-audit of this service (6-12 months) to reflect the National Data and relative performance of the UHB. This will include improving the uptake of training. This will be reported to the MHCLC to provide assurance to the MHCLC.

It is the Medical Directors assessment, that consistent with the CCSIW report, that until there is a change in the legislation that his will remain a challenging area of compliance across Wales and for the UHB.

Cardiff and Vale DoLS Partnership Board Report
April 2018

Appendix One

Cardiff and Vale of Glamorgan Deprivation of Liberty Safeguards and Mental Capacity Act Team

The Cardiff and the Vale DOLS / MCA Team operate the Supervisory Body responsibilities of the Deprivation of Liberty Safeguards on behalf of Cardiff and Vale UHB, City of Cardiff Council and Vale of Glamorgan Council, through a partnership management board consisting of senior representatives of each Supervisory Body.

The team acts on behalf of the three Supervisory Bodies in the:

- **Coordination of DoLS assessments as requested by Managing Authorities by undertaking the following six assessments, to determine the following:**
  - Age - 18 and over
  - Mental Illness- Is medically diagnosed with a mental disorder
  - Mental Capacity - Lacks capacity for the decision to be accommodated in the hospital or care home
  - No refusals - there is no Advanced Decision previously made to refuse treatment or care, or conflict relating to this such as LPA or Deputy
  - Eligibility - This determines whether the person meets the requirements for detention under the Mental Health Act 1983;
  - Best Interests - The person needs to be deprived of liberty for reasons of health, safety and best interests.
- **Supervision and workload management of over 20 Best Interest Assessors;**
- **Advice and support to health and social care teams across the sector in relation to MCA/DoLS issues;**
- **Training for care homes and all inpatient sites across the hospitals of Cardiff and the Vale of Glamorgan areas.**

The DoLS team is based in the Vale of Glamorgan and consists of:

- 1 full time administrator
- 1 full time DOLS/MCA Coordinator (Band 7)
- 2.5 full time Best Interest Assessors

- 1.0 full time Best Interest Assessors (Cardiff Council funded)
  - Cardiff Council withdrew 1.0 FTE BIA from the team in July 2017

Cardiff and Vale DoLS Partnership Board Report
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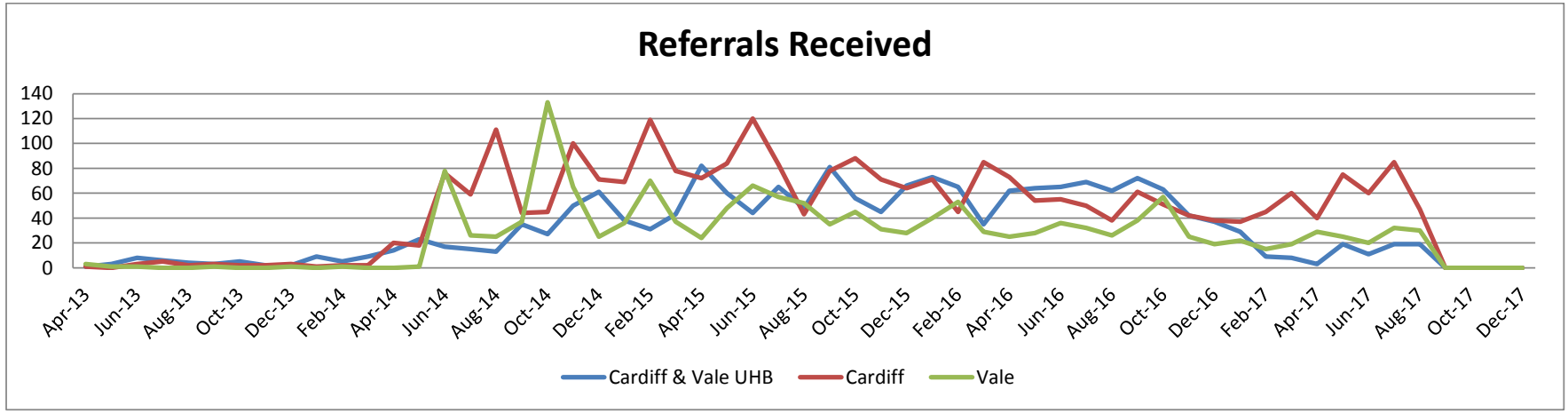
Referral rate…

The effects of the revised definition of Deprivation of Liberty following the Cheshire West Ruling continue to impact on the number of requests for Standard and Urgent Authorisations as described in the graph below. It is noticeable that in the three and a half years post Cheshire West, the number of referrals has remained high, but is stabilising leading to greater confidence in workforce planning.



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Referral Information

The table below shows the number of DoLS referrals per Supervisory Body over the last 4 years.

REFERRALS	2013/14	% of Referrals	2014/15	% of Referrals	2015/16	% of Referrals	2016/17	% of Referrals	2017/18	% of Referrals
Cardiff	32	34.4%	866	49.1%	778	39.4%	882	41%	1012	40%
Vale Council	6	6.4%	489	27.7%	534	27%	424	20%	458	18%
C&V UHB	55	59.1%	406	23%	661	33.5%	837	39%	1036	42%
Total	**93**	100%	**1761**	100%	**1973**	100%	**2143**	100%	**2506**	100%

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The figures shown above indicate a continued increase in the number of referrals being received by the team.

The table below demonstrates the % increase for each partner in 2017/18 from the numbers in 2016/17

Cardiff Council	**14%**	**882>1012**
Vale Council	**8%**	**424>458**
Cardiff & Vale UHB	**24%**	**837>1036**

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The following table shows referrals broken down into type of request (2017/18) :

	Urgent	Standard	Further	Part 8 Review	Total
Cardiff Council	118	702	180	12	**1012**
Vale of Glamorgan	65	300	90	3	**458**
C&V UHB	639	175	113	8	**1036**

As demonstrated in the figures above the UHB have a significantly higher number of urgent requests. The team is able to meet statutory timescales for Urgent Authorisation Requests which primarily are made from hospital wards. The Partnership Board has accepted that Urgent Requests need to be prioritised. The DoLS co-ordinator continues to use the prioritisation matrix in order that we can respond in a timely manner to requests which have the highest priority.

The following table shows the number of requests that have subsequently been withdrawn (2017/18) :

	Urgent	Standard	Further	Part 8 Review	Total
Cardiff Council	11	238	44	0	**294**
Vale of Glamorgan	11	178	19	0	**208**
C&V UHB	129	156	54	0	**339**

Assessment requests are withdrawn for a variety of reasons, it is the responsibility of the managing authority to inform the DOLs Team that the assessment request is no longer required. Work is ongoing with the DOLs co-ordinator and the managing authorities to ensure they are consistently advising us of withdrawn requests. There are a number of administrative processes associated with withdrawn requests and the code requires that processes are followed following withdrawn requests.

Best Interest Assessments

ASSESSMENTS	Completed Assessments 2015/16	% Completed Assessments 2015/16	Completed Assessments 2016/17	% completed assessments 2016/17	Completed Assessments 2017/18	% completed Assessments 2017/18	Outstanding Assessments 2017/18
Cardiff Council	305	32.4%	409	36%	508	31%	503
Vale Council	216	22.9%%	191	17%	328	19%	230
C&V UHB	419	44.5%%	522	47%	840	50%	95
Total	**940**		**1122**		**1676**		**828**

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The WeTThe Welsh Government Expert Group have estimated by talking to each Supervisory Body that each DoLS Assessment takes on average one whole working day when taking into account the coordination, interview, consultation and administration for each assessment. The Cardiff and Vale DoLS Team averages 1.5 assessments per BIA, per working day.

Outstanding Assessments

The previous table indicates the number of outstanding assessments for those requests received in 2017/18. The table below details the number of overall outstanding assessments broken down by type of request :

	Urgent	Standard	Part 8 Review	Further	Total
Cardiff Council	27	714	1	177	**919**
Vale of Glamorgan	4	318	1	95	**418**
Cardiff & Vale UHB	23	63	31	0	**117**
TOTAL	**54**	**1095**	**33**	**272**	**1454**

As the figures above demonstrate the team are working hard to respond to all requests, however have to prioritise using the All Wales Priority Matrix. The demand across all three partners is recognised and assessments are completed on behalf of all three in a fair and proportionate way.

The Deprivation of Liberty Safeguards Annual Monitoring Report (2016/17) demonstrates the high level of urgent applications across all health boards due to the acute nature of the settings.

DoLS Authorisations

The Authorisation of completed DoLS assessments is an essential and important part of safeguarding vulnerable people. The Code is clear that the Authorisation must be undertaken by a senior manager independent of the provision of the care. The Partnership Board is asked to note that:

- Cardiff Council have recruited a MHA/MCA Lead to act as main Authoriser which has seen a significant reduction in the number of assessments awaiting authorisation (previously outstanding numbers were 76 March 2017; 63 Sept 2017
- C&V UHB are reviewing their Authoriser protocol;
- Vale of Glamorgan will continue with OM and HoS Authorisation

AUTHORISATIONS	Outstanding Authorisations 31 March 2018
Cardiff Council	8
Vale Council	10
C&V UHB	54

Authorisers from Cardiff Council & Vale of Glamorgan Council attended a training event specifically for authorisers in 2018. The training aimed to provide authorisers further awareness and insight into the role and the requirements/ criteria that should be evidenced.

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Section 12 Doctors

Currently each and every DoLS Assessment requires a mental health and eligibility assessment by a Section 12 (MHA83) medical examiner at a cost of £182. The cost per Supervisory Body is indicated in the table.

The LPS scheme, although requires a medical assessment, the independent reviewer is able to make use of existing medical assessments rather than commissioning a stand-alone assessment. This represents a significant saving over the resource heavy DoLS process.

Use of Section 12 Doctors	Total number of occasions Sec 12 doctor used (2017/18)	Total Cost (£)
Cardiff Council	254	£46,319.98
Vale Council	116	£21,189.46
C&V UHB	613	£111,648.48

7.1

RPR/IMCA Reviews

The role of the IMCA/Relevant Persons Representative in protecting the rights of people deprived of their liberty cannot be overstated. AJ vs A Local Authority [2015] reminded supervisory Bodies of the duty to nominate a paid RPR (IMCA) where the SB is not satisfied that the relevant person has a representative to appropriately maintain contact, represent and support him or her. The table shows the number of referrals for a paid RPRs per authority and the number of reviews requested by RPRs.

It should be noted that since this case law the use of advocacy services to fulfil the role of RPR has increased. This has resulted in significantly increased costs for Cardiff Council & Vale of Glamorgan Council for 2017/18. Cardiff & Vale UHB use their own advocacy arrangements for RPRs and do not contribute towards the RPR arrangements. Costs for this period are detailed in the table below.

Relevant Persons Representative 2017/18	Total Cost
Cardiff Council	£55,147.40
Vale Council	£49,253.79
C&V UHB	0

Although the volume of applications for DoLS are lower in the Vale, the length of time the service users remain subject to DoLS and therefore require further assessment is significantly more than Cardiff. This is due to the number of large residential homes and age demographic of Vale residents.

Partnership Agreement

A formal partnership agreement has been proposed, utilising Vale of Glamorgan template setting out the following:

- Function of Partnership Board
- Confirmation of Vale of Glamorgan as lead provider
- Confirmation of Funding agreement
- Resolution of complaints
- Quality Assurance
- Information Sharing Protocol

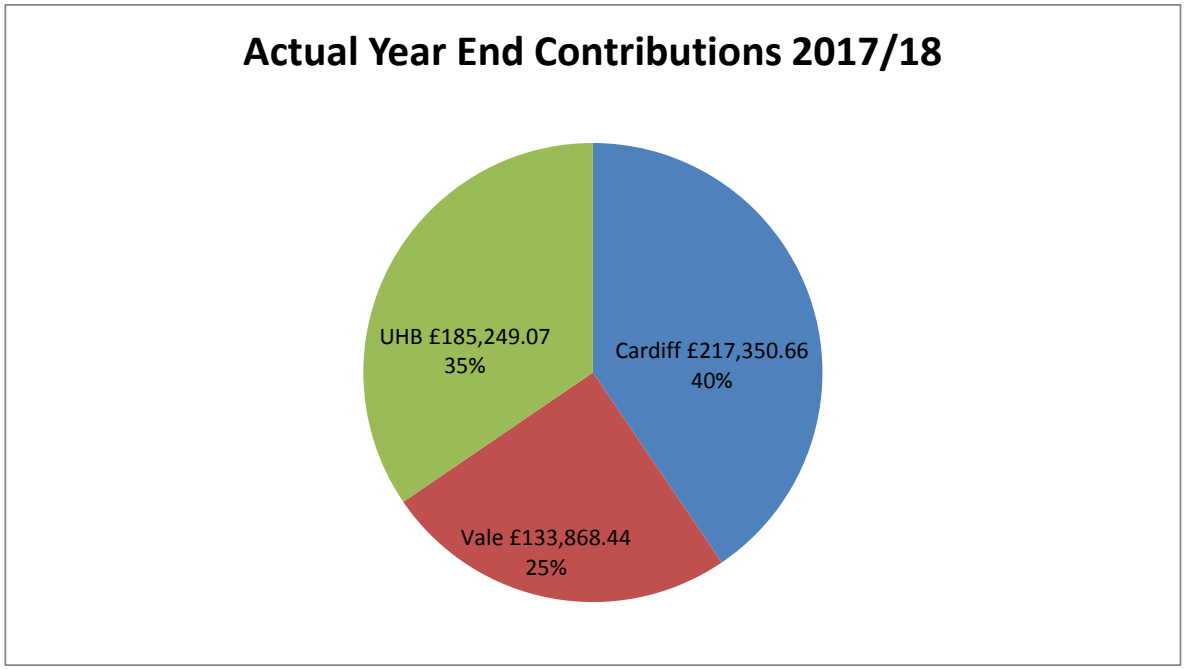
Cardiff and Vale Partnership Funding

The funding contributions from the three partners are as follows:

- Cardiff Council 40.74% plus 1 BIA post @ £45,000
- Vale of Glamorgan Council 14.65% plus 1 BIA post @ £45,000

- Cardiff & Vale UHB 44.61% with additional contribution of £7,000 in 2017/18

The total expenditure for the DoLS team for 2017/18 period is £536,468.18. The contribution of each partner is detailed below:



	Actual Funding % 2017/18	No. of assessments according to funding %	Actual Assessments Completed	Difference between allocation and actual
Cardiff Council	40%	670	508	-162
Vale Council	25%	419	328	-91
C&V UHB	35%	569	840	+271

As the figures demonstrate there is a disproportionate amount of assessments undertaken compared with the actual funding contribution. However, what needs to be taken into consideration is also the acute nature of the deprivation and the requirement, Cardiff & Vale UHB will have more urgent requests due to the unplanned nature of the admissions.

Issues to consider

The Cardiff and Vale DoLS Partnership Board is asked to note and consider:

Best Interest Assessors capacity/resource

- Ongoing risk associated with the number of outstanding DoLS Authorisation requests.

DoLS Team Funding

- The UHB might wish to consider increasing funding to the DoLs Team to ensure continued compliance with the safeguards
- Renegotiating the DoLS funding equation or revising funding arrangements

Partnership Agreement

- Letter of Understanding confirming Vale of Glamorgan as Lead Provider – this needs to be agreed and signed off
- Information Sharing Protocol - this needs to be agreed and signed off

Cardiff and Vale DoLS Partnership Board Report
April 2018

Natasha James
Operational Manager, Safeguarding & Service Outcomes
Vale of Glamorgan Council

7.1

Deprivation of Liberty Safeguards

Annual Monitoring Report for Health and Social Care 2015-16

7.2

AGGCC CSSIW
Arolygiaeth Gofal a Gwasanaethau Cymdeithasol Cymru
Care and Social Services Inspectorate Wales

agic hiw
Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

DRIVING IMPROVEMENT THROUGH INDEPENDENT AND OBJECTIVE REVIEW

7.2

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Introduction

This is the seventh annual report on the operation of Deprivation of Liberty Safeguards (DOLS) in Wales.

The intention of the Mental Capacity Act 2005 is to protect and empower people who lack mental capacity, but in certain circumstances need to be deprived of liberty in order to receive appropriate care and treatment in hospitals and care homes. The DoLS were established in 2009 and set out a process to ensure that people who lack capacity to consent to their care are deprived of their liberty only if it is determined to be in their best interests. Independent assessments of their capacity are made, and decisions can be challenged by appeal to the Court of Protection.

A deprivation of liberty is described as:

- when a person is under continuous or complete supervision and control, and
- is not free to leave, and
- lacks capacity to consent to these arrangements.

The Cheshire West case set a precedent that anyone who meets the new legal test (as above) will be considered to be deprived of their liberty and subject to a protective care regime. They should benefit from regular independent reviews to ensure that their placement and any restrictions on their movement remain in their best interests. The DoLS have brought human rights centre stage and ensure that people who lack capacity and are deprived of their liberty have a representative voice. The safeguards provide for access to advocates and the right to legally challenge any deprivation of liberty.

Care homes and hospitals must apply to the relevant supervisory body for approval to deprive someone of their liberty. The DoLS set out the process that must be followed. The supervisory body must make sure that a number of specific assessments are carried out before granting an authorisation. In exceptional circumstances, a hospital or care home can deprive liberty for a short time through an urgent authorisation but a standard application must also be submitted to the relevant supervisory body.

Welsh Ministers are responsible for monitoring the operation of DoLS in Wales. This is carried out on their behalf by Healthcare Inspectorate Wales (HIW) and Care and Social Services Inspectorate Wales (CSSIW). This report analyses the 2015/16 data on the use of DoLS and summarises the key findings. The data is collected from the supervisory bodies, comprising 22 local authorities (councils) and seven health boards (HBs), which carry out the independent assessments of capacity.

The most recent data continues to show a rise in applications. To help address the increased volume of applications and to support health boards and councils to fulfil their legal obligations, Welsh Government provided funding to assist with best interest assessor training. A conference was held in October 2015 to promote awareness and understanding of the Mental Capacity Act provisions.

In addition, the Welsh Government established an action plan to improve the operation of DoLS which included the development of guidance for supervisory bodies and managing authorities with the aim of providing a 'once for Wales' solution. Revised standard forms for DoLS were published in October 2015 in order to ensure the correct processes are followed and promote consistency.

In March 2014, the House of Lords published a post-legislative scrutiny report of the Mental Capacity Act. The report concluded that DoLS were "not fit for purpose" and recommended a comprehensive review. The conclusion of the Law Commission review which followed, found that local authorities and the NHS were struggling to meet their legal obligations, and people living in other settings – such as supported living – were being left unprotected. After consultation on emerging solutions, the final report of the Law Commission review and a draft Bill were published on 13 March 2017. They recommend that the DoLS be repealed with pressing urgency and set out a replacement scheme, called the Liberty Protection Safeguards. In addition the draft Bill proposes wider reforms to the Mental Capacity Act that will provide greater safeguards for people before they are deprived of their liberty.

This year's Monitoring Report reaffirms the findings of the Law Commission and shows a system that is struggling to cope – in practice, the DoLS system is not 'fit for purpose' and consequently, the provision of additional resource and improved operating practices have had a limited impact in improving the operation of the system.

Key Findings

- **The number of applications**

There was a continued increase in the total number of DoLS applications received by supervisory bodies across Wales, rising by over fifteen per cent from 2014/15 to 12,298 applications from 10,681. The rate of increase was greatest in health boards (HBs) at 41 per cent. Local Authorities (councils) in the south west had a substantially higher number of applications than the rest of Wales. Also, there were large variations in the rate of increase between the different councils with some seeing a decrease in applications received.

- **Rate per 100,000 population**

The number of applications received per 100,000 people in each council varied across Wales with an average of 356 per 100,000. Whilst HBs received considerably fewer applications than councils overall, with an average of 142 per 100,000, there was also a wide variation in the rate of applications: Abertawe Bro Morgannwg received 340 applications per 100,000 population and Aneurin Bevan only 35. This extreme difference in applications between HB's seems difficult to explain

- **Urgent authorisations**

Seventy four per cent of applications relating to urgent authorisations processed by councils and HBs exceeded the seven day timeframe and two councils did not meet the timescale for assessments on any of the urgent applications they received. HBs had a higher proportion of urgent applications than councils with an average of just over 60 per cent of all applications being urgent. The volume of urgent applications appears to have resulted in longer delays before a decision could be made and there were significant variations across supervisory bodies in the time taken to process applications.

- **Standard authorisations**

Almost 27 per cent of applications to either councils or HBs had a decision within the required time scales. The average rate of standard applications to councils which met the 21 day target was almost 20 per cent. The volume of applications across both councils and HBs clearly had a negative impact on processing times for standard authorisations and the number of days taken to make a decision. The number of days taken to make a decision indicates that generally urgent applications were prioritised over standard.

- **Authorisations**

The average authorisation rate across councils was 56 per cent and for HBs the figure was 38 per cent. Again, there was a wide variation in rates across the supervisory bodies and between the authorisation rates of standard and urgent applications.

- **Length of time that authorisations are in place**

The length of time that authorisations were in place increased from last year and there were differences in the average length of time authorisations were granted across the different regions. Applications to councils were more likely to be authorised for up to a year at an average of just over 69 per cent; whereas applications to HBs were less likely to be authorised for a year and had an average duration of 120 days.

- **Reviews, Independent Mental Capacity Advocates and Court of Protection**

The number of DoLS authorisations where a review was carried out during the period still remained low at only 1% of authorisations. Overall, the vast majority of authorisations lapsed before a review was undertaken. Of the 12,298 applications in 2015/16, 336 had an Independent Mental Capacity Advocate (IMCA) appointed and 39 were referred to the Court of Protection.

Analysis

This year's report has looked at whether the additional resources and the revised guidance have helped in streamlining the process for supervisory bodies and improving effectiveness. While there has undoubtedly been benefit in Welsh Government having established a single process and a consistent set of documents for DoLS applications, it is not possible to determine whether this has helped to improve practice. The continuing volume of applications has meant that overall, the provision of additional resource and streamlined processes have had a limited impact in improving the operation of the system.

- **Effectiveness of DoLS**

The proportion of authorisations meeting decision time targets indicates that overall councils and HBs are continuing to struggle to cope with the volume of applications despite evidence of having increased capacity in most cases. The data indicates that urgent applications are prioritised but this does appear to have a knock on effect on the time taken to process standard applications. Most councils are dealing with significant backlogs. The delays in processing applications and carrying out assessments, coupled to the low levels of reviews, increase the risk that people could be deprived of their liberty without the protection of the safeguards.

- **Validity of longer length authorisations and people's best interest**

Whilst The Code of Practice on DoLS supports the use of short authorisations, the data shows that the length of time authorisations were in place has further increased. Applications to councils are more likely to be authorised for up to a year and the safety net provided by the completion of reviews is not effective with only one percent of reviews carried out during the year.

- **Capacity to support the demand for DoLS applications**

The continued high level of applications for authorisations, together with the further increase in 2015/16, remains a significant pressure on council resources. The data indicates that in most if not all councils, the pressure of managing the DoLS processes (including conducting assessments and reviews) exceeds the available resources. This is despite evidence that capacity has been increased with councils seeking to appoint dedicated staff. Welsh Government funding has enabled an increase in best interest assessors (BIAs). In some councils this has been achieved by training social workers to undertake this role. The availability and cost of appointing independent BIAs remains a challenge.

- **Training of staff in hospital settings to address possible over reliance on DoLS**

During HIW's inspection process the knowledge of staff in relation to DoLS has been very variable. HIW has found that some staff have very little knowledge around the process whereas other staff have a good working knowledge. Clearly the second group of staff are more equipped to explore options other than DoLS and conversely, where there is less understanding other options maybe less likely to be considered.

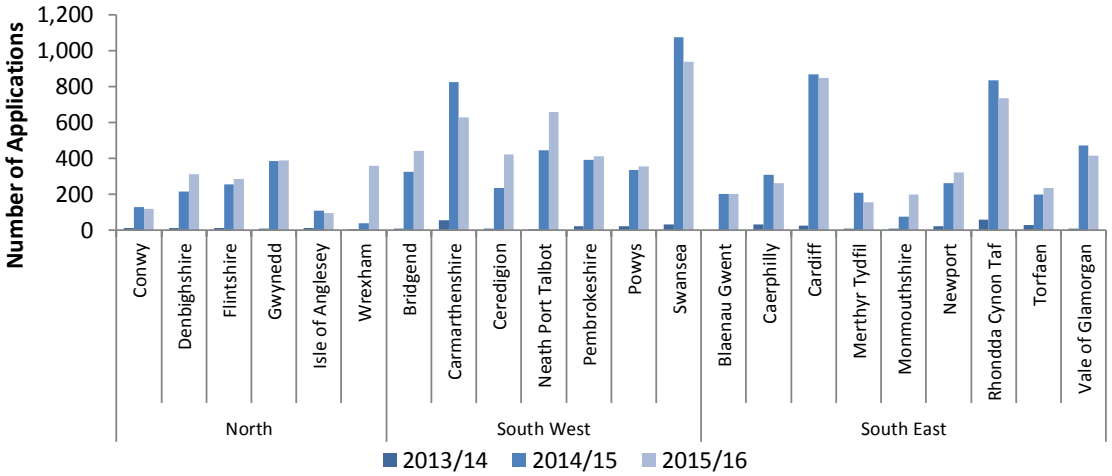
Also there may be an issue within some dementia care wards where there appears to be a blanket approach to making all the patients accommodated subject to the DoLS process. Training of staff in this area is essential to ensure they are equipped and able to determine when patients require the application of the DoLS. We did not find that such training was consistently being used to improve skills in this area.

Number of applications

There has been a substantial increase in applications since 2014-15. In 2013/14 there were 631 applications, this increased to 10,681 in 2014/15 and in 2015/16 there were 12,298 applications[1]. Of the 12,298 applications received, 8,792 were to councils. This is an increase of 7.3 per cent since 2014/15.

However, there are large differences in the rate of change between the different councils, for example, Wrexham had nearly ten times the number of applications in 2015/16 as received in 2014/15; however, Monmouthshire had only three times as many. During the same period Merthyr Tydfil and Carmarthenshire both saw a decrease in applications received of approximately 25 per cent, see Figure 1a.

Figure 1a. Number of applications to Local Authorities (2013 to 2016)

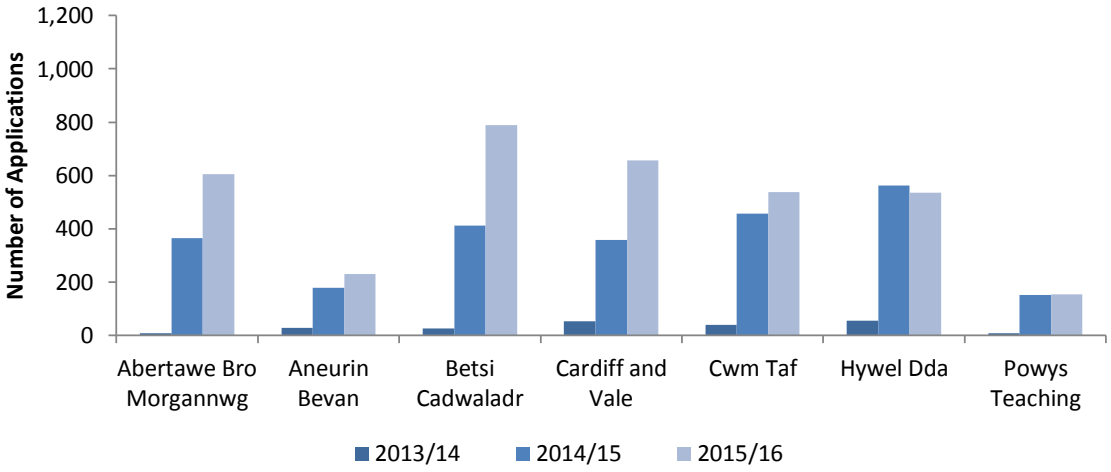


Councils in the south west (Bridgend, Carmarthenshire, Ceredigion, Neath Port Talbot, Pembrokeshire, Powys and Swansea) had a substantially higher number of applications than the rest of Wales, with an average of 551compared to a national average of 400. This is despite the number of care homes in this region being roughly the same as the other regions (256 in the south west, 255 in the north and 250 in the south east). In comparison, HBs received an average of 501 applications.

HBs received 3,506 applications and show a similar pattern of increase. The rate has been greater for HBs than for councils with an increase of 41.0 per cent (2,486 applications were received in 2014/15). However, this is not consistent as both Betsi Cadwaladr and Cardiff and Vale had nearly double the number of applications, while Hywel Dda had a small decrease, see Figure 1b.

[1] 7,679 applications were processed during the year with the remainder either still in progress at 31st March 2016 or had missing data.

Figure 1b. Number of applications to Health Boards (2013 to 2016)

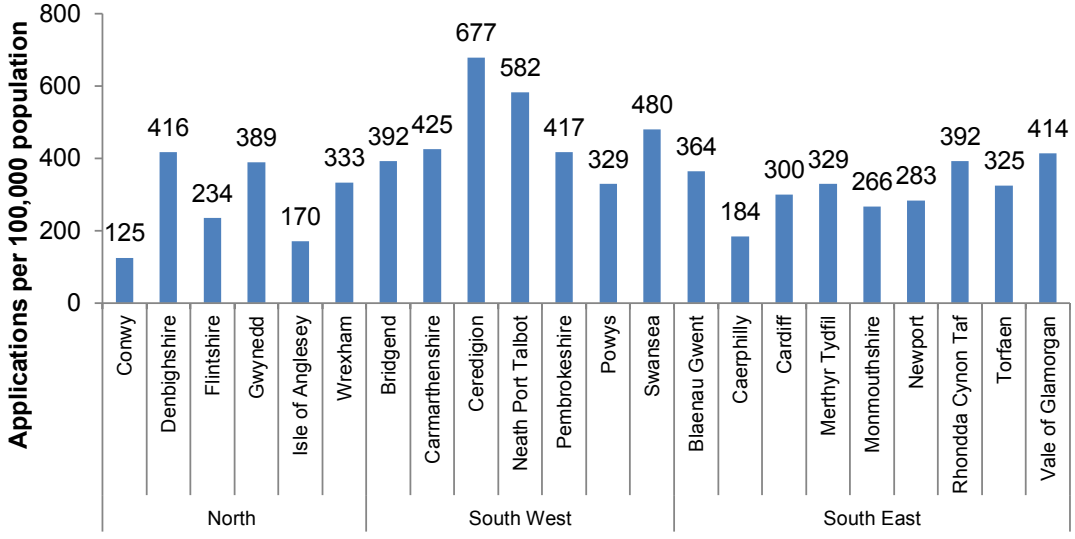


7.2

To aid comparison Figure 2a shows the number of applications received per 100,000 population. For councils, the average number received was 356 per 100,000 population but there were significant variations. Ceredigion had the highest number of applications when compared to the population, with 677 per 100,000 while Conwy had 125 applications per 100,000.

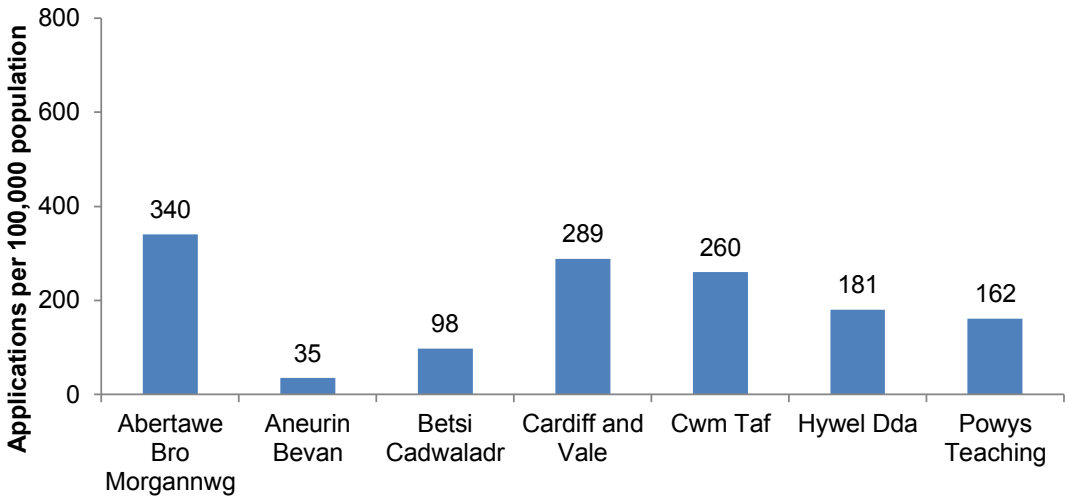
Councils in the south west had a considerably higher rate of applications with an average of 472 applications per 100,000 people, while those in the south east had an average of 317 and the North 278.

Figure 2a. Number of applications to Local Authorities by 100,000 population (2015-16)



For the purpose of this analysis, the population for HBs has been calculated by aggregating the populations of the council areas they cover. The average for HBs is 142 applications per 1000 population and Figure 2b shows there are also significant variations across the HBs with Abertawe Bro Morgannwg receiving 340 applications per 100,000 and Aneurin Bevan receiving only 35.

Figure 2b. Number of applications to Health Board by 100,000 population Boards (2015/16)



Authorisation type and timeliness

The authorisation of a deprivation of liberty can take two forms, urgent or standard. Where deprivation of liberty unavoidably needs to commence before a standard authorisation can be obtained, managing authorities may authorise a deprivation of liberty for a short period of time – seven days (this may be extended by a further seven days). This urgent authorisation must be accompanied by a request to the supervisory body for a standard authorisation for which the assessments must be completed within five days.

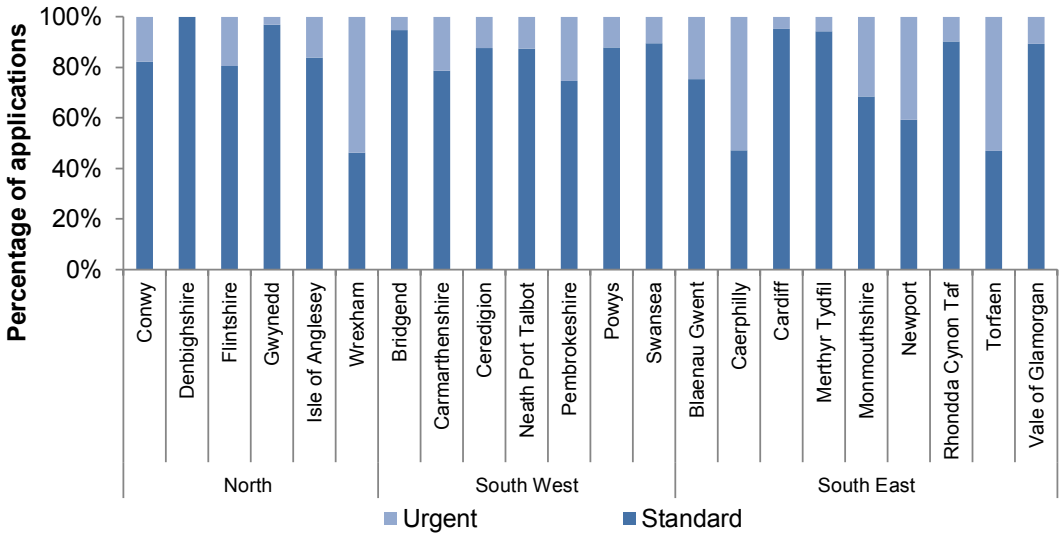
For other cases, an application for a standard authorisation must be made to the Supervisory Body. Assessments relating to the standard authorisation should be completed by the supervisory body within 21 days.

Ratios of urgent to standard applications

Figure 3a shows the ratios of urgent applications to standard applications for each council. Of the total applications to councils in 2015/16, 7,181 related to standard and 1,496 to urgent authorisations. On average across councils, nearly 20 per cent of all applications related to urgent authorisations.

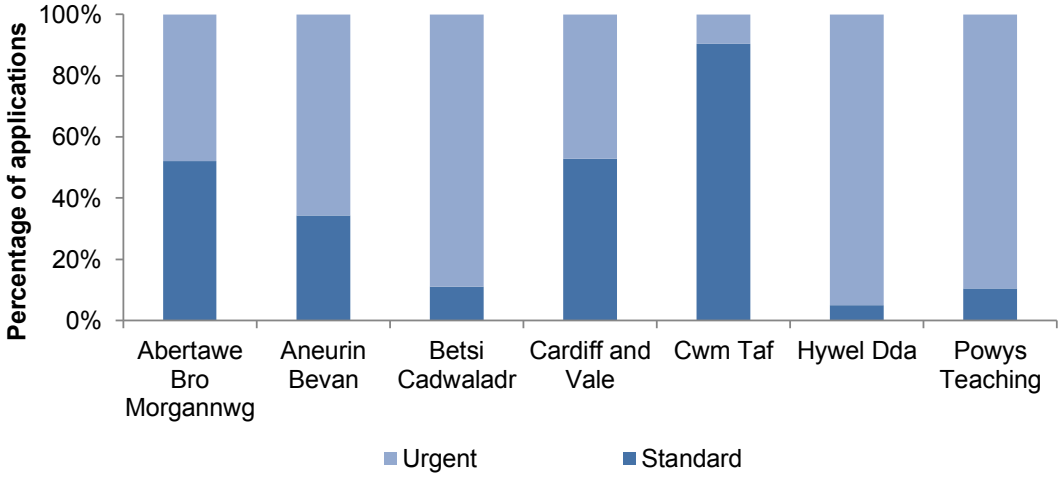
Some councils such as Caerphilly, Wrexham and Torfaen have over 50 per cent of their applications relating to urgent authorisations. In contrast, Denbighshire received no applications relating to urgent authorisations and Gwynedd had only 3 per cent.

Figure 3a. Proportion of the type of applications to Local Authorities (2015/16)



HBs have a higher proportion of applications relating to urgent authorisations than councils with 1,340 applications for standard authorisations and 2,132 applications relating to urgent authorisations. This means an average of 63 per cent of all applications to HBs related to urgent authorisations, see Figure 3b. However, this rate varied considerably across HBs with 95 per cent in Hywel Dda, 89 percent in Powys Teaching and Betsi Cadwaladr and 9 per cent in Cwm Taf.

Figure 3b. Proportion of the type of applications to Health Boards (2015/16)



Time between application and decision

Urgent and standard authorisations have different timescales for the completion of assessments:

- 73 percent of standard applications that were processed exceeded the 21 day time period within which the supervisory bodies have to carry out the assessments.
- 74 per cent of applications relating to urgent authorisations exceeded the seven day time limit for a deprivation of liberty - with 53 per cent exceeding the maximum period of 14 days.

These results show a deteriorating position from last year where 56 per cent of standard applications exceeded the 21 day deadline.

Table 1 shows the detailed breakdown of the number of applications received, the percentage that were authorised, the percentage within the 21 and seven day timescales and the average number of days taken to make a decision.

The average percentage of applications relating to urgent authorisations that have a decision made within seven days is only 28 per cent for councils, increasing to 47 per cent within 14 days (the maximum period an urgent authorisation should be in force). Across all councils there were 220 requests for an extension to urgent authorisations, which represents 15 per cent of all urgent applications

Table 1 also shows how many days each application took on average to receive a decision. The results show that there were significant delays and a wide variation in times taken by councils. The picture is similar, though not so pronounced for HBs where 38 percent of standard applications had a decision within 21 days.

Table 1. The number, authorisation rate, percentage meeting decision time targets and the average number of days before a decision for all applications (2015/16)

	Standard				Urgent			
	Number Received	Authorised	Meeting Decision Time	Average Days Before Decision	Number Received	Authorised	Meeting Decision Time	Average Days Before Decision
Blaenau Gwent	153	40%	5%	126	50	53%	0%	71
Bridgend	419	73%	14%	88	24	77%	55%	13
Caerphilly	123	38%	23%	84	138	41%	2%	85
Cardiff	808	66%	21%	76	42	69%	38%	19
Carmarthenshire	465	7%	41%	61	127	23%	36%	32
Ceredigion	311	20%	45%	62	44	48%	24%	36
Conwy	97	99%	24%	77	21	81%	29%	13
Denbighshire	313	23%	9%	72	0	0%	None	None
Flintshire	230	81%	16%	74	56	82%	23%	39
Gwynedd	367	57%	30%	102	12	73%	18%	71
Isle of Anglesey	78	71%	0%	161	15	100%	0%	263
Merthyr Tydfil	145	53%	22%	77	9	33%	33%	11
Monmouthshire	136	44%	12%	121	63	50%	5%	111
Neath Port Talbot	575	82%	6%	99	83	57%	50%	10
Newport	191	55%	35%	80	132	48%	2%	116
Pembrokeshire	307	68%	41%	48	105	64%	49%	20
Powys	311	35%	7%	97	43	68%	5%	75
Rhondda Cynon Taf	664	44%	20%	84	72	69%	7%	56
Swansea	840	66%	14%	81	98	77%	48%	10
Torfaen	111	48%	39%	115	125	42%	4%	105
Vale of Glamorgan	372	64%	20%	87	45	63%	60%	9
Wrexham	165	26%	17%	97	192	42%	17%	51
LA Average	326	55%	20%	84	68	57%	28%	46
Abertawe Bro Morgannwg	299	50%	39%	36	274	49%	32%	23
Aneurin Bevan	79	41%	32%	52	151	30%	17%	40
Betsi Cadwaladr	87	53%	24%	40	701	28%	1%	29
Cardiff and Vale	346	56%	42%	37	309	62%	65%	7
Cwm Taf	486	14%	37%	45	51	21%	35%	20
Hywel Dda	27	19%	74%	15	509	15%	35%	18
Powys Teaching	16	7%	20%	44	137	11%	7%	56
HB Average	191	37%	38%	40	305	39%	28%	21

The delays in decision making raise a serious concern about the effectiveness of the safeguards and the risk of unauthorised and unnecessary deprivations of liberty in hospitals and care homes.

Authorised applications

When deciding whether an application should be authorised, there are six assessments that must be made (see Glossary). These are:

- Age
- Best Interests
- Mental Capacity
- Eligibility
- Mental Health
- No Refusals

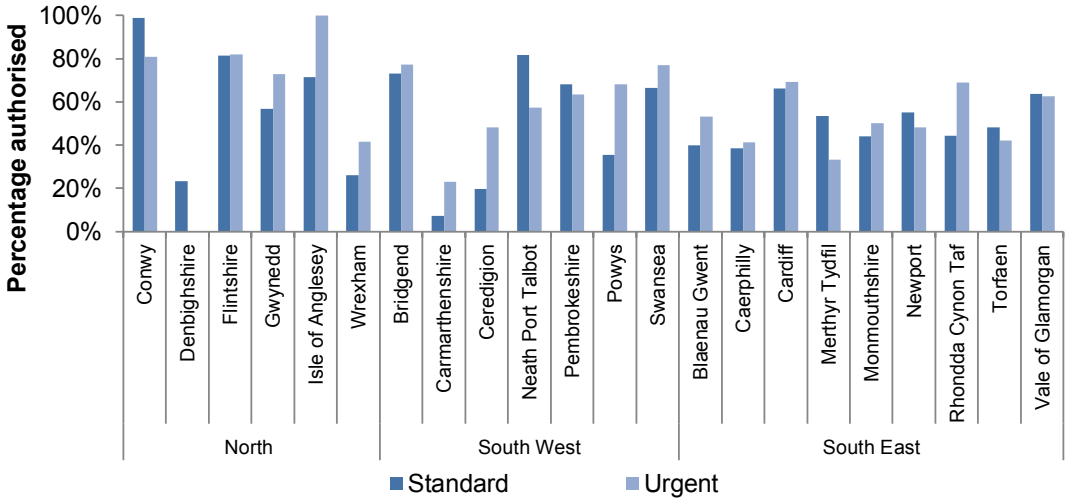
In addition to failing these assessments, applications may also not be authorised for other reasons such as being withdrawn, cancelled, or discharged from the service.

Of the 7,679 applications processed in 2015/16, the total number of authorisations was 3,394. This means that less than 50 per cent of all applications were authorised in 2015/16.

Councils processed 4,220 applications, of which 3,332 were standard authorisations and 888 related to urgent. A total of 2,324 authorisations were made by councils in 2015/16, 504 of which related to urgent authorisations. The average authorisation rate across all councils was 55 per cent.

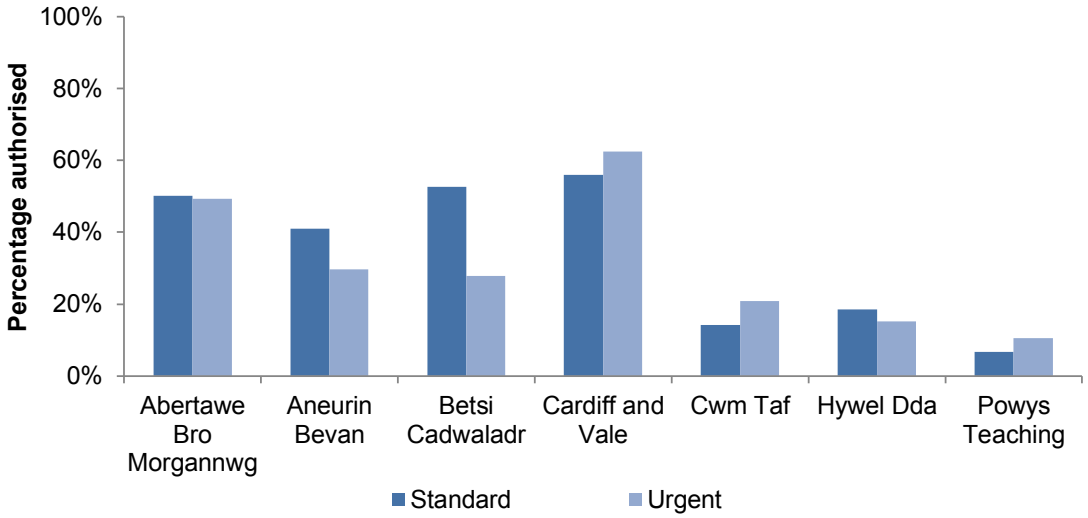
Figure 4a shows the proportion of applications that were authorised by each council. Applications relating to urgent authorisations were more likely to be authorised than standard across Wales. However, the position was variable and the rate of urgent to standard authorisations was much higher in some councils such as Powys, Ceredigion and Isle of Anglesey and lower in others, such as such as Neath Port Talbot and Merthyr Tydfil.

Figure 4a. Proportion of applications authorised by Local Authorities (2015/16)



Of the 3,506 applications received by HBs, 3,165 were processed in 2015/16, 1,171 of which were standard and 1,994 related to urgent authorisations. HBs authorised 1,070 applications in 2015/16, of which 438 were standard and 632 related to urgent authorisations. The average authorisation rate for HBs is lower than councils, with 34 per cent of all applications being authorised. Some HBs have a higher overall authorisation rate, such as Cardiff and Vale at 59 per cent. However, Powys Teaching authorised only 10 per cent of the applications received, see Figure 4b.

Figure 4b. Proportion of applications authorised by Health Boards (2015/16)



The number of applications that were refused on each of these bases is shown in Table 2. As can be seen, the majority of applications were withdrawn, cancelled or the individual in question died before a decision was made.

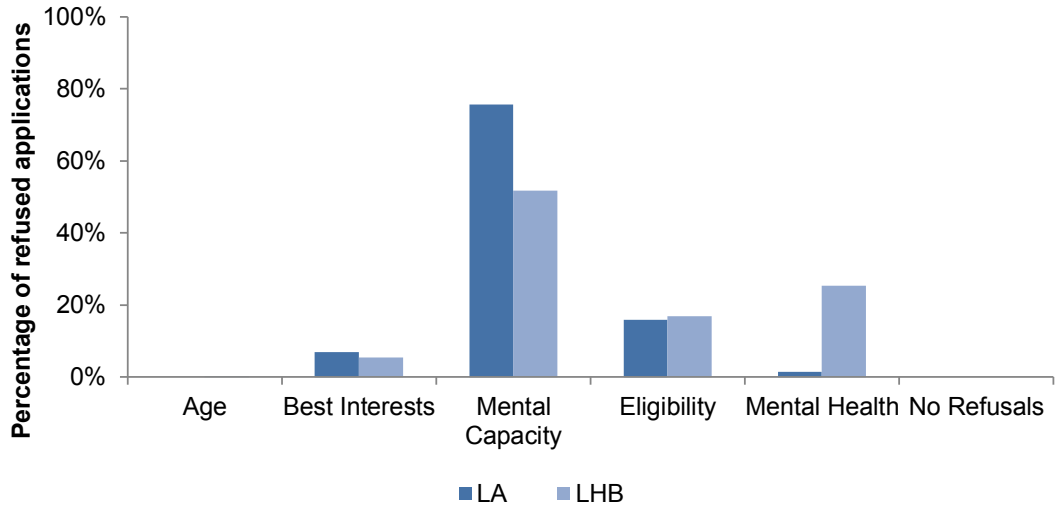
Table 2. The number of applications that were not authorised

	Age	Best Interests	Mental Capacity	Eligibility	Mental Health	No Refusals	Withdrawn, cancelled or deceased	Other
LA	0	19	209	44	Less than 5	0	1380	42
HB	Less than 5	14	131	43	64	0	1615	194
Total	Less than 5	33	340	87	68	0	2995	236[2]

However, if only those that were actually refused are included, the reasons differ between councils and HBs. Figure 5 shows that councils are more likely to refuse an application of the grounds of mental capacity than HBs. However, HBs are more likely to refuse of the basis of mental health.

[2] The others: 164 discharged, 14 transferred, 11 sectioned

Figure 5. The reasons applications were refused in Local Authorities and HBs (2015/16)



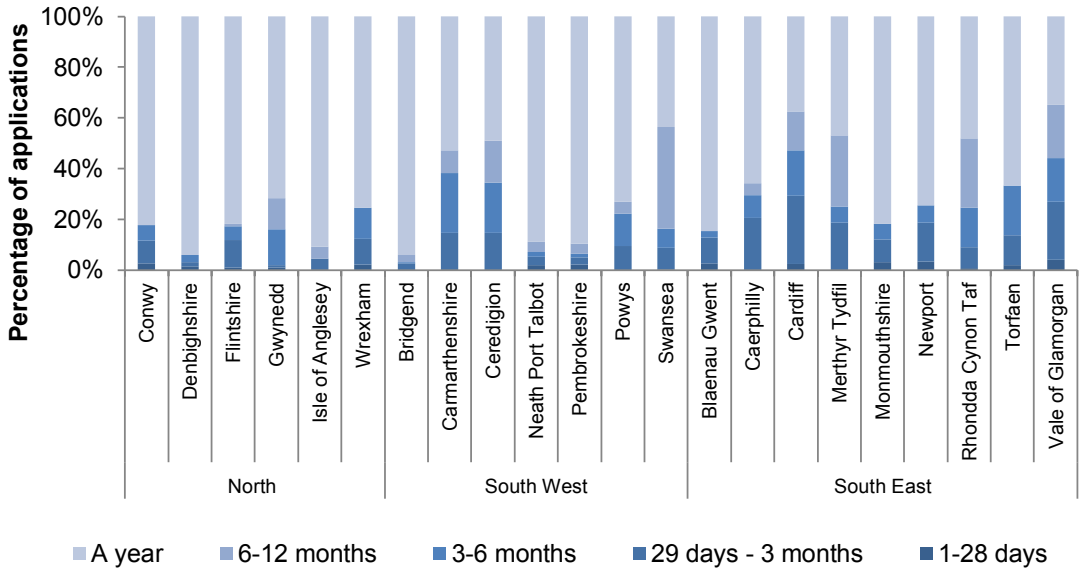
There were 2,995 applications that were withdrawn or where the relevant person died before a decision was made. This accounts for 24 per cent of the total applications. The average proportion of applications that were withdrawn or cancelled was 16 per cent for councils and 46 per cent for HBs.

While some councils had very few withdrawn, Carmarthenshire, Caerphilly and Ceredigion had over a quarter of all applications withdrawn. Compared to this, HBs had a much higher level of withdrawals, with the exception of Abertawe Bro Morgannwg and Cardiff and Vale which had fewer than half of the applications withdrawn.

Length of time authorisations were valid

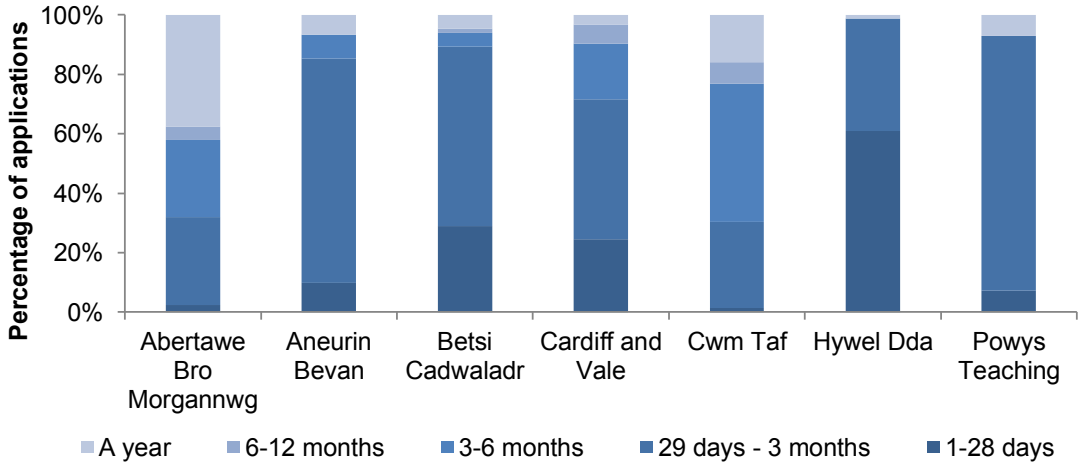
Once an application has been made, the supervisory body will then make an assessment of the information provided to determine how long the deprivation of liberty will be authorised for. Most applications to councils were authorised for up to a year - on average 69 per cent. This level varied across councils with some having considerably higher rates such as Bridgend and Denbighshire at 94 per cent, the Isle of Anglesey at 91 per cent. In contrast others had considerably lower rates: Vale of Glamorgan at 35 per cent and Cardiff at 37 per cent. See Figure 6a.

Figure 6a. Length of time applications are valid for by Local Authority (2015/16)



Applications to HBs were less likely to be authorised for a year with an average of 14 per cent. Sixty four percent were for three months or less. Here again, the rate varied across HBs: Abertawe Bro Morgannwg at 38 per cent for a year and 32 percent for three months or less; while Hywel Dda at 1 per cent for a year and 99 per cent for three months or less. See Figure 6b.

Figure 6b. Length of time applications are valid for by Health Board (2015/16)

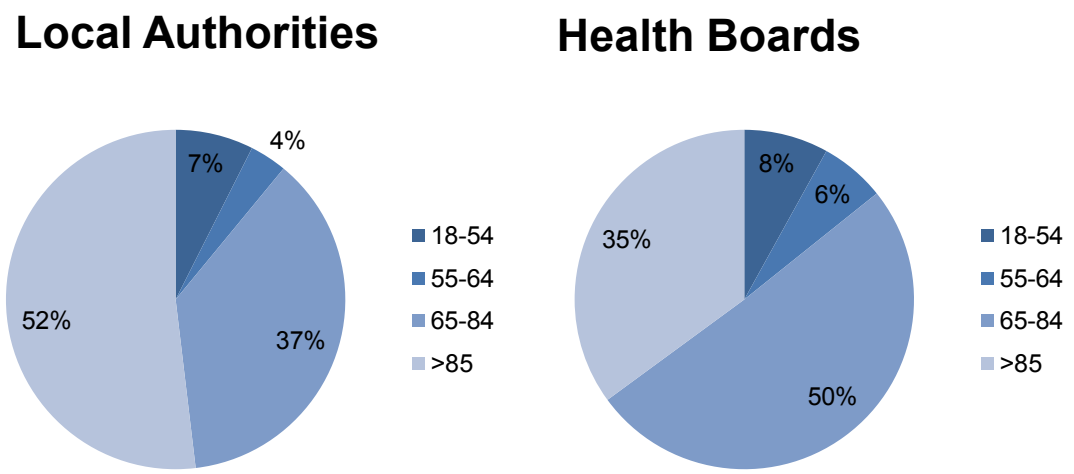


7.2

Demographic Profiles

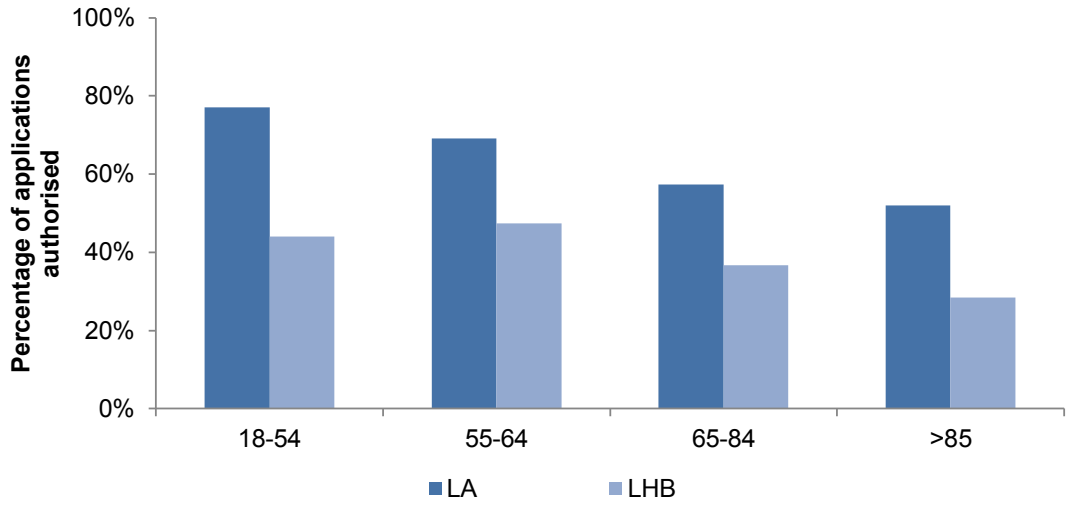
There were substantial differences in the demographic make up of the applications made to councils and HBs. In councils the majority of applications were in regards to older females with 66 per cent of the applications for females and 52 per cent for someone aged 85 and over, see Figure 7. However, HBs had a roughly equal gender split (51 per cent female) and a slightly younger profile with 35 per cent of applications being made for someone aged 85 and over. In both groups, nearly all applications were for someone who was white British (96 per cent).

Figure 7. Age profile of individuals who have had a DoLS application (2015/16)



Requests for older adults were significantly less likely to be authorised. The average authorisation rate across both councils and HBs was 48 per cent with a rate of 63 per cent for those aged 18 to 54 and 44 per cent for those aged 85 and over. As can be seen in Figure 8, the authorisation rate for applications to HBs was consistently lower than those to councils.

Figure 8. Percentage of application authorised by age bands (2015/16)



7.2

Reviews, Independent Mental Capacity Advocates (IMCA) and Court of Protection

The number of DoLS authorisations where a review was carried out during the period remained low at still only 1% of authorisations. The Code of Practice supports the use of short authorisations; however, the length of authorisations has increased and the vast majority lapse before a review is undertaken.

IMCAs are a safeguard for people who lack capacity to make some important decisions. The IMCA role is to support and represent the person in the decision-making process and make sure that the Mental Capacity Act 2005 is being followed.

There are three roles for IMCAs in cases of deprivation of liberty (39A, 39C and 39D):

- 39A appointed when the individual has no one to consult;
- 39C appointed in a case where the individual's representative is temporarily or suddenly no longer able to represent them; and
- 39D appointed to support the individual's representative, if that representative is unpaid (e.g. family member), and it is believed by the supervisory body is in need of support.

The number of cases where an IMCA was appointed decreased from over 500 in 2014/15 to 336 in 2015/16. Of these, 159 were 39A (81 per cent from councils), 37 were 39C (86 per cent from councils) and 140 were 39D (42 per cent from councils).

Any deprivation of liberty can be challenged, usually by the individual's representative, in the Court of Protection. A total of 39 referrals to the Court of Protection were made in 2015/16 (25 applications to councils and 14 to HBs). Despite their relatively small number of total DoLS applications, Wrexham and Flintshire had five referrals each

representing 20 per cent of council referrals. Similarly, nine of the 14 referrals in HBs were from applications to Aneurin Bevan. The majority of councils and HBs had one or fewer referrals in the year.

While any individual can challenge a deprivation of liberty, the appointment of an IMCA appears to make a difference as nearly half of referrals occurred when an IMCA had been appointed. Of the 39 referrals, ten occurred when a 39A was appointed, two when a 39C and five when a 39D was appointed.

Data Quality

The data in this report is used to monitor the use of the deprivation of liberty safeguards throughout Wales. It is submitted by Local Authorities and Health Boards to CSSIW but it is not verified by either CSSIW or HIW.

The monitoring report is published in the last quarter of each financial year. It is not accompanied by any additional tables or data releases.

The definition of what constitutes a deprivation of liberty was changed in 2014, and so data collected in the 2013/14 financial year is not directly comparable to that collected for the 2014/15 and 2015/16 financial years. More information about the changes introduced can be found here:

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/485122/DH_Consolidated_Guidance.pdf

There may be a small number of cases where applications are inappropriately labelled as either standard or urgent and there may be a margin of error in the results. This is not considered to be significant.

GLOSSARY: Key terms used in the DoLS Monitoring Report

Advocacy	Independent help and support with understanding issues and putting forward a person's own views, feelings and ideas.
Assessment for the purpose of the deprivation of liberty safeguards	All six assessments must be positive for an authorisation to be granted.
• Age	An assessment of whether the relevant person has reached age 18.
• Best interests assessment	An assessment of whether deprivation of liberty is in the relevant person's best interests is necessary to prevent harm to the person and is a proportionate response to the likelihood and seriousness of that harm. This must be decided by a Best Interests Assessor.
• Eligibility assessment	An assessment of whether or not a person is rendered ineligible for a standard deprivation of liberty authorisation because the authorisation would conflict with requirements that are, or could be, placed on the person under the Mental Health Act 1983.
• Mental capacity assessment	An assessment of whether or not a person has capacity to decide if they should be accommodated in a particular hospital or care home for the purpose of being given care or treatment.
• Mental health assessment	An assessment of whether or not a person has a mental disorder. This must be decided by a medical practitioner.
• No refusals assessment	An assessment of whether there is any other existing authority for decision-making for the relevant person that would prevent the giving of a standard deprivation of liberty authorisation. This might include any valid advance decision, or valid decision by a deputy or done appointed under a Lasting Power of Attorney.
Best Interest Assessor	A person who carries out a deprivation of liberty safeguards assessment.

Capacity	Short for mental capacity. The ability to make a decision about a particular matter at the time the decision needs to be made. A legal definition is contained in section 2 of the Mental Capacity Act 2005.
Care Home	A care facility registered under the Care Standards Act 2000.
CSSIW	Care and Social Services Inspectorate Wales is the body responsible for making professional assessments and judgements about social care, early years and social services and to encourage improvement by the service providers.
Carer	People who provide unpaid care and support to relatives, friends or neighbours who are frail, sick or otherwise in vulnerable situations.
Conditions	Requirements that a supervisory body may impose when giving a standard deprivation of liberty authorisation, after taking account of any recommendations made by the Best Interests Assessor.
Consent	Agreeing to a course of action-specifically in this report to a care plan or treatment regime. For consent to be legally valid, the person giving it must have the capacity to take the decision, have been given sufficient information to make the decision, and not have been under any duress or inappropriate pressure.
Court of Protection	The specialist court for all issues relating to people who lack mental capacity to make specific decisions. It is the ultimate decision maker with the same rights, privileges, powers and authority as the High Court. It can establish case law which gives examples of how the law should be put into practice.
Deprivation of Liberty	Deprivation of liberty is a term used in the European Convention on Human Rights about circumstances when a person's freedom is taken away. Its meaning in practice is being defined through case law.
Deprivation of Liberty Safeguards	The framework of safeguards under the Mental Capacity Act 2005 for people who need to be

	deprived of their liberty in a hospital or care home in their best interests for care or treatment and who lack the capacity to consent to the arrangements made for their care or treatment
HIW	Healthcare Inspectorate Wales (HIW) regulates and inspects NHS services and independent healthcare providers in Wales against a range of standards, policies, guidance and regulations on order to highlight areas requiring improvement. .
Local Health Board	Local Health Boards fulfil the supervisory body function for health care services and work alongside partner local authorities, usually in the same geographical area, in planning long-term strategies for dealing with issues of health and well-being. They separately manage NHS hospitals and in-patient beds, when they are managing authorities.
Independent Hospital	As defined by the Care Standards Act 2000 - a hospital, the main purpose of which is to provide medical or psychiatric treatment for illness or mental disorder or palliative care or any other establishment, not being defined as a health service hospital, in which treatment or nursing (or both) are provided for persons liable to be detained under the Mental Health Act 1983.
Independent Mental Capacity Advocate (IMCA)	A trained advocate who provides support and representation for a person who lacks capacity to make specific decisions, where the person has no-one else to support them. The IMCA service was established by the Mental Capacity Act 2005 whose functions are defined within it.
Local Authority/Council	The local council responsible for commissioning social care services in any particular area of the country. Senior managers in social services fulfil the supervisory body function for social care services.
Managing authority	Care homes run by the Council will have designated managing authorities. The person or body with management responsibility for the particular hospital or care home in which a person is, or may become, deprived of their liberty. They are accountable

	for the direct care given in that setting.
Maximum authorisation period	The maximum period for which a supervisory body may give a standard deprivation of liberty authorisation, which cannot be for more than 12 months. It must not exceed the period recommended by the Best Interests Assessor, and it may end sooner with the agreement of the supervisory body.
Mental Capacity Act 2005	The Mental Capacity Act 2005 provides a framework to empower and protect people who may lack capacity to make some decisions for themselves. The five key principles in the Act are: 1. Every adult has the right to make his or her own decisions and must be assumed to have capacity to make them unless it is proved otherwise. 2. A person must be given all practicable help before anyone treats them as not being able to make their own decisions. 3. Just because an individual makes what might be seen as an unwise decision, they should not be treated as lacking capacity to make that decision. 4. Anything done or any decision made on behalf of a person who lacks capacity must be done in their best interests. 5. Anything done for or on behalf of a person who lacks capacity should be the least restrictive of their basic rights and freedoms.
Mental Capacity Act Code of Practice	The Code of Practice supports the MCA and provides guidance to all those who care for and/or make decisions on behalf of adults who lack capacity. The Code includes case studies and clearly explains in more detail the key features of the MCA
Mental Disorder	Any disorder or disability of the mind, apart from dependence on alcohol or drugs. This includes all learning disabilities.
Mental Health Act 1983	Legislation mainly about the compulsory care and treatment of patients with mental health problems. It includes detention in hospital for

	mental health treatment, supervised community treatment and guardianship.
Qualifying requirement	Any one of the six qualifying requirements (age, mental health, mental capacity, best interests, eligibility and no refusals) that need to be assessed and met in order for a standard deprivation of liberty authorisation to be given.
Relevant hospital or care home	The particular hospital or care home in which the person is, or may become deprived of their liberty.
Relevant person	A person who is, or may become, deprived of their liberty in a hospital or care home.
Relevant person's representative	A person, independent of the particular hospital or care home, appointed to maintain contact with the relevant person and to represent and give support in all matters relating to the operation of the deprivation of liberty safeguards.
Restriction of liberty	An act imposed on a person that is not of such a degree or intensity as to amount to a deprivation of liberty.
Review	A formal, fresh look at a relevant person's situation when there has been, or may have been, a change of circumstances that may necessitate an amendment to, or termination of, a standard deprivation of liberty authorisation.
Section 12 Doctors	Doctors approved under Section 12(2) of the Mental Heath Act 1983
Standard authorisation	An authorisation given by a supervisory body, after completion of the statutory assessment process, giving lawful authority to deprive a relevant person of their liberty in a particular hospital or care home.
Supervisory body	A local authority social services or a local health board that is responsible for considering a deprivation of liberty application received from a managing authority, commissioning the statutory assessments and, where all the assessments agree, authorising deprivation of liberty.

Supreme Court	The Supreme Court is the final court of appeal in the UK for civil cases, and for criminal cases from England, Wales and Northern Ireland. It hears cases of the greatest public or constitutional importance affecting the whole population
Unauthorised deprivation of liberty	A situation in which a person is deprived of their liberty in a hospital or care home without the deprivation being authorised by either a standard or urgent deprivation of liberty authorisation.
Urgent authorisation	An authorisation given by a managing authority for a maximum of seven days, which subsequently may be extended by a maximum of a further seven days by a supervisory body. This gives the managing authority lawful authority to deprive a person of their liberty in a hospital or care home while the standard deprivation of liberty authorisation process is undertaken.

MENTAL CAPACITY ACT (MCA) 2005 UPDATE REPORT	
Name of Meeting:	**Mental Health and Capacity Legislation Committee**
Date of Meeting:	**26th June**

Executive Lead: Medical Director
Author: Mental Capacity Act Manager – tel: 029 2074 3652
Caring for People, Keeping People Well: This report underpins the Health Board's "Culture" element of the Health Board's Strategy – "Working better together…"
Financial impact: No direct impact of this report, but the failure to comply with MCA could lead to costly complaints and litigation
Quality, Safety, Patient Experience impact: Adherence to MCA will mean that vulnerable patients will receive the treatment and care they need, in line with their best interests.
Health and Care Standard Number: 4.2
CRAF Reference Number: 8.1.3
Equality and Health Impact Assessment Completed: ~~Yes / No /~~ Not Applicable

8

ASSURANCE AND RECOMMENDATION

LIMITED ASSURANCE is provided by;

This Report which is to raise awareness of this aspect of the legal framework within which treatment and care must be provided. The highest area of training outcomes is with nursing staff and then allied healthcare professionals. There is poor engagement by Medical and Dental staff with Mental Capacity Act training.

The Committee is asked to:

Note this report and in particular the action that the Medical Director is taking to improve doctors' compliance with Mental Capacity Act training with the Mental Capacity Act Manager.

SITUATION

The Mental Health and Capacity Legislation Committee has asked for information about the use of MCA in the UHB in order to retain awareness of this issue.

This information does not provide direct assurance about compliance with MCA, which can only be done by scutinising patients' notes. It is possible to pick up trends from the report of the Mental Capacity Act Manager (appendix one) IMCA reports (appendix two) and separate DoLs reports.

These provide evidence of adherence to the MCA but only Limited Assurance.

In view of the particularly poor compliance by doctors with mandatory MCA training (see Appendix 1), the Medical Director will be undertaking to develop a programme of work, with the Mental Capacity Act Manager, to significantly improve the training of doctors and dentists within the next year (using benchmarking as appropriate). This will include:

1. Each Clinical Board will be requested to report for the next meeting of the MHLC their own action plan for training and in particular doctors and dentists.

2. The Mental Capacity Act Manager will liaise with the Clinical Boards and the Learning Education and Development Department for any additional support and ideas for training initiatives.

3. Use of the Clinical Governance Sessions and protected time.

4. Awareness raising of the EIDO on-line training course and The All-Wales MCA e-learning course for use on ESR

5. Communication from the Medical Director to all MCA leads, Clinical Board Directors and Nurse Directors indicating the importance of increased uptake in training opportunities.

6. Use of training sessions (induction sessions) for training grade doctors to facilitate greater awareness of the MCA.

7. Awareness raising using targeted communication methods e.g. Medical Director's Bulletin.

8. Benchmarking against other Health Boards, to measure relative performance for all professional groups in MCA training and ensure upper quartile performance for Cardiff and Vale UHB within the year.

BACKGROUND

The Mental Capacity Act 2005 (MCA) has been in force for over 10 years. It was amended to include the Deprivation of Liberty Safeguards (DoLS), which came into force in April 2009.

The MCA covers three main issues –

- The process to be followed where there is doubt about a person's decision-making abilities and decisions may need to be made for them (e.g. about treatment and care)
- How people can make plans and/or appoint other people to make decisions for them at a time in the future when they can't take their own decisions

- The legal framework for authorizing deprivation of liberty when adult, mentally disordered, incapacitated people are deprived of their liberty in hospitals or care homes (DoLS)

People, aged 16 years and over, who have impaired decision-making abilities may present in any of the services that the UHB provides.

Failure to comply with MCA could lead to the following –

- Patients refusing treatment that they need and their refusal being taken at face value, with no assessment of their capacity to make the decision being made. This could (and does) result in serious harm to vulnerable patients
- Patients not receiving care and treatment tailored to their individual circumstances
- Healthcare professionals and the UHB being sued, prosecuted, complained about and being reported to professional bodies
- Adverse inspection reports and publicity for the UHB

In order to assist UHB staff with understanding and using MCA, the following are in place -

Training (mandatory)

- A module of the EIDO consent e-learning course (not linked with the electronic staff record (ESR))
- Face-to-face teaching from the MCA Manager including Monthly UHB wide sessions at various locations, "Mandatory May and November" training and Senior Medical Induction
- Bespoke training on request
- The All-Wales MCA e-learning course is available for use on ESR

Information and advice

The MCA Manager provides information and advice to UHB staff on all aspects of MCA. There is also a "Mental Capacity" page on the intranet.

Policies and procedures

A number of policies and procedures are in place to support UHB staff in implementing MCA. The MCA Manager also tries to ensure that other policies adequately and accurately reflect MCA where appropriate.

Additional information

Use of MCA within the UHB

Appendix 1 sets out information that indicates the use of MCA within the UHB.

Independent Mental Capacity Advocacy

See also the report (Appendix 2) provided by Advocacy Support Cymru (ASC) – the statutory advocacy provider.

Clinical Board MCA Leads

The following updates have been provided by the MCA Leads –

PCIC CB

- Training on covert meds delivered to the GP CPET sessions meds
- Covert meds decision tool and record taken to PCIC Q&S meeting
- Covert meds scoping exercise with Care Homes (Nursing)
- A section of the PCIC draft dementia plan will include

  "*A capacity assessment should be considered at each contact following a diagnosis of cognitive impairment in relation to having the ability to accept care and support*" as a lesson learnt from an adverse incident.

Surgery CB

- Working with MCA Manager to improve doctors' documentation of mental capacity and best interests

Specialist Services CB

- All Directorates have now completed an audit of mental capacity assessments and the results are in the process of being compiled

Dental CB

- An Easy Read leaflet on anaesthesia is being developed
- An audit of mental capacity assessments is underway – results should be available in August 2018

CD&T CB

No update received

Women and Children CB

Have requested further MCA training sessions from the MCA Manager.

Medicine CB

No update received.

Mental Health CB

No update received.

APPENDIX 1

Mental Health & Capacity Legislation Committee

MENTAL CAPACITY ACT ISSUES AND INFORMATION
May 2018

Information on the use of MCA is as follows –

1) Queries to Mental Capacity Act Manager

Period	No of queries
1/1/17 – 31/3/17	30
1/4/17 – 30/6/17	28
1/7/17 – 30/9/17	36
1/10/17 – 31/12/17	19
1/1/18 - 31/3/18	23

There are no obvious themes or trends to the queries. Some are straightforward, whilst others are complex.

2) Monitoring reports from the Independent Mental Capacity Advocacy (IMCA) service

Referrals from the UHB to IMCA are as follows:

Decision/Issue	Jan-Mar 17	Apr – Jun 17	July – Sept 17	Oct - Dec 17	Jan – March 18
Accommodation	16	18	15	20	14

8.1

POVA Safeguarding	2	2	3	1	2
Care Review	6	1	2	4	2
Serious Med T/ment	4	5	6	7	9
DoLS s.39A	1	4	1	1	0
DoLS s.39C	0	0	0	0	0
DoLS s. 39D	7	5	9	11	7
DoLS RPR	76	82	83	78	59
TOTAL	**112**	**117**	**119**	**122**	**93**

For further information, please see the IMCA service report (Appendix 2)

3) Healthcare Inspectorate Wales (HIW) reports

No inspection reports for the UHB were published in this quarter.

4) Complaints from patients/carers

No complaints concerning or related to MCA issues during this period have been brought to the attention of the MCA Manager. However, it is very likely that there are other complaints in this period which include MCA issues.

5) Public Services Ombudsman for Wales reports - http://www.ombudsman-wales.org.uk/en/publications/The-Ombudsmans-Casebook.aspx

The Ombudsman's Case Book for the periods January to March 2018 includes 4 cases that were upheld or partially upheld against Cardiff and Vale UHB. MCA issues do not appear to be a factor in any of the cases.

6) Staff training as at 31st May 2018

CLINICAL BOARD	Prof Group	Head Count	No. required to undertake training	No. who have undertaken training	Compliance %
Children & Women					
	Allied Health Profs	117	117	106	90.6
	Nursing & Midwif	1104	1104	855	77.45
	Medical & Dental	233	233	93	39.91
CD&T					
	Allied Health Profs	685	685	543	79.27
	Nursing & Midwif	47	47	36	76.6
	Medical & Dental	102	102	39	38.24
Dental					
	Allied Health Profs	5	5	5	100
	Nursing & Midwif	11	11	10	90.91
	Medical & Dental	124	124	91	73.39
Medicine					
	Allied Health Profs	3	3	1	33.33
	Nursing & Midwif	814	814	661	81.2
	Medical & Dental	244	244	36	14.75
Mental Health					
	Allied Health Profs	39	39	33	84.62
	Nursing & Midwif	532	532	379	71.24

	Medical & Dental	76	76	18	23.68
PCIC					
	Allied Health Profs	83	83	76	91.57
	Nursing & Midwif	371	371	238	64.15
	Medical & Dental	7.89	10	10	100
Specialist					
	Allied Health Profs	41	41	28	68.29
	Nursing & Midwif	857	857	586	68.38
	Medical & Dental	236	236	32	13.56
Surgery					
	Allied Health Profs	12	12	3	25
	Nursing & Midwif	512	512	367	71.68
	Medical & Dental	378	378	53	14.02

8.1

These figures do not include the EIDO online consent training course, which includes a module on mental capacity.

Clinicians must not provide treatment and care to patients outside of the legal framework that covers these issues - in general, patients can only be treated/cared for with valid consent, or through Mental Capacity Act 2005 or Mental Health Act 1983.

It is essential that all clinicians have a good basic understanding of MCA and comply with it. If they do not, they are not protected from being sued or prosecuted in connection with the care or treatment they have provided. They are also unlikely to have a defence to complaints made against them either to the UHB or to their professional body.

APPENDIX 2

INDEPENDENT MENTAL CAPACITY ADVOCACY (IMCA)

January to March 2018

General

The IMCA team continues to work with professionals to improve communication and understanding of the IMCA role as well as promoting the MCA 2005 when required. IMCAs are significantly affecting the decision making process by ensuring that correct processes and procedures are followed in line with the MCA 2005 and case judgements. IMCAs are ensuring that the decision maker is pursuing the least restrictive option in relation to the decision that needs to be made, as well as acknowledging the Act's guiding principles.

IMCAs continue to refer cases to the Court of Protection when necessary, and also highlight to professionals when court involvement may be appropriate in cases relating to Serious Medical Treatment (SMT) decisions, Long Term Move of Accommodation (LTMA) decisions, Adult Safeguarding (POVA) and Care reviews.

Service Issues

- The IMCA team is continuing to experience a number of DoLS referrals that are being sent either as the authorisation is about to expire or when P has already been discharged from hospital.
- General lack of understanding and acknowledgement from professionals across the UHB in relation to IMCA role.
- General lack of POVA and Care Review referrals.
- General lack of understanding and acknowledgement from professionals across the UHB in relation to Court of Protection processes and requirements.

Example Case

- IMCA received two referrals, one in respect of a LTMA decision and the second in regard to the Relevant Person's Representative (RPR) role. IMCA attended the ward in order to meet with P and ascertain her wishes and views. Having spoken with P the IMCA then liaised with the Social Worker who informed the IMCA that he had been consulting with family in respect of this matter. The IMCA highlighted to the Social Worker that as a result of this information, IMCA would not be able to attend the Best Interest Meeting as LTMA IMCA but solely as the RPR (due to family involvement). The Social Worker expressed significant confusion over this and as the decision maker failed to formally confirm the appropriateness of the family until approximately one week post the Best Interest

Meeting (having acknowledged family's inability to reflect P's wishes and views). During the course of the Best Interests Meeting it emerged that an up to date capacity assessment re P's ability to determine discharge destination had not been undertaken by the decision maker. Having explained the paramount importance of this assessment the decision maker agreed to complete the capacity assessment prior to the meeting. The IMCA also highlighted the potential need for Court of Protection involvement due to P requesting to return home upon discharge and the MDT stating that a residential placement may be required. Following completion of this meeting, the IMCA as the RPR has received several phone calls to the office from P expressing her distress at being on the ward. In accordance with the client's objections the IMCA has instructed a Solicitor to lodge an appeal with the Court of Protection.

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MENTAL HEALTH ACT MONITORING
Name of Meeting : Mental Health & Capacity Legislation Committee **Date of Meeting :** 26 June 2018

Executive Lead : Chief Operating Officer
Author : Mental Health Clinical Board Director of Operations
Caring for People, Keeping People Well: This report underpins the Health Board's "Sustainability" and "Values" elements of the Health Board's Strategy.
Financial impact : None
Health and Care Standard Number: 1 (governance & assurance); 2 (Equality and Diversity); 5 (Patient Experience); 9 (Information and consent); 10 (Dignity and Respect); 11 (Vulnerable adults); 18 (Communicating effectively); 19 (Information); 20 (Records Management); 22 (Managing risk), 23 (Dealing with concerns and managing incidents), 26 (Workforce training organisational development)
CRAF Reference Number – 5.1.8
Equality and Health Impact Assessment Completed: Not Applicable

ASSURANCE AND RECOMMENDATION

ASSURANCE is provided by:

- Mental Health Clinical Board Director of Operations

The Board is asked to:

- **Note the contents of the report for assurance**

SITUATION

Detention without authority

Any exceptions highlighted in the Mental Health Act Monitoring report are intended to raise the Committee's awareness of matters relating to the functions of hospital managers and give assurance that the care and treatment of patients detained by Cardiff and Vale University Health Board and those subject to a community treatment order is only as the Act allows.

Section 62

Authorises the administration of treatment in circumstances where the procedures under section 57 (special treatments), 58 (medication after three months) or 58A (ECT) cannot be followed because there is an urgent need to give the treatment.

Section 136

Guidance for the implementation of changes to police powers and places of safety provisions in the mental health act 1983 has been issued by Welsh Government since amendments were made to s.136 by the Policing and Crime Act 2017:

https://www.gov.uk/government/publications/mental-health-act-1983-implementing-changes-to-police-powers

Hospital Managers' Discharge Power

Section 23 of the Mental Health Act 1983 gives hospital managers the power to discharge most detained patients and all patients subject to a community treatment order.

A Managers' discharge panel may consist of three or more people who are non-executive directors of the local health board that is responsible for the hospital or members of a committee which is authorised for the purpose (Hospital Managers Power of Discharge group).

Policies, Procedures and Guidance

It is essential that compliance with the legal requirements of the Mental Health Act 1983 and the Mental Health Act 1983 Code of Practice for Wales, Revised 2016 are monitored.

BACKGROUND

Detention without authority

The number of patients detained without authority has been eradicated since January 2017. However this quarter there have been three incidents reported.

One incident was in relation to a minor under section 136. Two incidents were due to the Approved Mental Health Professional not being authorised to act on behalf of the Local Authority.

The application's were accepted on behalf of the hospital managers, who when performing the task of scrutiny will take certain statements on face value. Therefore would have no reason to question the AMHP making the application. It is the responsibility of the Local Authority to ensure that their AMHP's are authorised to carry out the required functions.

Section 62

An analysis of the reasons for the use of urgent treatment has been undertaken. It was found that 75% of the uses were due to procedures under section 58 not being followed.

The MHA Department routinely send reminders to the clinical team a month before the consent to treatment provisions are due. This is to allow for a Second Opinion Appointed Doctor (SOAD) request to be made if necessary. The whole process takes between three and four weeks for the certificate to be issued.

During the period only three requests were made in good time for the SOAD to visit, assess the patient and issue a certificate.

Section 136

The amendments made to s.136 by the Policing and Crime Act 2017 reduced the detention period from 72 hours to 24 hours which could be extended under certain circumstances to a maximum of 36 hours. The detention period commenced when the person arrived at the designated place of safety which is H
afan Y Coed, University Hospital Llandough for Cardiff and Vale University health Board.

However 4.4 of the guidance for the implementation of changes to police powers and places of safety provisions in the mental health act 1983 states:

"If a person is subject to a section 135 or 136 is taken first to an Emergency Department of a hospital for treatment of an illness or injury (before being removed to another place of safety) the detention period begins at the point when the person arrived at the Emergency Department (because a hospital is a place of safety)."

Hospital Managers' Discharge Power

In comparison to the other UHB's in Wales the power of discharge is rarely exorcised by the Hospital Managers Power of Discharge Group here at Cardiff and Vale UHB.

Policies, Procedures and Guidance

The Mental Health Act 1983 Code of Practice for Wales, Revised 2016 sets out a non exhaustive list of recommended policies organised into categories and referenced to the relevant chapters.

All policies should be developed to ensure that the care and treatment patients receive is in line with the guiding principles.

ASSESSMENT AND ASSURANCE

Detention without authority

No	Analysis	Action Taken at the Time
1	**A & E Department UHW** Minor detained under section 136 and taken to A&E after not being accepted at Hafan Y Coed, UHL. Mental health act assessment conducted, no mental disorder was identified but the patient presented risky behavior. Outcome of assessment was to admit under section 136 for CAMHS team to assess the following day. The authority to detain a person ends as soon as the assessment under section 136 has been completed and suitable arrangements have been made. If a doctor concludes, that the person is not suffering from a mental disorder then the person must be discharged. There was no authority to detain following the assessment. Therefore the patient was detained without authority for a total period of 13 hours and 50 minutes.	Information in relation to the outcome of assessment and further detention under 136 has been widely circulated to ensure all staff are aware that they cannot detain a person under s136 following a mental health act assessment which concludes that the person is not suffering from a mental disorder. A management plan has been completed and agreed by the social worker, police, CAMHS and UHB's to ensure that this person is appropriately managed in future.
2	**Hafan Y Coed, UHL** Patient detained under section 2 subject to an application for section 2 made by Approved Mental Health Professional (AMHP). Subsequent to the patient being discharged the Local Authority notified the Mental Health Act Department that the AMHP was not authorized to carry out this function on their behalf. Patient detained for a total period of 19 days without authority.	The LA have drafted a new policy addressing recruitment, approval and reapproval of AMHP's. It also addresses authorisation of AMHP's who are approved by other LSSA's, stipulating what evidence is required before such authorisation takes place. This is pending approval by the management team. The requirements detailed within the draft policy have been discussed with the EDT service manager who employed the MH professional under discussion via an agency. There is pre-existing documentation for authorisation

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		of AMHP's employed by EDT which will be used for future appointments. The person who undertook the assessment will not be undertaking any further assessments under the Act unless formally approved under section 114, and duly authorised. This incident has been reported to CCSIW and HIW.
3	**Hafan Y Coed, UHL** Patient detained under section 2 subject to an application for section 2 made by Approved Mental Health Professional (AMHP). Subsequent to the patient being discharged the Local Authority notified the Mental Health Act Department that the AMHP was not authorized to carry out this function on their behalf. Patient detained for a total period of 20 days without authority.	As above.

Section 62

This has been escalated to the Clinical Directors who have reminded consultants to ensure that SOAD requests are made in good time to ensure urgent treatment is used appropriately.

The MHA department will continue to monitor the use of urgent treatment.

Section 136

Legal advice has been obtained and confirmed that the position is fairly clear with regard to practitioners in Wales because of the guidance given in the Welsh Code of Practice. This means that time does not begin to run while the person is in the A and E department **as long as the s.136 interview and examination procedures are not commenced at the department.** If they are, time will begin to run when the person enters the A and E department.

Hospital Managers' Discharge Power

During the period the Hospital Managers Power of Discharge Group did exercise their power of discharge on one occasion.

Cardiff and Vale UHB have secured funding from Welsh Government to provide an All Wales Hospital Managers Training event in November 2018 covering the following topics:

Role of Hospital Managers
Human Rights
Mental Health Act
Risk
Aftercare
Considering discharge
Decision making
Mental Capacity Act
Case law

Policies, Procedures and Guidance

An All Wales Mental Health Act Policy Group has been established to ensure that policies, procedures and guidance are developed in line with the Mental Health Act 1983, Code of Practice for Wales, Revised 2016. These documents differ slightly depending on local arrangements.

The following documents have been approved by the Mental Health Quality, Safety and Experience Committee on 13 December 2017:

- Community Treatment Order Policy
- Community Treatment Order Procedure
- Hospital Managers' Scheme of Delegation Policy
- Hospital Managers' Scheme of Delegation Procedure
- Section 5(2) Doctors' Holding Power Policy
- Section 5(2) Doctors' Holding Power Procedure
- Section 5(4) Nurses' Holding Power Policy
- Section 5(4) Nurses' Holding Power Procedure

The following documents were approved by the Mental Health Quality, Safety and Experience Committee on 11 April 2018:

- Hospital Managers' Power of Discharge Handbook
- Power of Discharge Hospital Managers Hearing Conduct Protocol

The Head of Operations and Delivery, Mental Health Clinical Board and the Mental Health Act Manager continue to work with Mental Health Act Leads from other Health Boards to agree and collate core data so that reliable and valid information can be routinely compared from each Health Board.

Mental Health Measure Monitoring Report **June 2018**
Name of Meeting : Mental Health and Capacity Legislation Committee **Date of Meeting:** 26th June 2018

Executive Lead: Chief Operating Officer
Author : Mental Health Clinical Board Director of Operations
Caring for People, Keeping People Well : This report underpins the Health Board's "Sustainability" and "Values" elements of the Health Board's Strategy.
Quality, Safety, Patient Experience impact : Applicable to all Health Care Standards
Health and Care Standard Number: 1&6
CRAF Reference Number: 8.1.2
Equality and Health Impact Assessment Completed: N/A

RECOMMENDATION

The Board/Committee is asked to:

- **Agree the approach taken by the Mental Health Clinical Board**

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SITUATION

The UHB Mental Health Measure performance is reported to and monitored by the Welsh Government on a monthly basis, with reports back to the UHB Performance Monitoring Committee.

BACKGROUND

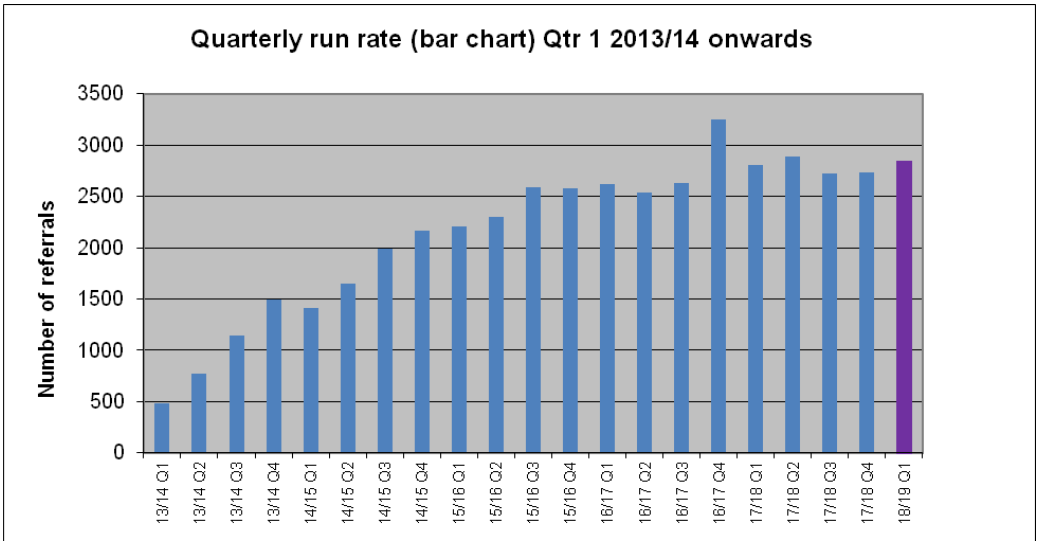
The Mental Health (Wales) Measure 2010 (the Measure), is a National Assembly for Wales law that has similar legal status to an Act of Parliament. The Measure introduces a number of important changes to the assessment and treatment of people with mental health problems in Wales. Parts 1 to 4 of the Measure set the main legislative requirements relating to Mental Health service provision and are supported by subordinate legislation and guidance.

ASSESSMENT AND ASSURANCE

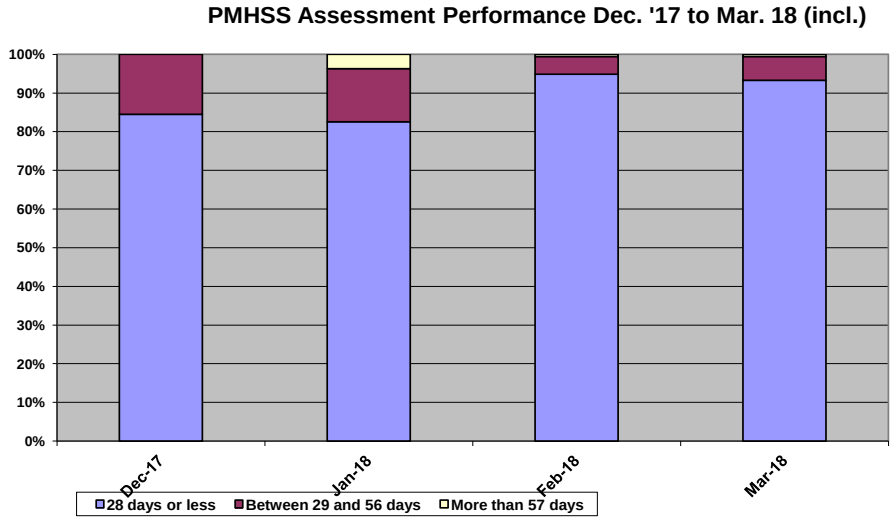
For Parts 1, 2 & 3 of the Measure, local activity and compliance information is collated and submitted to WG via standard reporting templates.

Part 1 : PMHSS

Following a marked spike in referrals to PMHSS in Q4 2016/17, quarterly referral rates have generally leveled out with no significant peaks or troughs in referral numbers. Bar chart below shows the Quarterly referral run rate for PMHSS with confirmed data in blue and estimated data in purple. Estimated data is based on previous average month-on-month changes in referral rates for the previous three years.



For the reporting period PMHSS has maintained compliance with the Tier 1 target of assessing 80% of patients within 28 days of referral.



In the same period, PMHSS has dipped below the Tier 1 compliance target for treatment, i.e., of those assessed by PMHSS who were then offered a PMHSS intervention, 80% should start that intervention within 28 days. The performance rate for Q1 2018/19 is about 70%. The reasons for this are less to do with demand for interventions and more to do with the sorts of interventions now being offered, i.e. a need to offer a wider array of Matrics Cymru (Recently released All Wales strategy for Psychological Interventions) compliant interventions, many of which are one-to-one and some of which entail sessions of 16 or more. In Matrics Cymry there is explicit reference to group therapies, for BDD, Health Anxiety, OCD, and Panic Disorders for example.

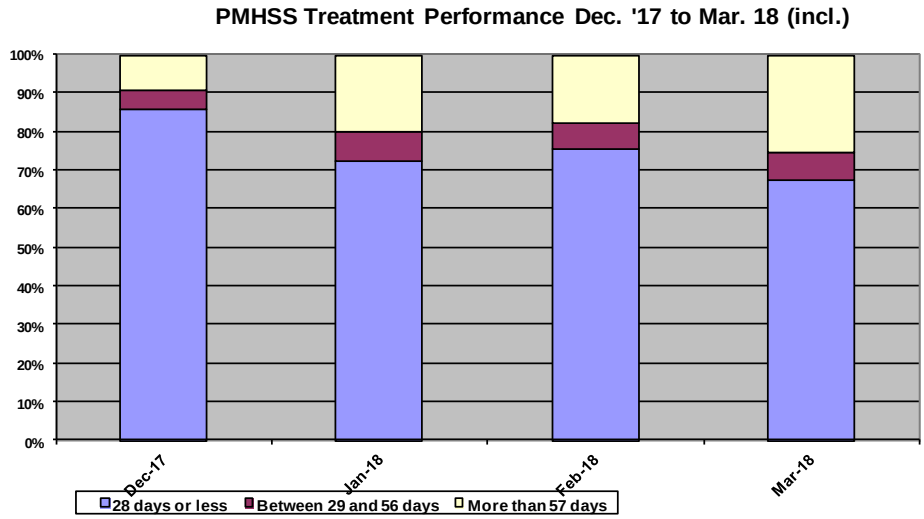
Prior to the Matrics, PMHSS's across Wales were working to the broad National Service Model guidelines of delivering interventions of between "six to ten sessions". This has meant that PMHSS is now offering a wider range of Psychological interventions of longer duration which are difficult to run with sufficient patient numbers not to risk the participant's numbers being so low that they are not worthwhile or therapeutic within the 56 day target cycle.

The consequence of this is that the potential for breaching the target going forward is greater and likely to continue due to this high integrity approach to delivering effective evidence based therapies and with outcome measurement coming on stream within the National plan, we will have potential for demonstrating significant compliance to MC and improved outcomes, rather than moving people out of the waiting list or intervention measurement through a "brief" intervention

The MHCB has already discussed this with the Mental Health Delivery Unit who are prepared to prompt a National discussion on this issue to support the MHCB in Cardiff & Vale to balance the priority of meeting the Part 1b target with compliance with Matrics Cymru.

The Director of Operations in Mental Health is awaiting a response from the Welsh Government similarly. In addition the national PMHSS Community of Practice are feeding back similar concerns via the Mental Health Network forum which is chaired by a policy official for the Welsh Government. It is felt that the targets themselves are appropriate but challenging, with the manner in which the data is collated.

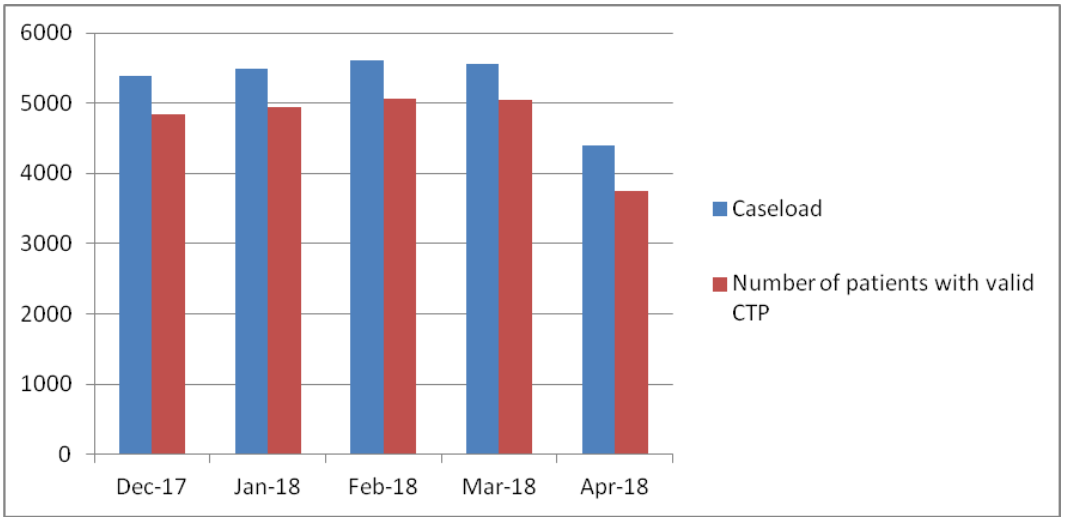
The MHCB can feasibly report 100% compliance for Parts 1a and/or 1b one month and then 0% the next but the difference in performance between the two months can be a mere 24 hours.



Part 2 – Care and Treatment Planning Within Secondary Mental Health Services

The performance target set by Welsh Government for Part 2 is 90%. Monthly caseload variance is due to rates of referrals and discharges. The data includes Adult, Older Adult, Forensic, Learning disabilities and CAMHS services:

	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18
Total number of patients in receipt of secondary MH services in C&V	5,384	5,492	5,617	5,560	4,395
90% of Service users have a valid CTP	4,847 90.0%	4,947 90.1%	5,059 90.1%	5,040 90.6%	3,752 85.4%



Performance Issues

Between December 2017 and March 2018, Adult, Older Adult and Leraning Disabilty are all reprorting performance of 90% and above for. Learning Disability within Cardiff West has traditionally had a disproportionately high number of relevant patients and has been reviewing the need for many to remain under the Measure. 54 patients have been discharged from their service in the last 4 months. CMHS has also had a rather large data cleanse and has discharged 103 patients form secondary care in between December 2017 and March 2018.

Because of the cleanse, CAMHS are reporting that their performance has increased to 69.7% compliance between December 2017 and March 2018 from below 40% in the previous quarter. CAMHS service in Cardiff is commissioned by Cwm Taf.

During the past month the clinical lead for quality, safety and governance in mental Health has been undertaking extensive work relating to C&V's returns and cleansing what our computerized system (PARIS) has been reporting – particularly in relation to duplication of patient records and how PARIS counts total caseload numbers. This has reduced somewhat the total caseload numbers in secondary mental health services for April and impacted on compliance.
The impact on compliance is due to low CTP completion compliance for service users that are solely looked after by a psychiatrist - which are now a larger proportion of the total number. The poor CTP compliance amongst the medical staff is due to many of their caseloads being very large, up to 200 in some cases, with many on the caseloads having low health needs not requiring being in secondary care. Often these patients may not have been discharged back to primary care due to 117 eligibility or high workloads preventing this.
The clinical board is reluctant to re-categorize these service users into a primary care labeled service whilst in secondary care in order to put them outside the CTP requirement as strategically this approach would not support the implementation of New Ways of Working. The director of Operations is in discussion with the DU and the WG to support the MHCB in using this position as a supportive strategic lever to modernize professional rolesand careers and seeks tolerance around the breached position during this period.

The MHCB has current plans and is developing further plans to work closely with the care co-ordinators to improve the uptake of CTP's. Urgent actions include the following:

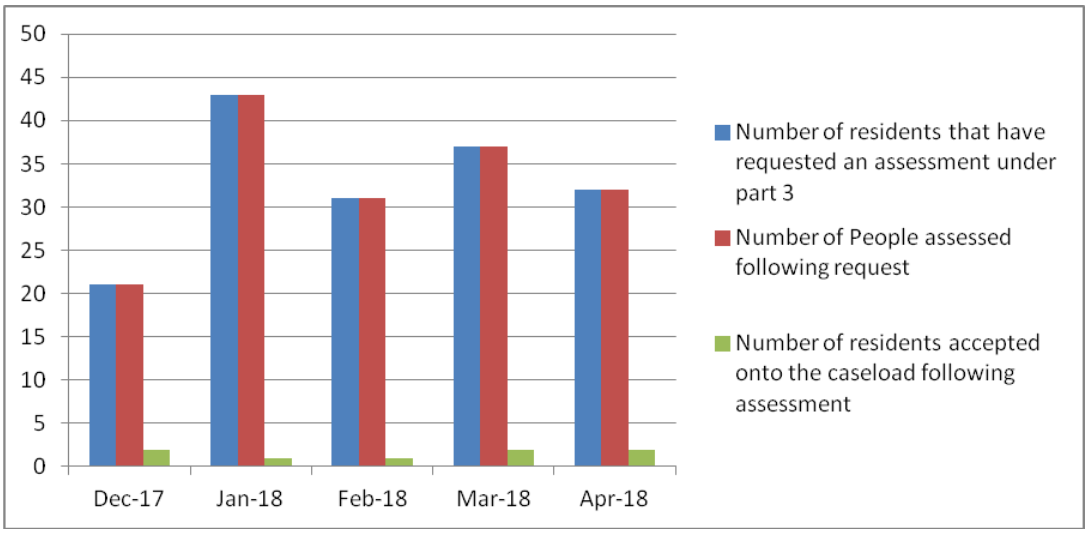
- Each directorate within the Mental Health Clinical Board has been directed to undertake their own audit, which they will feed back to the Clinical Board. The audits will relate to the quality of the care and treatment plans as well as the quantity.
- Where there are medical shortages or vacancies the CB is using the opportunity to support the position by reviewing and reducing medical caseloads in order that the role is manageable for subsequent post holders.
- For the adult directorate to meet with the consultant staff though the job planning process to highlight these issues and offer supportive actions to remedy.

- To pilot a whole locality New Way of Working for the MDT in the Vale from the autumn in terms testing a more sustainable model of CTP development and review.

Part 3
Right to request an assessment by self –referral

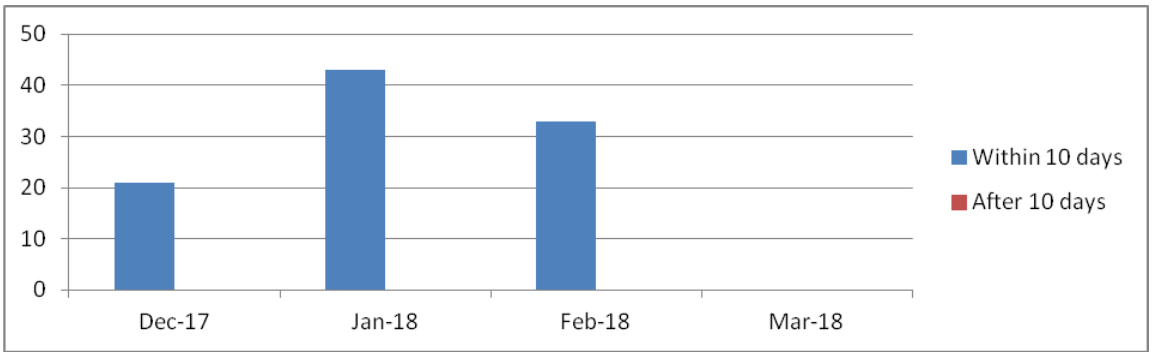
Service user's who have previously received secondary mental health services and have been discharged have a right to self refer for an assessment of their mental health for up to three years following discharge.

	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18
Number of residents that have requested an assessment under part 3	21	43	31	37	32
Number of People assessed following request	21	43	31	37	32
Number of residents accepted onto the caseload following assessment	2	1	1	2	2



All part three requests and outcomes are scrutinised prior to reporting. It has previously been reported that there was a high rate of DNA for self referral assessments but attendance has remained at 100% attendance over the last 34months.

Following part 3 requests there is a requirement to issue an outcome of assessment report within ten working days. The target set out by Welsh Government for this is 100%.



Part 4 – Advocacy

100% Compliance

Children and Young People Primary Mental Health – Part 1

Rachel Burton
Director of Operations
Children and Women Clinical Board

GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol Caerdydd a'r Fro
Cardiff and Vale University Health Board

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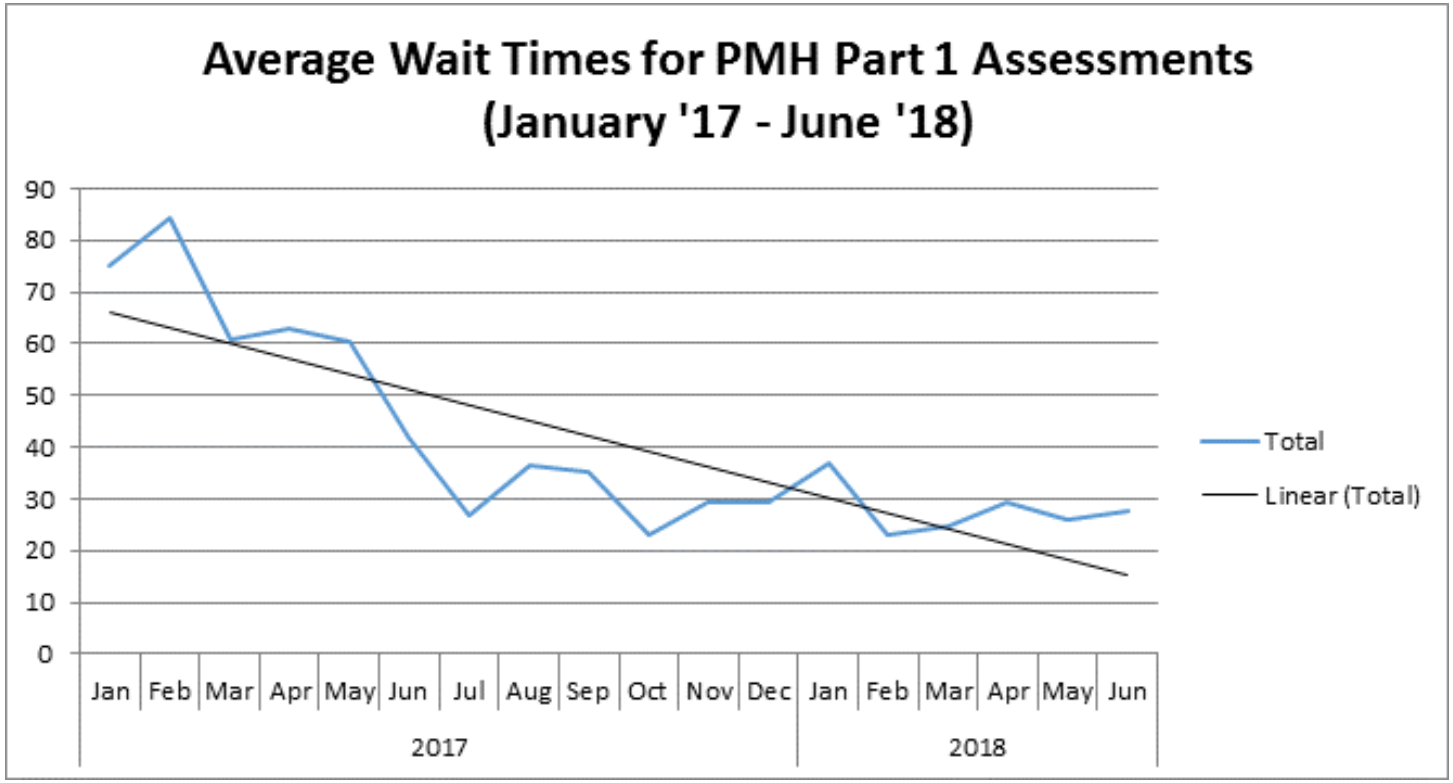
Primary Mental Health – Part 1 Measure

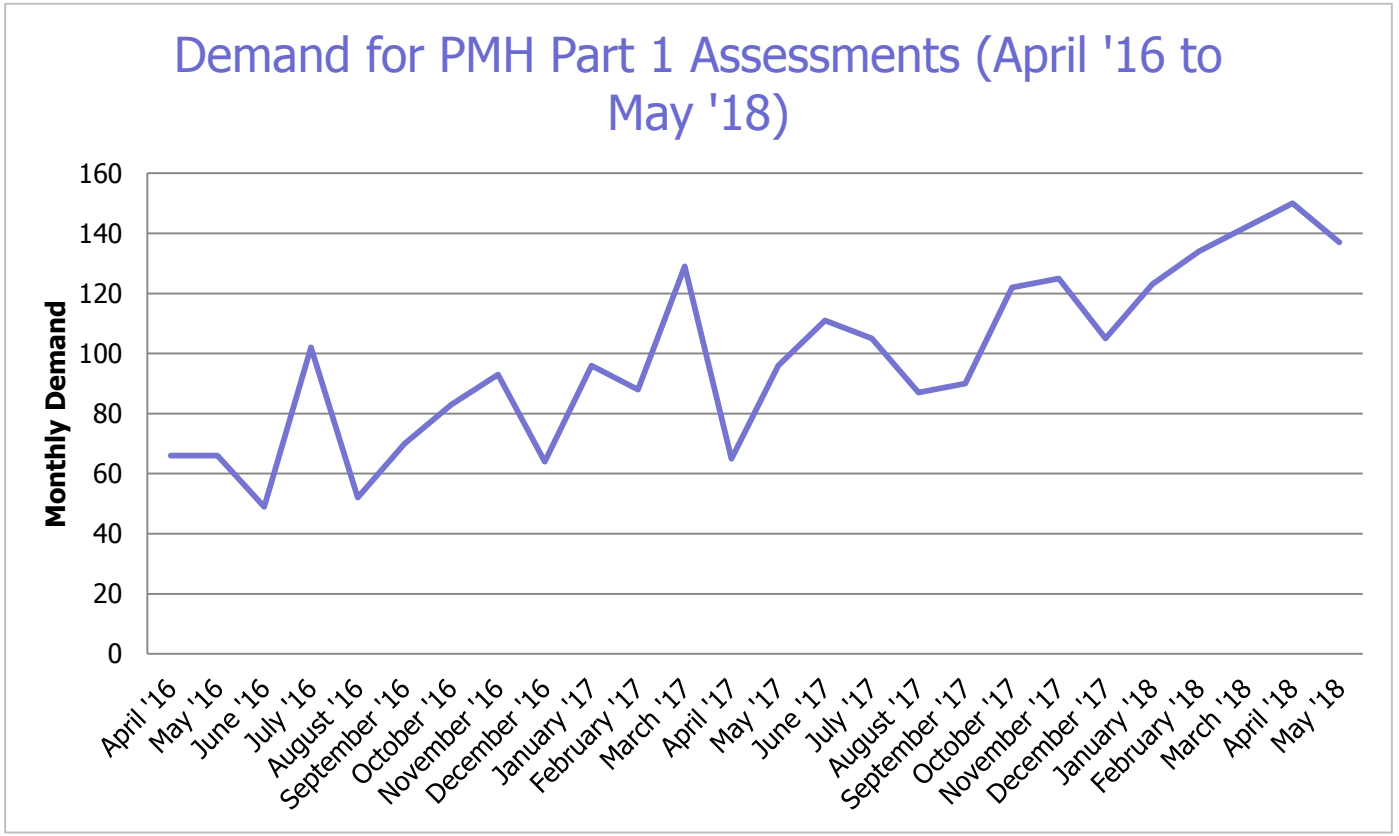
- Establish a primary mental health service which meets the targets of Part 1 (Mental Health Measure 2010) provides a good quality service, and is valued by the people who use the service.

- Target 80% of children referred to the service are seen within 28 days

Primary Mental Health – Part 1 Measure



Primary Mental Health – Part 1 Demand

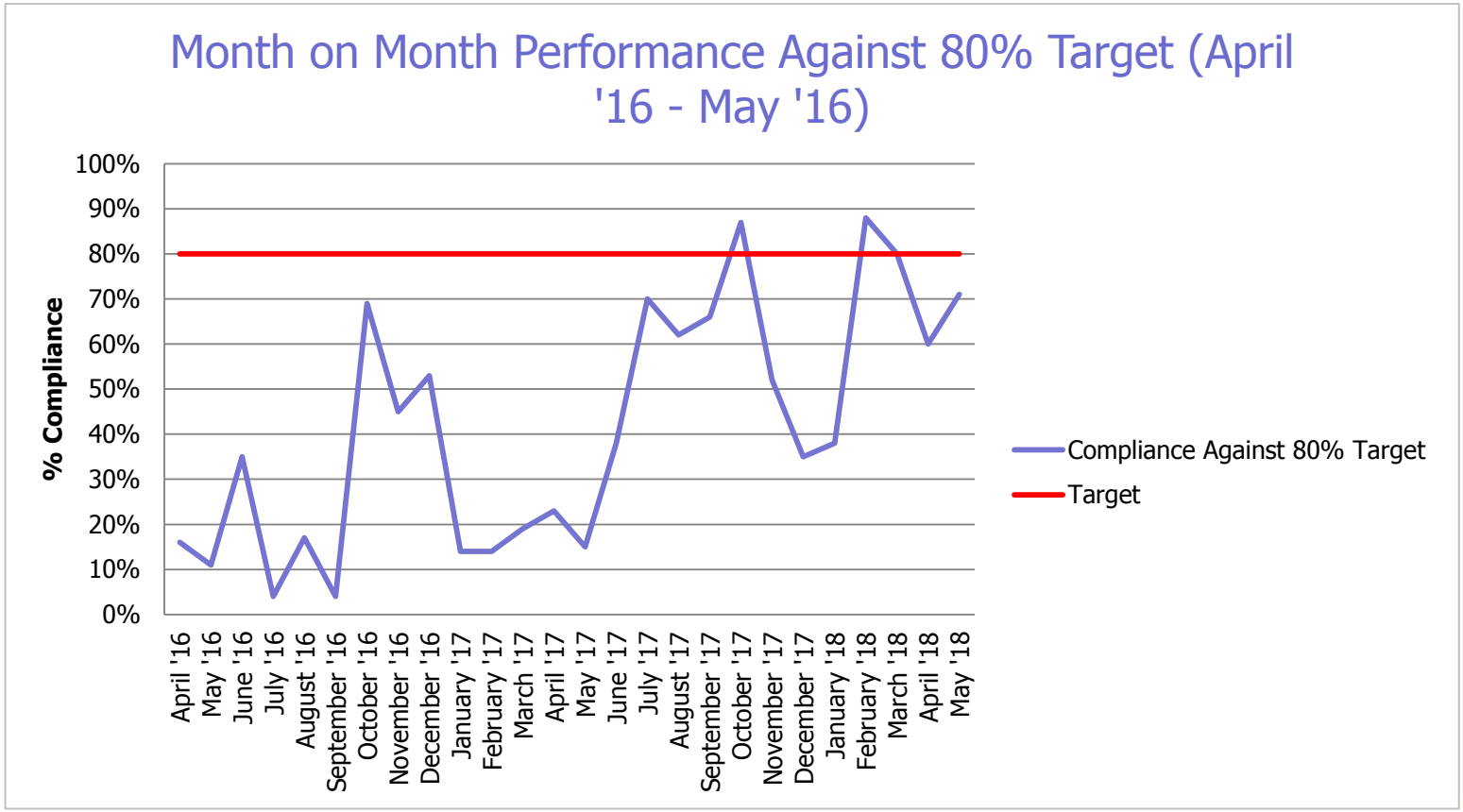


Primary Mental Health – Part 1 Demand

- Why has the demand increased?

- Mental Health concerns in CYP have received a great deal of media attention
- Greater public awareness and reduced stigma
- Discussed more widely in adolescent peer groups
- Information accessible on social media
- Emotional wellbeing part of the curriculum in many schools
- Austerity often leads to heightened periods of insecurity and uncertainty

Primary Mental Health – Part 1 Performance



Primary Mental Health – Part 1

- Over provide
- Transformation
- Focus on early intervention
- Multi faceted approach
- Manage the service for patients

Repatriation of CAMHS

CAMHS Repatriation Key Project Actions & Timelines — June 2018

	PROJECT ACTIVITY	RAG	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	Apr-19 - Mar 20	Notes
1	Project meetings planned & established	A													
2	Relevant Project Governance, Documentation & Strategies established (PID, Risk Register, Business Case, Benefits)	A													18.06.18 - Project Manager now in post & planning underway
3	Initial Project Plan Drafted	A													
4	Project Meetings - Steering Group, Delivery Board, Task & Finish, Stakeholder Liaison & Focus Groups Commence	R													
5	Development of Communications & Engagement Strategy	A													18.06.18 - Project Manager now in post & strategy under development
6	Implementation of Communications & Engagment Strategy	R													
7	Scoping of Current Service Reality: Staffing Structure, Clinical Pathways, Accommodation, Performance, Equipment, IT Systems, Policies	R													
8	Determine funding streams & service budget	A													18.06.18 - budget laregly scoped, work to undertake to understand payments to the networks
9	Project & service budget monitoring in line with required developments	A													18.06.18 - RM with clear finance plan & monitoring mechanisms in place
10	Development of Service Delivery Model & Clinical Pathways (T4CYP, Parternships, Systemic Approach, Networks, NICE, Evidence Based, Budget)	R													18.06.18 - Initial meeting held with CAMHS Clinical Lead 13.06.2018
11	Determine Clinical Governance Arrangements to Support New Model	R													
12	Scoping & Development of Single Point of Access Model & Arrangements	R													
13	Gap Analysis of Current Service Delivery to Future Model - Action plan in order to achieve (possible phased approach)	R													
14	Review current service accommodation & development of accommodation strategy for future service delivery (linked to service model & CYPF Feedback)	R													
15	Determine IT & telephony requirements; equipment, networks etc. & action new requirements (dependency with accommodation strategy)	R													
16	Scope out requirements for patient records & PARIS (dependency with service delivery model & SPoA)	R													
17	Development of PARIS system for patient record & data capture	R													
18	Development of Workforce & OD Plan; including specific workforce integration strategy	R													
19	TUPE Planning & due diligence	R													
20	Commence staff consultation and TUPE arrangements in line with new service model	R													
21	Commence communications to inform patients, referrers & stakeholders of new service arrangements	R													
22	Service repatriated & go live at CAVUHB	R													
23	Go live of CAMHS SPoA	R													
24	Phase 2 transformation commences	R													

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Minutes of the Mental Health Legislation and Governance Group held at 10:00 on 10 May 2018 in Training Room 2, Hafan Y Coed, Llandough Hospital

Present

Robert Kidd	(Chair) Consultant Forensic Clinical Psychologist
Sunni Webb	Mental Health Act Manager
Simon McDonald	Mental Health Act Coordinator
Owen Baglow	Clinical Lead for Quality, Safety and Governance
Wayne Parsons	Senior Nurse in EU/AU
Ceri Lovell	Team Leader – CAMHS Crisis Liaison Team
Simon Amphlett	Senior Nurse – Crisis and Liaison Service
Peter Thomas	South Wales Police
Will Adams	Team Leader – North Cardiff Crisis Team
Adele Watkins	M/H Clinical Nurse Specialist - Women and Child Health
Wendy Davies	MHCB Pharmacist
Sue Broad	Depravation of Liberty Safeguards
Rebekah Vincent-Newson	Social Work Lead for Vale of Glamorgan
Myfanwy Moran	Operational Manager Cardiff
Linda Woodley	Operational Manager Vale of Glamorgan
Dr Munawar Al-Mudhaffar	Consultant in Emergency Medicine
Dr Arpita Chakrabarti	MHSOP Consultant and Interim Deputy Director
Julia Barrell	Mental Capacity Act Manager
Jeff Champney-Smith	Power of Discharge Group Chair
Sara Thomas	Advocacy Manager – IMCA
Alex Allegretto	Advocacy Manager – IMHA
Mark Warren	Senior Nurse Manager – Criminal Justice and Forensic
Dr Mary Lawrence	Approved Clinician Representative
Kara Hannigan	ECT Clinic Manager

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Apologies

Sue Power	Lead Team Manager – Emergency Duty Team
Dr Katie Fergus	Adult MH Consultant and Interim Director
Dr Michael Ivenso	MHSOP Consultant and Interim Director
Keithley Wilkinson	Equality Manager
Jayne Bell	Lead Nurse Adult Mental Health
Dr Tayyeb Tahir	Consultant Liaison Psychiatrist - Liaison Psychiatry
Lorinda Walters	Quality and Performance Manager - Complex Care & Commissioning Team
Stephen Johnson	Patient Safety/Clinical Risk Manager – Welsh Ambulance Services Trust
Mark Doherty	MHSOP Lead Nurse
Ian Wile	Mental Health Head of Operations and Delivery
Jayne Tottle	Clinical Board Nurse Mental Health

1 Welcome and Introductions

The chair welcomed members and those in attendance

2 Apologies for Absence

Apologies were accepted and noted.

3 Terms of Reference

Robert Kidd explained that the purpose of the group is to:

- Review the functioning of the Health Board and its associated partners when carrying out their powers and duties under the Mental Health Act and associated legislation.
- Provide assurance to the Health Board that we are compliant with the Human Rights Act.
- Carry out operational scrutiny of the Mental Health Act Activity reports to identify themes or issues that require further investigation or resolution.
- Create an inter-agency forum where issues regarding the exercise of the Act can be openly discussed and to ensure that learning from others meetings can be shared.

We are expecting the Terms of Reference to be signed off for the next meeting.

4 Previous minutes

The previous minutes from the last meeting in 2013 have been distributed more for interest than to discuss. Many of the themes discussed in the last meeting will still be relevant today.

6 Interagency feedback on operation issues

Section 135

The Operational manager, Cardiff LSSA gave a brief explanation of Section 135(1) and 135(2) and raised an issue about who can apply for a Section 135(2) warrant. Currently AMHPs tend to be the only people who apply for these warrants. This uses unnecessary resource in terms of paying for the warrant and the AMHP's time obtaining it. There is no reason that another person involved in the patients care couldn't apply for the Section 135 (2) warrant, including NHS staff or even Police.

MHA Assessment Requests

Social Services report that there is currently an issue with the late application of a Mental Health Assessment for Section 3 for patients who have been expected to be placed onto a Section 3 for some time. On several occasions the application for a Section 3 assessment has been made on either the last

day or the day before, which makes it much more difficult to setup due to staff availability.

The Approved Clinician Representative stated that this can happen if the patient is making significant improvements over the Section 2 period, and that this situation can occur as the RC believes that the patient may be well enough to discharge from Section 2 rather than apply Section 3.

Conveyance

There are issues getting an ambulance to convey patients to hospital either before or post MHA assessment. There is a tendency to rely on the Police to transport these people to hospital. There is no funding available to arrange private transport – private ambulances are very expensive.

The hardest part of an assessment is the transport. AMHPs are using their own cars, asking for staff from wards and various other improvised methods to arrange patient transport.

Social services believe that a serious issue will occur if the situation doesn't change.

The Senior Nurse, Crisis and Liaison Service's informed the group that there has been a paper submitted exploring the possibilities of using a private ambulance service such as St John's for conveyance. The outcome of this will be brought back to this group at a later date. There is precedence for this, Cwm Taff UHB use St John's for this purpose.

Section 136

There have been a small number of Section 136 lapse's prior to mental health assessment's being carried out in A&E. It was noted that this has been since the change in the law that came into effect towards the end of last year. There is some confusion about when the new 24 hour limit commences.

The Senior Nurse, Crisis and Liaison Service's informed the group that A&E staff don't always inform Mental Health that they have a person there who is detained under Section 136.

The South Wales Police Representative stated:

- The 136 clock starts as soon as the patient arrives at either the Place of Safety or Accident and Emergency.
- That the phone call from the Police to the Crisis team whilst in A&E is all that is necessary for the Police. It is then up to the Crisis teams to ensure that the Section 136 is either extended or a mental health assessment takes place within the allowed time period.
- There is an Escalation Procedure that the Police have not yet used, but do have the option for the future.

The Consultant representing A&E stated that he has not seen an increase in the numbers of Section 136 patients, and that they were not aware of the change to the time scales. They had not identified the Section 136 changes as being a problem for them.

The Paediatrics representative stated that there had been an incident with a child who was brought in under Section 136. The child was assessed and deemed not to have a mental illness, but the assessing doctor stated to hold the child on the ward under section 136. This was unlawful. Paediatric staff have been instructed not to accept anybody brought in under Section 136 until they have spoken to somebody in Mental Health.

A clear need for section136 training/guidance for A&E staff was identified.

People brought into A+E under 136 do not always have the 136 paperwork that should accompany them.

7 MHA Activity January – March 2018

MHA Monitoring Report

Section 136

No assessments took place in custody

There were four CAMHS occurrences; three of those were the same person.

It was noted that there are more admissions following Section 136, which was confirmed as a trend across South Wales over the past year by South Wales Police who also informed the group that the use of Section 136 over the past year had increased by 23%.

The Group were also informed about a trial in the operations room in Police Headquarters, Bridgend where they will have Community Psychiatric Nurses who will be able to advise Police when section 136 may be required.

Section 136 lapsed 3 times with no request for extension.

A discussion took place about who requests the 136 extension.

Section 62

It was noted that Section 62 was high this quarter. Following further investigation the Mental Health Act Manager confirmed this appeared to be due to late requests for a SOAD. It takes two to three weeks after a request before a SOAD can visit. Most SOAD requests are being made with less than 2 weeks before a certificate is required. The Mental Health Act Manager confirmed that reminders are sent to the clinical team both four and two weeks prior to due date. A brief explanation of a planned automated report for each Responsible Clinicians caseload was given to the group. It is hoped that this will improve the situation and provide one place for Responsible Clinicians to prioritise their workload in relation to the Mental Health Act.

It was noted that there has been an uptake in the use of Advocacy, rising to over half of the Hearings that have taken place.

Advocacy Support Cymru stated that there is an ongoing issue in relation to the late submission of reports for managers' hearings which does not allow good time to prepare for the hearing with the patient. It was requested that reports are available for the advocate two weeks prior to the Hearing. The Mental Health Act Manager explained that this would not be possible to

accommodate to ensure that information contained in the reports is as up to date as possible the Mental Health Act Office request reports two weeks prior to the hearing with a view to making them available to the advocate at least a week beforehand.

All Wales MHA Monitoring Report

Provided for information

Mental Health Act Manager to distribute to the group.

8 Power of Discharge Group

Comments and recommendations

The Chair of the PoD Group stated that Care and Treatment Plans are a constant concern. They tend to be not up to date, not accurate, issues with cut and pasted badly from previous reports, and have been submitted late.

Both the Advocacy Manager and the Chair of the PoD Group expressed concerns about the accuracy of reports, citing one hearing where the Nursing report not only contradicted the other reports but also held a different view to the nurse present.

Social workers non attendance is increasing. Adjournments have occurred as the panel felt they needed a verbal update from the absent social worker. A future meeting has been setup between Social Services and the Mental Health Act Manager to look at this issue.

It has been noted that patients from the Low Secure service do not attend their hearings. Advocacy say that there is also a tendency for these patients to either refuse advocacy, or request an advocate but then won't get involved in the process themselves.

9 External Reviews

HIW Inspection Report

There has been a recent local HIW review, but only verbal feedback has been received so far.

The Deputy MHSOP Clinical Director stated that in the verbal feedback one of the issues picked up was the lack of documentation explaining the reason for requesting a MHA Assessment and a lack of documentation upon discharge from the Mental Health Act with a request for a DoLS assessment.

10 Interface MHA/MCA/DoLS

The DoLS representative explained that there is a future meeting arranged to investigate any potential unlawfully detention of patients under DoLS when the patients on the UHL campus were ineligible.

There has been an issue in Hafan Y Coed where a patient under DoLS lapsed. That is currently going through the courts and will be fed back when the result is known.

There is no set system for keeping track of patients under DoIS who are going to expire. The MHSOP wards use a white board where they list the patient and if they are under DoLS or MHA with expiration dates.

The Mental Capacity Act Manager clarified that DoLS does not allow for forcible treatment, only the depravation of liberty, and that the Mental Capacity Act does allow for forcible treatment.

11 Quality Indicators and Audit Activities

For discussion in the next meeting

12 Feedback from other meetings

It was agreed that the AMHP Forum and consultants meeting will provide feedback to this group at future meetings.

13 Any other business

Missing or leaving procedure for under 18's

The Paediatrics Representative confirmed that there isn't a policy for this. Security stated that they cannot bring back an under 18 who has absconded as they are not SIMA trained. This is currently being addressed. A procedure is being written to address this. The group agreed for it to be circulated for comments.

117 Responsibility

The Senior Nurse Manager, Criminal Justice and Forensics raised the subject of patients Cardiff and Vale UHB are responsible for but where we are not the detaining authority. These people cannot be recorded in the Mental Health Act model of Paris as we would not be able to differentiate them from the patients who we are the detaining authority for. The Mental Health Act Manager and the Vale Social Work Manager informed the group that this is being looked at but that there is nothing in place yet.

14 Date of future meetings

Date of future meetings to be held at 10.00hrs:

13 September 2018

17 January 2019

These are likely to change due to a clash with the Lessons Learned meeting.

GIG CYMRU NHS WALES | Bwrdd Iechyd Prifysgol Caerdydd a'r Fro / Cardiff and Vale University Health Board

Mental Health and Capacity Legislation committee Draft Work Plan 2018-19	Feb-18	Jun-18	Oct-18	Feb-19
Patient Story	Mental Capacity Act	Mental Health Act S117	Mental Health Act	Mental Health Measure
Mental Health Act				
MHA Monitoring Exception Report (CRAF 8.1.2, risk rating 16) *Standing item*	x	x	x	x
Section 117 Compliance	x	x	x	x
Section 136 Partnership arrangements	x	x	x	x
HIW MHA Annual Report	x			
HIW MHA Inspection Reports (as received)	x			
Hospital Managers Power of Discharge sub-Committee Annual Report			x	
Hospital Managers Power of Discharge sub-Committee minutes	x	x	x	x
Mental Health Measure Act Monitoring Report				
Mental Health Measure Monitoring Report	x	x	x	x
Mental Capacity Act				
MCA Monitoring Report (CRAF 8.1.3) *Risk rating 16*	x	x	x	x
DoLS Monitoring Report	x	x	x	x
DoLs Audits			x	
Committee Governance				
Committee Work planner / Review of Effectiveness to include self assessment			x	
Review of Hospital Managers Power of Discharge sub-Committee Terms of Reference	x			
Review of Terms of Reference				x

13

APPROVAL OF COMMUNITY TREATMENT ORDER POLICY
Name of Meeting: Mental Health and Capacity Legislation Committee **Date of Meeting:** 26 June 2018

Executive Lead : Chief Operating Officer
Author : Mental Health Act Manager, sunni.webb@wales.nhs.uk
Caring for People, Keeping People Well: This report underpins the Health Board's "Sustainability" and "Values" elements of the Health Board's Strategy.
Financial impact : None
Quality, Safety, Patient Experience impact: Patients subject to the Mental Health Act must be treated only in compliance with the legal framework.
Health and Care Standard Number: 3 (Effective Care), 4 (Dignified Care), 6 (Individual Care)
CRAF Reference Number: 8.1.2
Equality and Health Impact Assessment Completed: Yes

ASSURANCE/RECOMMENDATION

ASSURANCE is provided by consultation with:

- All Wales Mental Health Act Administrators Policy Group
- Mental Health Policy Group
- Mental Health Quality and Safety Sub Committee
- Internet consultation

The Mental Health and Capacity Legislation Committee is asked to:

- **APPROVE** the Community Treatment Order Policy and Procedure

and

- **APPROVE** the full publication of the Community Treatment Order Policy and Procedure in accordance with the UHB Publication Scheme

14.1

SITUATION

It is essential that compliance with the legal requirements of the Mental Health Act 1983 and the Mental Health Act 1983 Code of Practice for Wales, Revised 2016 are monitored. Local Health Boards and Local Authorities should have agreed governance processes for ensuring the appropriate policies and procedures in place are regularly reviewed. A non exhaustive list of relevant policies required are detailed in the Mental Health Act 1983 Code of Practice for Wales, Revised 2016.

The Community Treatment Order (CTO) Policy sets out the requirements for provision of community treatment orders under section 17A of the Mental Health Act 1983 (as amended by the Mental Health Act 2007) to the practitioners and agencies involved in the management of patients subject to a CTO**.**

BACKGROUND

This is a new policy to ensure statutory requirements under the Mental Health Act 1983 are met.

This Policy and Procedure provides clear direction and guidance which will be easily accessible on our internet/intranet sites to particular individuals including registered medical practitioners ('doctors'), approved clinicians, managers and staff of hospitals in relation to their legal responsibilities under the Mental Health Act 1983 as amended by the MHA 2007.

ASSESSMENT

Wide consultation has taken place to ensure that the Policy meets the needs of our stakeholder and the Health Board. The consultation undertaken specific to this document was as follows:-

- The document was added to the Policy Consultation pages on the intranet between 06 November 2017 and 01 December 2017;
- The document was shared with the Mental Health Policy Group, Adult Directorate Medics, Cardiff Local Authority, Vale of Glamorgan Local Authority, the Mental Health Clinical Board Quality and Safety Sub Committee and the All Wales Mental Health Act Administrators Policy Group;
- Comments were invited via individual e-mails from the Mental Health Policy Group, the Equality Manager, the Principal Health Promotion Specialist

Where appropriate comments were taken on board and incorporated within the document.

The primary source for dissemination of this document the Community Treatment Order Policy within the UHB will be via the intranet and clinical portal. It will also be made available to the wider community and our partners via the UHB internet site.

Reference Number: *TBA* **Version Number:** 1	**Date of Next Review:** *To be included when document approved* **Previous Trust/LHB Reference Number:**

Community Treatment Order Policy
Mental Health Act, 1983

Policy Statement

To ensure the Health Board delivers its aims, objectives, responsibilities and legal requirements transparently and consistently, we will ensure staff are aware of their individual and collective responsibilities when considering and assessing individuals for a community treatment order (CTO).

Practitioners will have due regard to the Mental Health Act Code of Practice generally and specifically to the Guiding Principles when they are considering the use of CTOs. This will ensure that considerations are given as to whether the objectives can be met in a less restrictive way.

The Responsible Clinician must be fully aware of the diverse needs of the patient when considering a CTO and must take them in to account at all times. They must ensure the patient fully understands what is happening to them in a language and format which they are able to understand, this will include sensory and cognitive abilities and physical impairment. Where necessary, an interpreter should be obtained.

Policy Commitment

We will set out the requirements for provision of community treatment orders under section 17A of the Mental Health Act 1983 (as amended by the Mental Health Act 2007) to the practitioners and agencies involved in the management of patients subject to a CTO**.**

We will ensure statutory requirements under the Mental Health Act 1983 are met by providing clear direction and guidance which will be easily accessible on our internet/intranet sites to particular individuals including registered medical practitioners (‘doctors’), approved clinicians, managers and staff of hospitals in relation to their legal responsibilities under the Mental Health Act 1983 as amended by the MHA 2007.

Supporting Procedures and Written Control Documents

This Policy and the Community Treatment Order Procedure describe the following with regard to a CTO:

- The purpose of a CTO
- The process for assessing the suitability for the use of a CTO
- The duties of the practitioners and agencies involved in the management of patients subject to a CTO

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Other supporting documents are:

- The Mental Health Act 1983 (as amended by the Mental Health Act 2007)
- Mental Health (hospital, guardianship, community treatment and consent to treatment)(Wales) regulations 2008
- The Mental Capacity Act 2005 (including the Deprivation of Liberty Safeguards delegated to this Act under the Mental Health Act 2007)
- The respective Codes of Practice of the above Acts of Parliament
- The Human Rights Act 1998 (and the European Convention on Human Rights)
- Domestic Violence, Crime and Victims Act, 2004

Scope

This policy is applicable to employees within all Mental Health inpatient settings, community settings and general hospital settings, including those with honorary contracts where patients are subject to Community Treatment Orders.

Equality and Health Impact Assessment	There is potential for both positive and negative impact. The procedure is aimed at improving services and meeting diverse needs. Mitigation actions are already in place to offset any potential negative outcome, e.g. through the monitoring of the procedure. There is nothing, at this time, to stop the procedure from being implemented.

Policy Approved by	Pending - Mental Health and Capacity Legislation Committee
Group with authority to approve procedures written to explain how this policy will be implemented	Mental Health and Capacity Legislations Committee
Accountable Executive or Clinical Board Director	Chief Operating Officer

Disclaimer

If the review date of this document has passed please ensure that the version you are using is the most up to date either by contacting the document author or the Governance Directorate.

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Summary of reviews/amendments

Version Number	Date Review Approved	Date Published	Summary of Amendments
1	Date approved by Board/Committee/Sub Committee dd/mm/yyyy	TBA *[To be inserted by the Gov. Dept]*	*New document*
2			

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Equality & Health Impact Assessment for

COMMUNITY TREATMENT ORDER POLICY

1.	For service change, provide the title of the Project Outline Document or Business Case and Reference Number	COMMUNITY TREATMENT ORDER POLICY
2.	Name of Clinical Board / Corporate Directorate and title of lead member of staff, including contact details	Mental Health Clinical Board Sunni Webb, Mental Health Act Manager 029 21824745 Sunni.webb@wales.nhs.uk
3.	Objectives of strategy/ policy/ plan/ procedure/ service	The aim of this policy is to ensure staff are aware of their individual and collective responsibilities when considering and assessing individuals for CTOs. Provide clear guidance to staff in relation to their legal responsibilities under the Mental Health Act 1983 as amended by the MHA 2007. Ensure that statutory requirements under the Mental Health Act 1983 are met. Practitioners should have due regard to the Mental Health Act Code of Practice generally and specifically to the Guiding Principles when they are considering the use of CTOs. This would ensure that considerations are given as to whether the objectives can be met in a less restrictive way.
4.	Evidence and background information considered. For example	**Related policies/information -** Mental Health Act 1983, Code of Practice for Wales (Revised 2016), Welsh Language Act 2016, Mental

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	• population data • staff and service users data, as applicable • needs assessment • engagement and involvement findings • research • good practice guidelines • participant knowledge • list of stakeholders and how stakeholders have engaged in the development stages • comments from those involved in the designing and development stages Population pyramids are available from Public Health Wales Observatory[1] and the UHB's 'Shaping Our Future Wellbeing' Strategy provides an overview of health need[2].	Health Wales Measure 2010, Deprivation of Liberty Safeguards, Equality Act 2010 **Stakeholders -** Service Users, Nursing Staff, Responsible Clinicians, Approved Clinicians, Mental Health Act Administrators, Approved Mental Health Professionals, Qualified nursing staff and other professionals working within mental health services. **Age -** 20 per cent of children have a mental health problem in any given year, and about 10 per cent at any one time. A quarter of older people in the community have symptoms of depression that require an intervention, and this increases to 40 per cent of care home residents (Mind "Our Communities, Our Mental Health) Older people (aged 60 and above) are more vulnerable to mental health problems, depression is a common disorder amongst this population and it has been estimated that 7% of older people suffer with uni-polar depression (World Health Organisation, 2016). Further Older people are more likely to experience a combination of physical and mental health issues (WHO, 2016). Younger adults are susceptible to mental health issues, with 6.2% of 16-24 year olds attempting suicide in their lifetime and 16.4% experiencing neurotic symptoms (Young Minds, 2016). Further, student populations are disproportionately affected by mental health issues, with an estimated 1 in 4 reporting mental health problems. Poor mental health amongst young people can lead to reduced life chances and

[1] http://nww2.nphs.wales.nhs.uk:8080/PubHObservatoryProjDocs.nsf
[2] http://www.cardiffandvaleuhb.wales.nhs.uk/the-challenges-we-face

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		impact on their education, social participation and ability to find and sustain employment. Results of Welsh Health Survey 2015 – reported in Mental Health Foundation Fundamental Facts 2016:- Results from the 2015 survey found that 13% of adults (aged 16 and older) living in Wales were reported to have received treatment for a mental health problem, an increase from 12% reported in 2014. Unlike other illnesses, the percentage who reported being treated for mental ill health did not increase with age, however trends suggest that an increase in treatment towards middle age before decreasing in retirement age. These rates have not significantly changed since the 2014 health survey. The total number of CAMHS referrals to treatment in Wales doubled between April 2010 (1,204) and July 2014 (2,342). Young people awaiting outpatient's treatment has the highest numbers (2,410) compared to adults (1,291) and those in later life. The Mental Health Act relates to all patients suffering from a mental disorder who meet the criteria for detention, irrespective of age. **Disability -** Physical illness more than doubles the risk of depression, and between 30 per cent and 50 per cent of adults with learning disability in the UK have mental health problems. (Mind "Our Communities, Our Mental Health) Sensory loss: Sensory loss currently affects 1 in 5 people in Wales, with 1 in 6 people affected by hearing loss and an estimated 115,000 people

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		living with sight loss which has a significant impact on their daily lives (Sensory Loss in the Adult population in Wales, 2012). Those affected by sensory loss are more susceptible to the development of mental health issues, especially older people. Older people with sight loss are three times more likely to experience depression than people with good vision (Depression and Anxiety in Visually Impaired Older People, 2007) with the British Medical Journal reporting that sight loss is one of the top three causes of suicide among older people The proposed policy will apply to all patients detained regardless of disability, as the policy is reference to the scrutiny of the documents completed by staff rather than the processes. All documents will have been completed in conjunction with consideration of the Mental Health Act, Mental Capacity Act, DoLS and the Mental Health Wales Measure. **Gender -** There are clear differences in the way women and men experience mental health problems. Women are more likely to report common mental health problems. Girls are also more likely than boys to self-harm, and eating disorders are more common in young women compared to young men. Men are more likely to have undiagnosed depression, be detained under the Mental Health Act and take their own life compared to women. (Mind, “Our Communities, Our Mental Health”) Results of Welsh Health Survey 2015 – reported in Mental Health Foundation Fundamental Facts 2016:- A higher percentage of women report being treated for a mental health problem than men (16% vs 10%). Treatment figures show an increase of 1% for both men and women from 2014 statistics. Health (and social care) services have a duty to treat people fairly and

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		equally. However, the Stonewall **Unhealthy Attitudes 2015** report highlights some major gaps in the knowledge and training of staff relating to lesbian, gay, bisexual and trans (LGBT) people, which is resulting in unfair treatment of both LGBT patients and colleagues. Gay and Bisexual Men's Health Survey With 6,861 respondents from across Britain, the 2013 report is the largest survey ever conducted of gay and bisexual men's health needs in the world. However, it demonstrates that many of those needs are not being met and that there are areas of significant concern – most particularly in mental health and drug use – that have been overlooked by health services which too often focus solely on gay men's sexual health. This report also provides hard evidence that gay and bisexual men nationwide are more likely to attempt suicide, self-harm and have depression than their straight peers. This policy will apply regardless of gender. **Gender Reassignment -** Trans people are at increased risk of depression and self-harm, and a third of trans people have attempted to take their own life.(Mind, "Our Communities, Our Mental Health") This policy will apply regardless of whether patients have transitioned or not. Health (and social care) services have a duty to treat people fairly and equally. However, the Stonewall **Unhealthy Attitudes 2015** report highlights some major gaps in the knowledge and training of staff relating to lesbian, gay, bisexual and trans (LGBT) people, which is resulting in unfair treatment of both LGBT patients and colleagues.

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		The NHS Centre for Equality and Human Rights (CEHR) has published a new guide for all staff in NHS Wales. *"It's Just Good Care – A guide for health staff caring for people who are trans*"* aims to help health staff provide trans* people with the respectful and appropriate care they are entitled to. The document is available for downloading from the staff intranet. Also available on the intranet is a Top Tips for Making your Service Inclusive and Welcoming for Trans People **Human Rights -** The proposed policy promotes human rights in ensuring that all patients are detained lawfully. **Pregnancy and Maternity -** Mental health problems affect between 10 and 20 per cent of women at some point during the perinatal period (pregnancy and one year after birth). Poor maternal health can also increase the risk of mental health in children. Within the Mind report the following issues are also identified as contributory risk factors:- Trauma and stressful events, poverty, unemployment and housing insecurity, social isolation and loneliness, discrimination and inequality. (Mind, "Our Communities, Our Mental Health") Results of Welsh Health Survey 2015 – reported in Mental Health Foundation Fundamental Facts 2016 Mental health problems affect more than 1 in 10 women during pregnancy and the first year after childbirth, and can have a devastating impact on new mothers and their families. According to a 2014 report from the London School of Economics and the Centre for Mental Health, in the UK, 20% of women are affected by mental health problems during the perinatal period. In Wales, 70% of people have no

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		access to specialist perinatal mental health services; a figure significantly higher than the UK average of 40%. According to NHS Choices website If you have had in the past, or now have, severe mental health problems, you are more likely to become ill during pregnancy or in the first year after giving birth than at other times in your life. Severe mental health problems include bipolar affective disorder, severe depression and psychosis. After giving birth, severe mental illness may progress more quickly and be more serious than at other times. This policy will apply regardless of whether patients are pregnant at the time of being detained. In relation to staff there are no changes to be made in relation to applying holding powers. Wards will have completed risk assessments in relation to staff. **Race/ Ethnicity or nationality –** A disproportionate number of people admitted as inpatients in mental health services come from BAME groups. In 2010, 23 per cent of inpatient admissions were from a BAME background. According to the mental health organisation 'Mind', the admission rate for 'other black' groups is six times higher than average, suggesting discrimination within the mental health system. Black African and Caribbean people living in the UK have lower reported rates of common mental health problems compared to other ethnic groups, however they are more likely to be diagnosed with severe mental health problems. Black African and Caribbean people are also much more likely to be detained under the Mental Health Act compared to other ethnic groups. According to Black Mental Health UK,

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		people of African or Caribbean descent are 50 per cent more likely to be referred to mental health services via the police than their white counterparts.Young women from ethnic minorities are much more likely to take their own life than White British women. (Mind, “Our Communities, Our Mental Health”) The proposed policy will apply regardless of the race / ethnicity of patients or staff. Health inequalities are further linked to unequal access to healthcare. Some BAME groups face considerable barriers to healthcare. In 2009 the Department for Communities and Local Government noted that Gypsies and Travellers face particular difficulties accessing healthcare. Many of them felt that health workers and doctors misunderstood their needs and circumstances. Additionally, Gypsy and Traveller access to healthcare can also difficult if there is an inability to provide proof of identity. The West Midlands Strategic Health Partnership noted, in 2010, that migrant populations faced significant barriers accessing healthcare including difficulties that were related to registering, contracting and commissioning processes as well as a lack of knowledge about services available. Other common difficulties included poor continuity of care and the experience of not having the same doctor in the practice. A Cultural Competency Toolkit, was developed by Diverse Cymru, with assistance from UHB staff. Its aim is to help staff better interact with clients with mental ill health who are from different cultures

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		A proportion of patients first language may not be English or Welsh. The statutory documents in relation to the Mental Health Act are provided by Welsh Government are only available in English and Welsh. Within the explanation of rights this now details if the information has been given in the patients preferred language and will be reported on. Access to an interpreter is available and translation of written information can be obtained as and when required. **Religion or Belief -** Spiritual awareness, practices and beliefs (of any religion or for those engaging in spiritual practices without a particular faith) is associated with psychological benefits, including subjective wellbeing (Mind, Our Communities, Our Mental Health"). There are religious beliefs and practices that have been shown, across all the cultures studied, to have some salutary effects on well-being. Other ways in which culture may impact on the relations between religion and well-being have been less consistently documented. The recent growth of interest in positive psychology, and in the relations between religion and spirituality, and maturity, morality and virtue has not yet incorporated a marked focus on cultural issues. Religious beliefs and practices supported in one culture may appear disturbed to people (including mental health professionals) from another, affecting diagnosis and treatment. Many commonly held ideas about the role of religion in shame, guilt and anxiety (including obsessive-compulsive disorder), voices, visions and spirit possession require closer examination in the light of evidence from different cultural groups. Clinical practitioners are

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		keen to reach a better understanding of the roles played by religious factors in different cultures, in affecting mental health. The proposed policy will apply regardless of the religion or belief of patients or staff. **Sexual Orientation -** Lesbian, gay and bisexual people are at increased risk of mental health problems, including self-harm and attempted suicide. Lesbian, gay and bisexual people have a 1.5 fold increased risk of depression and anxiety. (Mind “Our Communities, Our Mental Health”). Health (and social care) services have a duty to treat people fairly and equally. However, the Stonewall **Unhealthy Attitudes 2015** report highlights some major gaps in the knowledge and training of staff relating to lesbian, gay, bisexual and trans (LGBT) people, which is resulting in unfair treatment of both LGBT patients and colleagues. Gay and Bisexual Men’s Health Survey With 6,861 respondents from across Britain, the 2013 report is the largest survey ever conducted of gay and bisexual men’s health needs in the world. However, it demonstrates that many of those needs are not being met and that there are areas of significant concern – most particularly in mental health and drug use – that have been overlooked by health services which too often focus solely on gay men’s sexual health. This report also provides hard evidence that gay and bisexual men nationwide are more likely to attempt suicide, self-harm and have depression than their straight peers.

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		The proposed policy will apply regardless of the sexual orientation of the patients or staff. **Welsh Language -** No evidence of disproportional representation to date, but a proportion of service users may be Welsh speakers **Welsh Language and its use in Cardiff & Vale of Glamorgan** The latest census statistics available indicate that 16% of the population of Cardiff have one or more skills in the Welsh Language (ability to read, write or/and understand Welsh). 32,000 or 11% of Cardiff's population are fluent Welsh speakers. 24.5% are within the 3-15 age group, and 12.1% within the 16-24 age groups. When the results of previous Censuses are consulted, a significant increase in the incidence of Welsh speakers amongst the youngest age groups is noticed. For the 5-15 year age group, the proportion of Cardiff's residents able to speak Welsh has increased from 6.8% in 1971 to 7.5% in 1981 and 12.7% in 1991. By 2001 this figure had increased to 24.5%. In the Vale of Glamorgan 13,189 of 122,018 people, which is 10.8% of the population, are fluent Welsh speakers. As the statutory documents in relation to the Mental Health Act are provided by Welsh Government these are in English on the Website. Information leaflets for the patients are available in both English and Welsh. Within the explanation of rights this now details if the information has been given in the patients preferred language and will be reported on. Welsh Language Act is a consideration. **The impact of mental ill health on employment rates**

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		A national household survey in Great Britain conducted in 2000 found that 57% of people who have a common mental disorder are working, compared with 69% of people who do not have a common mental disorder. Just 9% of people with a probable psychotic disorder, which includes most people with a severe mental disorder, are working fulltime and a further 19% part-time (Meltzer et al., 2002)8. An earlier survey reported that 70% of those with a common mental disorder, who are unemployed and seeking work, have been unemployed for a year or more (that is 7% of all people with a common mental disorder) and are unlikely to return to work (Meltzer et al., 1995). Those who have a common mental disorder are four to five times more likely than those who have not to be permanently unable to work and three times more likely to be receiving benefits payments (Meltzer et al., 1995 and 2002). Between 30% and 50% of people with schizophrenia are capable of work but only between 10% and 20% are in employment (Marwaha and Johnson, 2004; Schneider, 1998). Although some are in managerial or senior official positions, most are in 'elementary' jobs, for example cleaning and labouring, or are in skilled trade occupations such as plumbing or metal work. The rate of employment in people with schizophrenia seems to have fallen from before 1990 when surveys reported that between 20% and 30% were in work. Several studies conducted at two time points seem to confirm this reduction (e.g. Rinaldi and Perkins, 2007). The reason for this is unknown but one factor might be a reduction in the number of sheltered employment schemes. For those who present to services for the first time, the likelihood of being in employment falls markedly over the subsequent year or two (Birchwood et al., 1992; Johnstone et al., 1986). For people with Schizophrenia, premorbid social and occupational history are associated with employment and some types of psychotic symptoms and the presence

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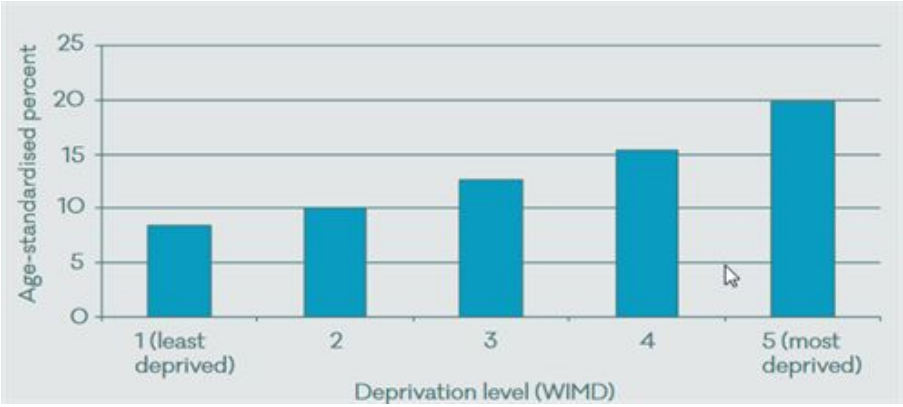
		of negative symptoms are associated with unemployment. The desire to have a job is one of the best predictors of future employment (Marwaha and Jonhson, 2004). **People according to where they live**  Findings from the 2015 survey found, that there was poorer mental health in more deprived areas. The percentage of adults that reported currently being treated for any mental health condition by area deprivation showed 8 per cent in the least deprived fifth in receipt of mental health treatment which rose steadily with higher levels of deprivation to 20 per cent in the most deprived fifth. There is a wealth of evidence that mental health influences a very wide range of outcomes for individuals and communities. These include healthier lifestyles; better physical health; improved recovery from illness; fewer limitations in daily living; higher educational attainment;

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		greater productivity, employment and earnings; better relationships with adults and with children; more social cohesion and engagement and improved quality of life. These outcomes are not just or necessarily a consequence of the absence of mental illness, but are associated with the presence of positive mental health, sometimes referred to as 'wellbeing'. Improving mental health is a worthwhile goal in itself: most people value a sense of emotional and social wellbeing; in addition, good mental health has many other far reaching benefits. Mental health is a fundamental element of the resilience, health assets, capabilities and positive adaptation that enable people both to cope with adversity and to reach their full potential and humanity. Mental health is also the key to understanding the impact of inequalities on health and other outcomes. It is abundantly clear that the chronic stress of struggling with material disadvantage is intensified to a very considerable degree by doing so in more unequal societies. An extensive body of research confirms the relationship between inequality and poorer outcomes, a relationship which is evident at every position on the social hierarchy and is not confined to developed nations. The emotional and cognitive effects of high levels of social status differentiation are profound and far reaching: greater inequality heightens status competition and status insecurity across all income groups and among both adults and children. It is the *distribution* of economic and social resources that explains health and other outcomes in the vast majority of studies. The importance of the social and psychological dimensions of material deprivation is gaining greater recognition in the international literature on poverty and informs current efforts to develop indicators that capture the missing dimensions of poverty.

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		Both health-damaging behaviours and violence, for example, may be survival strategies in the face of multiple problems, anger and despair related to occupational insecurity, poverty, debt, poor housing, exclusion and other indicators of low status. These problems impact on intimate relationships, the care of children and care of the self. In the United Kingdom, the 20% - 25% of people who are obese or continue to smoke are concentrated among the 26% of the population living in poverty, measured in terms of low income and multiple deprivation of necessities. This is also the population with the highest prevalence of anxiety and depression. It is already well established that mental illness, across the spectrum of disorders, is both a direct cause of mortality and morbidity and a significant risk factor for poorer economic, health and social outcomes, although these adverse outcomes vary by type of disorder and socioeconomic status (WHO 2005; 2006).[3] However, it is now becoming clear that the presence or absence of positive mental health or 'wellbeing' *also* influences outcomes across a wide range of domains. These include healthier lifestyles, better physical health, improved recovery, fewer limitations in daily living, higher educational attainment, greater productivity, employment and earnings, better relationships, greater social cohesion and engagement and improved quality of life (WHO 2004b; Barry and Jenkins 2007; Jane-Llopis et al 2004). This policy will apply regardless of where a person lives. (From: http://www.euro.who.int/__data/assets/pdf_file/0012/100821/E92227.pdf

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		Homeless Affordable and safe accommodation brings stability and security; provides a gateway to access health services like GPs; enhances social and community inclusion; and provides the basis for the right to private and family life. Put simply, a home is vital for good mental and physical health, allowing people to live in safety, security, peace and dignity. Whilst there is no such 'right to housing' in itself, the right to an adequate standard of living, including housing, is recognised in the UN Covenant on Economic, Social and Cultural Rights. Of course, there are numerous factors which can cause people to become homeless, many of which are beyond individual control, such as lack of affordable housing, disability and poverty. But what really needs to be highlighted is the two-way relationship between homelessness and mental health. Homelessness and mental health often go hand in hand, and can be a self-fulfilling prophecy. Having a mental health problem can create the circumstances which can cause a person to become homeless in the first place. Yet poor housing or homelessness can also increase the chances of developing a mental health problem, or exacerbate an existing condition. In turn, this can make it even harder for that person to recover – to develop good mental health, to secure stable housing, to find and maintain a job, to stay physically healthy and to maintain relationships.

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		It is a fundamental fact that single homeless people are much more likely to have mental health problems compared to the general population. In 2015, 32% of single homeless people reported a mental health problem, and depression rates, for example, are over 10 times higher in the homeless population. Unfortunately, other psychological issues such as complex trauma, substance misuse and social exclusion are also common This policy will apply regardless of where a person lives. **Asylum Seekers** Some asylum seekers will have been subjected to torture, as well as witnessing the consequences of societal breakdown of their home country – with consequences for their mental health. Culturally, mental illness may not be expressed or may manifest as physical Complaints. Stigma may also be attached to mental ill-health. Furthermore, Western psychological concepts are not universally applicable to asylum seekers. Mental health problems such as depression and anxiety are common, but post-traumatic stress disorder is greatly underestimated and under diagnosed and may be contested by healthcare professionals. Children are particularly neglected in this area. A shortage of mental health services for asylum seekers has been recognised. http://www.fph.org.uk/uploads/bs_aslym_seeker_health.pdf **Prisoners** 10% of men and 30% of women have had a previous psychiatric admission before they entered prison. A more recent study found that 25% of women and 15% of men in prison reported symptoms indicative of psychosis. The rate among the general public is about 4%.

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		26% of women and 16% of men said they had received treatment for a mental health problem in the year before custody. Personality disorders are particularly prevalent among people in prison. 62% of male and 57% of female sentenced prisoners have a personality disorder. 49% of women and 23% of male prisoners in a Ministry of Justice study were assessed as suffering from anxiety and depression. 16% of the general UK population (12% of men and 19% of women) are estimated to be suffering from different types of anxiety and depression. 46% of women prisoners reported having attempted suicide at some point in their lives. This is more than twice the rate of male prisoners (21%) and higher than in the general UK population amongst whom around 6% report having ever attempted suicide. http://www.prisonreformtrust.org.uk/ProjectsResearch/Mentalhealth **Information in relation to multiple protected characteristics -** Mental health issues can affect anyone among the population at any stage of life. However, national statistics show that that there are higher incidences of mental health issues among certain protected groups. Mind's report "Our Communities, Our Mental Health" identified the following contributory risk factors:- Trauma and stressful events, poverty, unemployment and housing insecurity, social isolation and loneliness, discrimination and inequality.

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		These risk factors may be present in any protected group. Reviews of the international research literature have found many methodological limitations and no robust evidence about either the positive or negative effect of community treatment orders on key outcomes such as hospital readmissions, length of hospital stay, improved medication adherence or patients' quality of life, and have queried whether community treatment orders are an effective alternative to standard care. Although not opposing community treatment orders in principle, the Royal College of Psychiatrists has pointed out that 'studies from abroad do not show community treatment orders to be the panacea the Government makes them out to be. Indeed the evidence is equivocal as to whether they bestow any benefits on a wide scale'. **Ethical Considerations** Community treatment orders pit patient autonomy against professional paternalism, raising serious ethical concerns. The 2007 Act is risk-based, not capacity-based. Given that the majority of psychiatric in-patients have the capacity to make treatment decisions, community treatment orders will commonly be imposed on people who have capacity. Community treatment orders are not a good thing -Simon Lawton-Smith / John Dawson and Tom Burns) **Examples of patient experience** Participants perceived both positive and negative impacts of CTOs. The positives included affirmation of experiences with the mental health system; improved rapport with the case management and clinical team,

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		increased medication compliance and feelings of empowerment. The negative feedback included feelings of being coerced and the stigma associated with it. (Community treatment orders and the experiences of ethnic minority individuals diagnosed with serious mental illness in the Canadian mental health system – Magnus Mfoafo-McCarthy International Journal of Equity in Health Sept 2014) Findings of **NO HEALTH WITHOUT MENTAL HEALTH: A cross-Government mental health outcomes strategy for people of all ages Analysis of the Impact on Equality (AIE) (DoH 2011) -** The Care Quality Commission (CQC) recently highlighted a number of human rights issues relating to the use of CTOs, including concern about appropriate usage, over-representation of black and minority ethnic (BME) groups among those issued with CTOs and a lack of consistent practice when involving patients in care decisions, such as the details of their CTO. A compulsory community-based treatment order requires a patient to comply with a set of conditions, such as taking their medication, while allowing them to live in the community, as a less restrictive alternative to hospital. These orders are particularly targeted at people who tend to have difficulty engaging with mental health services or taking their medication, leading to an exacerbation of their mental health problems, which can end up with a hospital admission. They are intended to increase compliance with medication and patient engagement with outpatient services, while reducing hospital admissions and lowering the risk of harm to themselves or others.

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		(A Question of Numbers – Potential Impact of Community Based Treatment Orders in England and Wales" Simon Lawton Smith for the Kings Fund Sept 2005) Community treatment orders are designed to ensure patients live in their home or supported accommodation. The power of recall under section 17E is used when a patient is not compliant with their conditions or becomes mentally unwell. They are used for patients who have frequent repeated admissions to hospital.
5.	Who will be affected by the strategy/ policy/ plan/ procedure/ service	Mental health issues affect the whole population, though some protected groups are disproportionately represented among service users**.** The policy addresses administrative issues and responsibilities in relation to the direct care and treatment of patients. The Community Treatment Order Policy covers mental health patients across community, outpatient and inpatient settings. Hospital managers must ensure that those acting on their behalf are competent to do so and receive suitable training to ensure they exercise their functions appropriately to ensure the functions are carried out on a day to day basis. The functions are carried out on a day to day basis.

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6. EQIA / How will the strategy, policy, plan, procedure and/or service impact on people?

Questions in this section relate to the impact on people on the basis of their 'protected characteristics'. Specific alignment with the 7 goals of the Well-being of Future Generations (Wales) Act 2015 is included against the relevant sections.

How will the strategy, policy, plan, procedure and/or service impact on:-	**Potential positive and/or negative impacts**	**Recommendations for improvement/ mitigation**	**Action taken by Clinical Board / Corporate Directorate.** Make reference to where the mitigation is included in the document, as appropriate
6.1 Age For most purposes, the main categories are: • under 18; • between 18 and 65; and • over 65	There is potential for a positive impact in that there is an awareness of this protected characteristic.	N/A	Under Policy Statement
6.2 Persons with a disability as defined in the Equality Act 2010 Those with physical impairments, learning disability, sensory loss or impairment, mental health conditions, long-term medical conditions such as diabetes	Disabled people with enduring mental health problems of all types are much less likely to be economically active than those with physical or sensory impairments. There is potential for a positive impact in that there is an awareness of this protected	A key duty is that the Doctor must be fully aware of the diverse needs of the patient when considering detention and must take them in to account at all times. They must ensure the patient fully	Under Policy Statement

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How will the strategy, policy, plan, procedure and/or service impact on:-	**Potential positive and/or negative impacts**	**Recommendations for improvement/ mitigation**	**Action taken by Clinical Board / Corporate Directorate.** Make reference to where the mitigation is included in the document, as appropriate
	characteristic and staff have to take into account the diverse needs of the individual patient.	understands what is happening to them in a language and format which they are able to understand, this will include sensory and cognitive abilities and physical impairment. Where necessary, an interpreter should be obtained.	
6.3 People of different genders: Consider men, women, people undergoing gender reassignment **NB** Gender-reassignment is anyone who proposes to, starts, is going through or	There is potential for a positive impact in that there is an awareness of this protected characteristic and staff have to take into account the diverse needs of the individual patient.	*"It's Just Good Care – A guide for health staff caring for people who are trans*" is made available to staff*	Under Policy Statement

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How will the strategy, policy, plan, procedure and/or service impact on:-	**Potential positive and/or negative impacts**	**Recommendations for improvement/ mitigation**	**Action taken by Clinical Board / Corporate Directorate.** Make reference to where the mitigation is included in the document, as appropriate
who has completed a process to change his or her gender with or without going through any medical procedures. Sometimes referred to as Trans or Transgender			
6.4 People who are married or who have a civil partner.	We are aware of potential negative impact in terms of the LGBT+ communities and access to health care services as noted elsewhere within the EHIA.	*"It's Just Good Care – A guide for health staff caring for people who are trans*" is made available to staff.*	Under Policy Statement
6.5 Women who are expecting a baby, who are on a break from work after having a baby, or who are breastfeeding. They are protected for 26 weeks after having a baby whether or not	No impact anticipated. However staff have to take into account the diverse needs of the individual patient.	N/A	Under Policy Statement

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How will the strategy, policy, plan, procedure and/or service impact on:-	**Potential positive and/or negative impacts**	**Recommendations for improvement/ mitigation**	**Action taken by Clinical Board / Corporate Directorate.** Make reference to where the mitigation is included in the document, as appropriate
they are on maternity leave.			
6.6 People of a different race, nationality, colour, culture or ethnic origin including non-English speakers, gypsies/travellers, migrant workers	There is a potential for a negative impact as there is a lot of well documented evidence to suggest that. However staff have to take into account the diverse needs of the individual patient.	A key duty is that the Doctor must be fully aware of the diverse needs of the patient when considering detention and must take them in to account at all times. They must ensure the patient fully understands what is happening to them in a language and format which they are able to understand, this will include sensory and cognitive abilities and physical impairment. Where necessary, an	Under Policy Statement A Cultural Competency Toolkit, was developed by Diverse Cymru, with assistance from UHB staff. Its aim is to help staff better interact with clients with mental ill health who are from different cultures.

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How will the strategy, policy, plan, procedure and/or service impact on:-	**Potential positive and/or negative impacts**	**Recommendations for improvement/ mitigation**	**Action taken by Clinical Board / Corporate Directorate.** Make reference to where the mitigation is included in the document, as appropriate
		interpreter should be obtained.	
6.7 People with a religion or belief or with no religion or belief. The term 'religion' includes a religious or philosophical belief	There is the potential for impact as suggested by the evidence above. However staff have to take into account the diverse needs of the individual patient. .		A Cultural Competency Toolkit, was developed by Diverse Cymru, with assistance from UHB staff. Its aim is to help staff better interact with clients with mental ill health who are from different cultures.
6.8 People who are attracted to other people of: • the opposite sex (heterosexual); • the same sex (lesbian or gay); • both sexes (bisexual)	We know from evidence that there are potential negative issues in terms of these protected characteristics. However staff have to take into account the diverse needs of the individual	N/A	N/A

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How will the strategy, policy, plan, procedure and/or service impact on:-	**Potential positive and/or negative impacts**	**Recommendations for improvement/ mitigation**	**Action taken by Clinical Board / Corporate Directorate.** Make reference to where the mitigation is included in the document, as appropriate
	patient.		
6.9 People who communicate using the Welsh language in terms of correspondence, information leaflets, or service plans and design Well-being Goal – A Wales of vibrant culture and thriving Welsh language	There is the potential for a negative impact. However staff have to take into account the diverse needs of the individual patient.	A key duty is that the Doctor must be fully aware of the diverse needs of the patient when considering detention and must take them in to account at all times. They must ensure the patient fully understands what is happening to them in a language and format which they are able to understand, this will include sensory and cognitive abilities and physical impairment. Where necessary, an interpreter should be	Under Policy Statement Staff are made aware of the translation and interpretation policy.

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How will the strategy, policy, plan, procedure and/or service impact on:-	**Potential positive and/or negative impacts**	**Recommendations for improvement/ mitigation**	**Action taken by Clinical Board / Corporate Directorate.** Make reference to where the mitigation is included in the document, as appropriate
		obtained.	
6.10 People according to their income related group: Consider people on low income, economically inactive, unemployed/workless, people who are unable to work due to ill-health	There is awareness that mental health problems have a greater impact on people's ability to work than any other group of disorders. However staff have to take into account the diverse needs of the individual patient. Disabled people with enduring mental health problems of all types are much less likely to be economically active than those with physical or sensory impairments.	N/A	Under Policy Statement

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How will the strategy, policy, plan, procedure and/or service impact on:-	**Potential positive and/or negative impacts**	**Recommendations for improvement/ mitigation**	**Action taken by Clinical Board / Corporate Directorate.** Make reference to where the mitigation is included in the document, as appropriate
6.11 People according to where they live: Consider people living in areas known to exhibit poor economic and/or health indicators, people unable to access services and facilities	No impact identified at this time, though it is recognised that there is poorer mental health in more deprived areas. However staff have to take into account the diverse needs of the individual patient.	N/A	Under Policy Statement
6.12 Consider any other groups and risk factors relevant to this strategy, policy, plan, procedure and/or service	Staff will respect the rights and needs of carers alongside the person's right to confidentiality. A Review of the person's consent to share information with family members, carers and other services will take place during the inpatient stay.	A key duty is that the Doctor must be fully aware of the diverse needs of the patient when considering detention and must take them in to account at all times. They must ensure the patient fully understands what is happening to them in a	Under Policy Statement

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How will the strategy, policy, plan, procedure and/or service impact on:-	**Potential positive and/or negative impacts**	**Recommendations for improvement/ mitigation**	**Action taken by Clinical Board / Corporate Directorate.** Make reference to where the mitigation is included in the document, as appropriate
	No impact has been identified at this time in relation to the homeless, asylum seekers and prisoners, though it is recognised that there is sometimes poorer mental health issues due to their circumstances and that there consequences for their mental health. However staff have to take into account the diverse needs of the individual patient.	language and format which they are able to understand, this will include sensory and cognitive abilities and physical impairment. Where necessary, an interpreter should be obtained.	

7. HIA / How will the strategy, policy, plan, procedure and/or service impact on the health and well-being of our population and help address inequalities in health?

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Questions in this section relate to the impact on the overall health of individual people and on the impact on our population. Specific alignment with the 7 goals of the Well-being of Future Generations (Wales) Act 2015 is included against the relevant sections.

How will the strategy, policy, plan, procedure and/or service impact on:-	**Potential positive and/or negative impacts and any particular groups affected**	**Recommendations for improvement/ mitigation**	**Action taken by Clinical Board / Corporate Directorate** Make reference to where the mitigation is included in the document, as appropriate
7.1 People being able to access the service offered: Consider access for those living in areas of deprivation and/or those experiencing health inequalities Well-being Goal - A more equal Wales	No Impact identified at this time, though it is recognised that there is poorer mental health in more deprived areas. However staff have to take into account the diverse needs of the individual patient.	N/A	Under Policy Statement
7.2 People being able to improve /maintain healthy lifestyles: Consider the impact on healthy lifestyles, including healthy eating, being active, no smoking /smoking cessation, reducing the harm caused by alcohol and /or	No impact identified at this time, though it is recognised that healthy lifestyles can have a positive impact on mental health and well-being. Staff have to take into account the diverse needs of the individual patient.	N/A	Under Policy Statement

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How will the strategy, policy, plan, procedure and/or service impact on:-	**Potential positive and/or negative impacts and any particular groups affected**	**Recommendations for improvement/ mitigation**	**Action taken by Clinical Board / Corporate Directorate** Make reference to where the mitigation is included in the document, as appropriate
non-prescribed drugs plus access to services that support disease prevention (e.g. immunisation and vaccination, falls prevention). Also consider impact on access to supportive services including smoking cessation services, weight management services etc Well-being Goal – A healthier Wales			
7.3 People in terms of their income and employment status: Consider the impact on the availability and accessibility of work, paid/ unpaid employment, wage levels, job security, working conditions	No impact identified at this time, though it is recognised that being employed can have a positive impact on mental health and well-being. Staff have to take into account the diverse needs of the individual patient.	N/A	Under Policy Statement

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How will the strategy, policy, plan, procedure and/or service impact on:-	**Potential positive and/or negative impacts and any particular groups affected**	**Recommendations for improvement/ mitigation**	**Action taken by Clinical Board / Corporate Directorate** Make reference to where the mitigation is included in the document, as appropriate
Well-being Goal – A prosperous Wales			
7.4 People in terms of their use of the physical environment: Consider the impact on the availability and accessibility of transport, healthy food, leisure activities, green spaces; of the design of the built environment on the physical and mental health of patients, staff and visitors; on air quality, exposure to pollutants; safety of neighbourhoods, exposure to crime; road safety and preventing injuries/accidents; quality and safety of play areas and open spaces Well-being Goal – A resilient Wales	No impact identified at this time, though it is recognised that environmental issues can have a positive impact on mental health and well-being. Staff have to take into account the diverse needs of the individual patient.	N/A	Under Policy Statement

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How will the strategy, policy, plan, procedure and/or service impact on:-	**Potential positive and/or negative impacts and any particular groups affected**	**Recommendations for improvement/ mitigation**	**Action taken by Clinical Board / Corporate Directorate** Make reference to where the mitigation is included in the document, as appropriate
7.5 People in terms of social and community influences on their health: Consider the impact on family organisation and roles; social support and social networks; neighbourliness and sense of belonging; social isolation; peer pressure; community identity; cultural and spiritual ethos Well-being Goal – A Wales of cohesive communities	No impact identified at this time, though it is recognised that social and community influences and related issues can have a positive impact on mental health and well-being. Staff have to take into account the diverse needs of the individual patient.	N/A	Under Policy Statement
7.6 People in terms of macro-economic, environmental and sustainability factors: Consider the impact of	No impact identified at this time, though it is recognised that macro-economic, environmental and sustainability factors social	N/A	Under Policy Statement

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How will the strategy, policy, plan, procedure and/or service impact on:-	**Potential positive and/or negative impacts and any particular groups affected**	**Recommendations for improvement/ mitigation**	**Action taken by Clinical Board / Corporate Directorate** Make reference to where the mitigation is included in the document, as appropriate
government policies; gross domestic product; economic development; biological diversity; climate Well-being Goal – A globally responsible Wales	and community influences and related issues can have a positive impact on mental health and well-being. Staff have to take into account the diverse needs of the individual patient.		

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Please answer question 8.1 following the completion of the EHIA and complete the action plan

8.1 Please summarise the potential positive and/or negative impacts of the strategy, policy, plan or service	There is some concern and debate around effectives of Community Treatment Orders. Whilst some protected groups may be disproportionately represented in the numbers accessing mental health services and who may be subject to the CTO Policy, there is no evidence at this stage that any individuals or group/s will be discriminated against or adversely impacted by the policy if implemented fairly and equitably. There is some concern that Community Treatment Orders may impact adversely on the human rights of people with mental health issues who have capacity as the decision making process is risk based rather than capacity based (Community treatment orders are not a good thing -Simon Lawton-Smith / John Dawson and Tom Burns). However, this is rebutted within the debate citing no difference between CTO and a hospital based imposed treatment regime. **https://www.google.co.uk/search?q=Impact+of+community+treatment+orders+on+protected+groups&oq=Impact+of+community+treatment+orders+on+protected+groups&gs_l=psy-ab.12...1837221.1854919.0.1857397.59.38.1.0.0.0.531.5383.0j2j4j6j3j1.16.0....0...1.1.64.psy-ab..50.0.0.gB1dGnixrkY** CTOs are intended to allow suitable patients to be safely treated in the community rather than under detention in hospital, and to provide a way to help prevent relapse and harm to the patient or to others.

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Action Plan for Mitigation / Improvement and Implementation

	Action	Lead	Timescale	Action taken by Clinical Board / Corporate Directorate
8.2 What are the key actions identified as a result of completing the EHIA?	To ensure that an interpreter/translation is requested immediately to avoid delay and ensure patients are provided with information in their preferred language in a timely manner.	All appropriate staff	As and When required/requested	Staff will be/are made aware of our Interpretation and Translation policy and its use with service users.
8.3 Is a more comprehensive Equalities Impact Assessment or Health Impact Assessment required? This means thinking about relevance and proportionality to the Equality Act and asking: is the impact significant enough that a more formal and full consultation is required?	Not required	N/A	N/A	No action

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	Action	Lead	Timescale	Action taken by Clinical Board / Corporate Directorate
8.4 What are the next steps? Some suggestions:- • Decide whether the strategy, policy, plan, procedure and/or service proposal: ○ continues unchanged as there are no significant negative impacts ○ adjusts to account for the negative impacts ○ continues despite potential for adverse impact or missed opportunities to advance equality (set out the justifications for doing so) stops. • Have your strategy, policy, plan, procedure and/or service proposal approved • Publish your report of this impact assessment • Monitor and review	No significant negative Impact. The policy will be submitted to the Health Systems Management Board for consideration and the Mental Health and Capacity Legislation Committee for approval. Once the policy has been approved the documentation will be placed on the intranet and internet. The EHIA and Policy will be reviewed three years after approval unless changes to terms and conditions, legislation or best practice determine t an earlier review is required.	N/A	N/A	N/A Following recall, the hospital managers are responsible for ensuring no patient is detained for longer than 72 hours unless the CTO is revoked. The relevant statutory form must be completed on the patients arrival at hospital. Arrangements should be put in place to ensure the patients length of stay following the time of detention after recall, as recorded on the form, is carefully monitored. The hospital managers should also ensure there are clear guidelines and procedures in place to cover any necessary transfers of responsibility between responsible clinicians in the community and in hospital and the procedure to be followed when a patient is receiving inpatient services from a private provider and a community treatment order is appropriate.

14.1

Reference Number: *TBA* **Version Number:** 1	**Date of Next Review:** *To be included when document approved* **Previous Trust/LHB Reference Number:** *Any reference number this document has been previously known as*

Community Treatment Order Procedure
Mental Health Act, 1983

Introduction and Aim

This document supports the Community Treatment Order Policy, Mental Health Act, 1983.

To ensure staff are aware of their individual and collective responsibilities when considering and assessing individuals for CTOs

To Provide clear guidance to staff in relation to their legal responsibilities under the Mental Health Act 1983 as amended by the MHA 2007.

To Ensure that statutory requirements under the Mental Health Act 1983 are met.

Objectives

This procedure describe the following with regard to a CTO

- The purpose of a CTO
- The process for assessing the suitability for the use of a CTO
- The duties of the practitioners and agencies involved in the management of patients subject to a CTO

Practitioners must have due regard to the Mental Health Act Code of Practice generally and specifically to the Guiding Principles when they are considering the use of CTOs. This will ensure that considerations are given as to whether the objectives can be met in a less restrictive way.

Scope

This procedure is applicable to employees within all Mental Health inpatient settings, community settings and general hospital settings, including those with honorary contracts where patients are subject to Community Treatment Orders.

Equality and Health Impact Assessment	There is potential for both positive and negative impact. The procedure is aimed at improving services and meeting diverse needs. Mitigation actions are already in place to offset any potential negative outcome, e.g. through the monitoring of the procedure. There is nothing, at this time, to stop the procedure from being implemented.
Documents to read alongside this	• The Mental Health Act 1983 (as amended by the Mental Health Act 2007)

Procedure	• Mental Health (hospital, guardianship, community treatment and consent to treatment)(Wales) regulations 2008 • The Mental Capacity Act 2005 (including the Deprivation of Liberty Safeguards delegated to this Act under the Mental Health Act 2007) • The respective Codes of Practice of the above Acts of Parliament • The Human Rights Act 1998 (and the European Convention on Human Rights) • Domestic Violence, Crime and Victims Act, 2004 All Cardiff and Vale policies on the Mental Health Act 1983 as appropriate including: Community Treatment Order Policy Hospital Managers' Scheme of Delegation Policy Hospital Managers' Scheme of Delegation Procedure
Approved by	Pending – Mental Health and Capacity Legislation Committee

Accountable Executive or Clinical Board Director	*Chief Operating Officer*
Author(s)	*Mental Health Act Manager*
Disclaimer **If the review date of this document has passed please ensure that the version you are using is the most up to date either by contacting the document author or the Governance Directorate.**	

Summary of reviews/amendments			
Version Number	**Date of Review Approved**	**Date Published**	**Summary of Amendments**
1	*Date of Committee or Group Approval*	*TBA*	*New document*

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Glossary of terms

Term	Definition
AC	Approved Clinician – A mental health professional approved by the Welsh Ministers to act as an approved clinician for the purposes of the Act. In practice, Health Boards take these decisions on behalf of the Welsh Ministers
AMHP	Approved Mental Health Professional - A professional with training in the use of the Act, approved by a local authority to carry out a number of functions under the Act.
AWOL	Absent without leave - when CTO patients and conditionally discharged restricted patients don't return to hospital when recalled
CTO	Community Treatment Order – Written authorisation on a prescribed form for the discharge of a patient from detention in a Hospital onto supervised community treatment
HIW	Healthcare Inspectorate Wales – The independent body which is responsible for monitoring the operation of the Act in Wales.
IMHA	Independent Mental Health Advocate – An advocate independent of the team involved in patient care available to offer support to patients.
MDT	Multi Disciplinary Team
MHRTfW	Mental Health Review Tribunal for Wales – A judicial body that has the power to discharge patients from detention, community treatment orders, guardianship and conditional discharge
Part 4A treatment	The Part of the Act which deals with the medical treatment for mental disorder of CTO patients when they have not been recalled to hospital.
RC	Responsible Clinician - The approved clinician with overall responsibility for the patient's case.
SOAD	Second Opinion Approved Doctor – An independent doctor appointed by Healthcare Inspectorate Wales who gives a second opinion on whether certain types of medical treatment for mental disorder should be given without the patient's consent.
Section 5	The powers in Section 5 allow hospital inpatients to be detained

	temporarily so that a decision can be made about whether an application for detention should be made.
Section 25	Restrictions on discharge by nearest relatives
Section 62	Urgent treatment given to detained patients
Section 20A	Community treatment period
Section 23	Discharge of patients
Section 58 treatment	A form of medical treatment for mental disorder to which the special rules in section 58 of the Act apply, which means medication for mental disorder for detained patients after an initial three-month period.
Section 117	Aftercare - Services provided following discharge from hospital; especially the duty of health and social services to provide after-care under section 117 of the Act following the discharge of a patient from detention for treatment under the Act. The duty applies to CTO patients and conditionally discharged patients, as well as those who have been absolutely discharged.

Keywords	CTO, Mental Health Act, Section, Supervised Community Treatment, Community Treatment Order

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1. INTRODUCTION

This procedure sets out to describe the process of using Community Treatment Orders (CTO). Those on CTO will be known as community patients. It also gives guidance on the duties of the practitioners involved in the management of CTO.

CTO provides a statutory framework for community patients to receive their aftercare. It also allows conditions to be applied to the patients and gives the Responsible Clinician (RC) the power to recall the patient to hospital for treatment if it becomes necessary. Hence, for suitable patients, CTO will provide a positive alternative to treatment in hospital and an opportunity to minimise the disruption in their lives and reduce the risk of social exclusion.

2. PROCEDURE STATEMENT

This procedure has been developed to guide staff on the implementation and management of Community Treatment Orders (CTOs) in accordance with the Mental Health Act 1983 as amended by MHA 2007. This guidance has been developed in line with the Mental Health Act 1983 Code of Practice for Wales 2016 ("the Code of Practice").

CTOs are intended to allow suitable patients to be safely treated in the community rather than under detention in hospital, and to provide a way to help prevent relapse and harm to the patient or to others. It is one of a range of options for mental health treatment in the community and is implemented through the making of a CTO.

3. SCOPE

This procedure is applicable to employees within All Mental Health inpatient settings, community settings and general hospital settings where patients are subject to Community Treatment Orders.

4. MATTERS FOR CONSIDERATION FOR CARE IN THE COMMUNITY

To support and deliver care in the community for a patient detained on a treatment order, the options include:

- Section 17 leave of absence. This can be short term or for extended leave of absence (Section 17);
- Section 117 aftercare;
- Transfer onto guardianship; or
- Community treatment order.

5. WHO IS ELIGIBLE FOR CTO

To be considered for CTO a patient must be currently detained under section 3 of the Mental Health Act (MHA) or an unrestricted Part 3 patient (section 37, section 45A, section 47 or

section 48). Those detained for assessment on section 2 are not eligible. Furthermore, CTO can only be used for patients whose treatment needs have already been assessed in hospital under one of the above-mentioned detention orders and if they meet the eligibility criteria.

6. ELIGIBILITY CRITERIA

The patient's treatment needs have already been fully assessed under section 3 or as an unrestricted Part 3 patient and the patient is still liable to be detained. An individual patient can be discharged onto CTO if s/he satisfies the eligibility criteria, which are that:

- The patient is suffering from a mental disorder of a nature or degree which makes it appropriate for them to receive medical treatment;
- It is necessary for the patient's health or safety or for the protection of other persons that they should receive such treatment;
- Subject to the patient being liable to be recalled as mentioned below, such treatment can be provided without the patient continuing to be detained in a hospital;
- It is necessary that the responsible clinician should be able to exercise the power under s17E(1) of the Act to recall the patient to hospital; and
- Appropriate medical treatment is available for the patient.

7. RECOMMENDATIONS BY THE MENTAL HEALTH REVIEW TRIBUNAL (MHRT)

The MHRT may decide not to discharge a patient who has made such an application to them. The MHRT may decide, instead, to recommend that the RC should consider whether the patient should go onto CTO (qualifying patients only). The RC will carry out the assessment of the patient's suitability for CTO in the usual way.

However, it will be for the RC to decide whether or not CTO is appropriate for that patient. The assessment may have to be carried out within a period of time as allowed for by the MHRT.

8. RISK ASSESSMENT

Whilst determining whether the criteria to recall the patient is met, the RC shall consider, having regard to the patient's history of mental disorder and any other relevant factors, what risks there would be of a deterioration of the patient's condition if s/he were not detained in a hospital. The following must be assessed:

- Failure to follow a treatment plan;
- Patient's insight and attitude to treatment;
- The risk of patient's condition deteriorating after discharge;
- The risk of harm arising from the patient's disorder is sufficiently serious to justify the power of recall;
- The co-operation of the patient in consenting to the proposed treatment.

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9. ASSESSMENT FOR CTO

The Responsible Clinician and the Approved Mental Health Professional (AMHP) will need to consider whether the objectives of CTO could safely and effectively be achieved in a less

restrictive way. The RC will decide whether CTO is the right option for any patient and requires the agreement of the AMHP. The RC must be satisfied that appropriate treatment is, or would be, available for the CTO patient in the community. The key factor is whether the patient can safely be treated for mental disorder in the community with the RC's power to recall the patient to hospital for treatment if necessary. The RC would also assess the risk there would be of the patient's condition deteriorating after discharge, e.g. as a result of refusing or neglecting to receive treatment.

10. CONSULTATION

When the RC considers that a patient may be suitable for CTO, then the first step would be to consult with those involved in the care of the patient including the care coordinator and, where applicable, a different RC who will take over the responsibility for the patient in the community. Consultation is necessary when a CTO is first considered but it should also take place on any review of CTO, when a change of condition is considered and prior to recall of a community patient unless the need for recall is too urgent.

The patient does not have to consent formally to CTO. However, in practice patients need to be involved in decisions about the treatment to be provided in the community and how and where it is to be given, and be prepared to co-operate with the proposed treatment.

The RC must be fully aware of the diverse needs of the patient when considering a CTO and must take them in to account at all times. They must ensure the patient fully understands what is happening to them in a language and format which they are able to understand, this will include sensory and cognitive abilities and physical impairment. Where necessary, an interpreter should be obtained.

11. WHO TO CONSULT

- The patient, who may be supported by the Independent Mental Health Advocate (IMHA);
- The care coordinator;
- A different RC (if applicable) who will take over responsibility for the CTO patient;
- The nearest relative/carers (unless the patient objects or it is not reasonably practical)
- The multi-disciplinary team involved in the care of the patient;
- Anyone with authority to act on behalf of the patient under the MCA 2005, such as an attorney or a deputy;
- The GP; it is important for the GP to be aware that the patient is to go onto CTO. A patient without a GP should be encouraged and helped to register with a practice; and
- Other relevant professionals.

12. WHO MAKES THE DECISION

The RC and the AMHP make the decision as to whether a CTO is the right option for the patient. They would also have considered whether there is a less restrictive way to achieve the same objectives. The RC must be satisfied that the relevant criteria are met. An AMHP must state in writing that they agree with that opinion and that it is appropriate to make the order. This will be done by completing the appropriate part of Form CP 1.

13. THE ROLE OF THE APPROVED MENTAL HEALTH PROFESSIONAL (AMHP)

The AMHP must reach an independent professional view. The AMHP should ensure that they consider the patient's wider social circumstances including any cultural issues. They should also consider any support networks the patient may have, the potential impact on the patient's family, employment and educational circumstances.

If the AMHP does not agree that a CTO should be made or does not agree to the conditions, the CTO cannot proceed. It would not be appropriate for the RC to approach another AMHP in the absence of changes to the plan. Where such disagreement occurs, an alternative plan should be developed by the relevant professionals.

When an AMHP disagrees to the making of a CTO, s/he should make a written entry to that effect in the patient's clinical record.

14. CARE AND TREATMENT PLANNING MEETING

CTO patients are entitled to aftercare services under section 117 of the Act. The care and treatment plan will reflect the needs to be met by the services from the Health Board and the Local Social Services Authority (LSSA). Such care plan, coherent with CTO, must be in line with the requirements of care and treatment planning and a care coordinator will need to be identified. Good care planning will be essential to the success of CTO. This would include an appropriate package of treatment and support services and the identification of a care coordinator. There would be a record of the patient having an attorney if applicable and also of any advance decisions.

As part of the pre-discharge arrangement, the team should identify the statutory consultees who will have to meet the second opinion approved doctor (SOAD) in person during their forthcoming visit for the purpose of providing a Part 4A Certificate. Again the local venue where the patient must attend to be examined by the SOAD must be agreed with the patient.

Before giving a Part 4A certificate, the SOAD will need to consult two other persons who have been professionally concerned with the patient's medical treatment. At least one must not be a doctor and neither must be the patient's RC or the Approved Clinician (AC) in charge of the patient's treatment in question (see s64(H)(3)(a)(b)).

15. CONDITIONS

A CTO will specify the conditions to which the patient is to be subject whilst on a CTO. All CTOs must include the ''mandatory conditions'':

- A condition that the patient must avail themselves for examination when an extension of the CTO is being considered; and
- Where necessary to allow a second opinion approved doctor (SOAD) to provide a Part 4A certificate authorising the patient's treatment in the community.

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The MHA Code of Practice for Wales suggests that the RC with the agreement of the AMHP may also set other conditions that are necessary or appropriate to ensure one or more of the following purposes:

- Ensuring that the patient receives medical treatment;
- Preventing risk of harm to the patient's health or safety;

- The protection of other persons.

With the exception of the two mandatory conditions, other conditions are in themselves not enforceable. The reasons for any conditions should be explained to the patient and others and be recorded in the patient's notes.

Where applicable the RC should take account of any representation from a victim or their family, where the provisions of the Domestic Violence, Crime and Victims Act 2004 apply.

The conditions might include stipulating:

- Where a community patient is to live;
- The arrangements for receiving treatment in the community;
- The avoidance of the use of illegal drugs and/or alcohol where their use has led to relapse in their mental disorder.

16. COMPLETING A COMMUNITY TREATMENT ORDER

The RC is responsible for initiating the process. The patient is entitled to ask the (IMHA) to support them at this point. Staff should assist the patient in contacting the IMHA if requested. The decision to go ahead is a joint one by the RC and the AMHP (who may be a member of the multidisciplinary team).

- The RC completes Part 1 of the Statutory Form CP1;
- The AMHP completes Part 2 of the Form CP1;
- The RC completes Part 3 of the above Form CP1;
- As soon as reasonably practical the RC shall furnish the Mental Health Act Administrator (on behalf of the managers of the responsible hospital) with the duly completed Form CP 1 together with an up-to-date risk assessment and care and treatment plan;
- The Mental Health Act Administrator will ensure that a copy of the Form CP1 is scanned onto PARIS and the original kept in the patients legal file;
- The date on which the patient is discharged on CTO shall be the date on Part 3 of the duly completed Form CP1;
- The community patient is informed of the effect of CTO by the care coordinator / Mental Health Act Administrator;
- A copy of the CP1 is sent to the patients GP

17. COMMENCEMENT OF CTO

The day on which the CTO is made is determined by the date on the duly completed Part 3 of Form CP1. Hence, that will be the date on which the patient shall be discharged onto CTO. Similarly, for patients who are already on s17 leave, they will instead be 'transferred' onto CTO from that date. This date may be a short period after the date on which the form is signed, to allow for arrangements to be put in place for the patient's discharge.

When the CTO is in force, the patient becomes a 'community patient' and the treatment order they are subject to does not expire and the hospital managers' authority to detain is suspended.

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18. DURATION OF CTO

The CTO will be in force, until:

- The community treatment period expires;
- The patient is discharged by the Responsible Clinician or Hospital Managers under s23 or under a direction by the MHRT under s72 (1)(c);
- (For Part 2 Patients) the nearest relative applies for discharge and it is not barred by the RC;
- The patient no longer satisfies all the criteria for CTO;
- The CTO is revoked under s17F.

19. COMMUNITY TREATMENT PERIOD

The community treatment period shall cease to be in force on expiry of the period of six months beginning with the day on which it was made. The day it was made is arrived at by the date on the duly completed Part 3 of Form CP1. Unless the CTO has previously ceased to be in force, it can be extended for a period of six months and thereafter for a period of one year at a time.

20. GIVING INFORMATION TO THE PATIENT

Following the decision to make the CTO, the RC should inform the patient and others consulted of:

- The decision;
- The conditions to be applied to the CTO; and
- The services which will be available for the patient in the community.

Unless the patient objects, the nearest relative should be informed where practicable of the conditions to be applied and of their right to apply for the discharge of the patient from CTO.

21. GIVING INFORMATION ABOUT THE IMHA TO CTO PATIENTS

CTO Patients are qualifying patients for the purpose of accessing the services of the Independent Mental Health Advocate (IMHA). The care coordinator will give CTO patients information both orally and in writing as soon as practicable after the patient goes onto CTO about the availability of the IMHA service. This may be done as soon as practicable when the CTO is being considered.

The Mental Health Act Administrator will send such information to the Nearest Relative, unless the patient requests otherwise (or does not have a Nearest Relative).

22. VARIATIONS IN / SUSPENSION OF ANY CONDITIONS OF A CTO

With exception of the two mandatory conditions, the RC may vary or suspend any of the above conditions applied to a community patient. There is no requirement for the RC to obtain an AMHP's agreement before doing so. Unless there is an urgent need to vary, it would be good practice to obtain an AMHP agreement before doing so. Any variation of the conditions by the RC shall be recorded on Form CP2. The RC may by order in writing vary the conditions of the CTO from time to time. Additionally, the RC may suspend any condition specified in the CTO. The RC may consider any failure to comply with the conditions for the purpose of recalling the

patient. However, the power to recall is not restricted to cases where there is such a failure. The RC should record any decision to suspend conditions in the patient's notes, with reasons.

As soon as practicable, the RC shall furnish the Mental Health Act Administrator with a duly completed Form CP2. The Mental Health Act Administrator will ensure that a copy is sent to the care coordinator and that the information about any such changes is brought to the attention of the patient and anyone affected by the changes. They must understand the reasons for the changes and how to comply with them. The original Form CP2 will be filed with the Form CP1 in the patient's legal file.

23. CHANGE OF RESPONSIBLE CLINICIAN

In certain circumstances, the RC for an inpatient may not be the RC for the CTO patient. In such cases, at an early stage of planning for the CTO the RC must liaise with the different RC to take over responsibility for the patient. Hence, as part of the CTP review, on the inpatient unit both the community team and the different RC who will take over the responsibility for the CTO patient must attend such reviews. Alternatively, transfer can take place during a CTP review and the CTO patient informed accordingly.

24. MEDICAL TREATMENT FOR MENTAL DISORDER IN THE COMMUNITY

The provision of medical treatment for mental disorder is governed by the new Part 4A of the Act. There are two types of requirements in Part 4A, namely authority and certification. In all cases, the person giving the treatment must have the authority to do so and the certificate requirement must be met for section 58 and 58A type treatment.

To a negligible extent, those on CTO who are under the age of 16 may have the competence to consent to the treatment. The MCA 2005 is not directly relevant. The child's own consent will provide the authority. However, the Act also requires a SOAD or the AC in charge of their treatment to certify this on a Part 4A certificate. Under 16 year olds, who do not have competence, can be treated by the AC in charge of the treatment or someone acting under the AC's direction provided certain conditions are satisfied.

CTO patients with capacity to consent cannot be treated in the community against their wishes. A CTO patient will be recalled to hospital when treatment for the patient's mental disorder is clinically necessary and the patient is not consenting. There are no exceptions to this rule, even in emergencies.

The authority to treat patients who lack capacity to consent to a treatment may come from an attorney, a deputy or the Court of Protection. The AC in charge of the treatment or someone acting under that AC's direction would be able to provide treatment to the person who lacks capacity provided certain conditions are met (see ch 24.17of the Code). The only exceptions will be in emergencies where patients lack the capacity to consent to treatment which is immediately necessary to prevent harm to the patient and is a proportionate response to that harm.

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25. AGREEING LOCATION FOR CTO PATIENT TO BE EXAMINED BY THE SOAD

As part of the above 'mandatory conditions' the RC will inform the patient of the exact location where the patient would be examined by the SOAD with regard to the provision of a Part 4A

certificate. The location would normally be a local outpatient facility, day hospital or somewhere that the patient might visit regularly such as a drop-in centre. In some circumstances a local inpatient facility may be used should the patient be required to attend the facility as part of the care plan. Prior to using such non-NHS locations the care coordinator would have obtained the agreement of the centre in question. The location will have a facility for the SOAD to interview the patient in private unless agreed otherwise.

26. CTO – PRIOR ARRANGEMENT AND PREPARATION FOR A SOAD'S VISIT

The Mental Health Act Administrator will be aware whenever a patient is discharged onto CTO. The MHA Administrator on behalf of the RC will contact Healthcare Inspectorate Wales (HIW) to request an SOAD for a patient discharged on CTO. The RC would also identify the location where the patient will attend for reviews and hence to be examined by the SOAD.

HIW or the SOAD will contact the care coordinator and/or Mental Health Act Administrator to confirm a date and time and a mutually agreed venue for the SOAD's visit.

27. ARRANGING FOR A SOAD VISIT

If a SOAD is required to provide for treatment under Part 4A, arrangements should be made prior to the CTO patient leaving the inpatient facility. The Community Responsible Clinician should complete HIW SOAD Request Form (CTO only) and identify the two consultees. In this instance, the care coordinator is ideally placed to be one of the consultees. The care coordinator may be a nurse, an Occupational Therapist (OT) or an AMHP but not a registered medical practitioner. The second consultee can be a registered staff member who has been professionally concerned with the patient's medical treatment such as a doctor, OT or AMHP, but not the patient's RC or the Approved Clinician in charge of the treatment in question.

In circumstances whereby the care coordinator would be on leave s/he will make the necessary arrangements for another registered staff member who has been professionally concerned with the patient's medical treatment to take his/her place as the lead professional. The patient's health record should be made available to the SOAD on the day of the visit.

28. CTO PATIENT – IDENTIFYING ATTORNEY / ADVANCE DECISIONS

If the patient lacks capacity to consent to treatment, the care coordinator will remind the RC/AC to inform the SOAD if the patient has an attorney or deputy and details of any advance decisions or any expressed views, wishes or feelings, both past and present.

29. SOAD VISIT – PLANNED VISIT TO A COMMUNITY FACILITY

The care coordinator will contact the patient to inform him/her of the venue, date and time s/he must attend for an examination by the SOAD. The care coordinator will remind the patient of the above and make suitable transport arrangements if necessary.

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The following should be made available on the day of the visit:

- The treatment proposal for the patient completed by the RC;
- The clinical records of the patient containing the MDT meeting notes on which it was based (can be given before or at the time of the visit);

- The relevant CTO papers;
- The statutory consultees;
- Any other relevant people, including the IMHA or any attorney/deputy of the patient;
- The treatment proposed to be authorised in case the patient is recalled to hospital completed by the RC/AC in charge of the treatment.

Wherever possible the SOAD will discuss the case with the RC/AC in charge of the treatment in question face to face and also the two statutory consultees. If this is not possible at the time of the visit the SOAD will make telephone contact with them.

The care coordinator may take copies of the Part 4A certificate to keep in the patient's record. The original must be posted to the Mental Health Act Administrator who will scan the certificate onto PARIS.

30. EFFECT OF CTO

The application for treatment will not cease to have effect because the patient has become a 'CTO patient'. However, whilst the patient remains on a CTO:

- The authority of the managers to detain him (section 6(2)) with regard to that application shall be suspended; and
- Any reference however expressed in this or any other legislation to patients liable to be detained or detained under this Act shall not include that patient on a CTO.
- Furthermore, whilst the patient remains on CTO, section 20 shall not apply to the patient, however, section 20A will apply.

The authority for the detention of the patient shall not expire during any period in which that authority is suspended.

31. APPLICATION FOR DISCHARGE FROM CTO

CTO patients are entitled to request the hospital managers to consider their discharge from CTO. Additionally, their nearest relative can apply for their discharge from CTO giving 72 hours' notice, unless the RC issues a barring certificate. They are also entitled to apply to the MHRT during each period of detention or renewal of detention. The hospital managers shall refer them, should they not have applied to a Tribunal, to a MHRT after six months and three years.

The unbroken period of detention together with the period of CTO, whether they have been recalled or not, and when the CTO is revoked counts as a continuous period of time for both referrals to the MHRT and treatment under Part 4 of the Act. Such a period will only be broken should the patient be received onto guardianship or when they are discharged by the MHRT or under section 23 of the Act.

The effect of discharge is to end the CTO and liability to detention. The patient can no longer be recalled to hospital or required to stay in hospital.

32. INFORMING CTO PATIENT OF LOCATION OF THE MHRT HEARING

CTO patients will be entitled to ask for a tribunal hearing. As they would be community patients the hearing need not necessarily take place in the hospital. When a CTO patient applies to the

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MHRT the care coordinator will inform the patient of the agreed location of the tribunal hearing. The Mental Health Clinical Board should identify a community setting where such hearings can take place for CTO patients being treated in the community.

33. ACCESS TO PATIENTS' CLINICAL RECORDS

The medical member of the Tribunal may want to examine the patient before the hearing takes place. Hospital Managers must ensure that the medical member can see the patient in private and any records relating to the patient's detention or treatment, to be produced for their inspection. The patient should be told of the visit in advance so that they can be available to meet the medical member.

34. LEGAL REPRESENTATION

Patients should be informed that they are entitled to free legal advice and representation. Hospital Managers and local social services authorities should inform patients of their rights to present their own case to the Tribunal or to be represented by someone else. A list of solicitors who undertake tribunal work should be available for use by patients – this is especially important for CTO patients who may not have daily contact with professionals.

35. ATTENDANCE AT HEARINGS

It is important that the Responsible Clinician and other relevant staff involved in the patient's care should attend for the full hearing, as their evidence will be crucial in the decision reached by the Tribunal as to whether the patient still meets the criteria for CTO under the Act.

Patients do not need to attend the hearing but should be encouraged to do so, unless it would be detrimental to their health or wellbeing. Wherever possible the RC and other relevant staff should attend the full hearing so they are aware of all the evidence and the tribunal's decision and reasons.

36. MONITORING CTO PATIENTS

CTO should form a part of the patient's care and treatment plan, in accordance with section 8 of the Mental Health (Wales) Measure 2010 and regulations pursuant to it.

It will be important to maintain close contact with a patient on CTO and to monitor their mental health and wellbeing. The care coordinator will normally be responsible for coordinating the care and treatment plan, working with the RC, the team responsible for the patient's care and any others with an interest. The type and scope of the arrangements will vary depending on the patient's needs and individual circumstances and would include access to services provided locally. Appropriate action will need to be taken if the patient becomes unwell, engages in high risk behaviour as a result of mental disorder, or withdraws consent to treatment or begins to object to it. The reasons for a failure to comply with any condition must be considered and if necessary reviewed. The patient's compliance with the conditions will be a key indication of how CTO is working in practice.

If the patient refuses crucial treatment, an urgent review of the situation will be needed. If suitable alternative treatment is available which would allow CTO to continue safely and which the patient would accept, the RC should consider such treatment if this can be offered.

A failure to comply with a condition is not in itself enough to justify recall. Each case should be considered on its own merits and any actions are proportionate to the level of risk posed by the patient's non-compliance.

37. RESPONDING TO CONCERNS RAISED BY CARERS AND OTHERS

The care coordinator / community team must give due weight to any concerns raised that the patient is not complying with any conditions and/or that their mental health is deteriorating. The care coordinator / Community Mental Health Team (CMHT) / out-of-hours services will deal with any such concern as an urgent referral. The practitioner concerned will access the CTO patient's records including the care plan and risk assessment.

The practitioner concerned will also obtain all the relevant details of the concerns to make a decision as to whether to meet with the person who raised the concerns and/or the CTO patient. Depending on the risk, the practitioner concerned / care coordinator will discuss the concerns with the RC / on-call consultant so that the RC / on-call consultant can decide whether to recall the CTO patient or not.

38. ADMISSION TO HOSPITAL OF CTO PATIENTS ON A VOLUNTARY BASIS

CTO patients may agree to be admitted to hospital on a voluntary basis. Clearly, on such occasions the CTO patient would not have been recalled to hospital by their RC. Such patients may be referred to as 'Part 4A patients'. CTO patients who are in hospital on a voluntary basis can be recalled if there is a need to. However, as Part 4A 'patients' the medical treatment they may receive is governed by the rules applied to CTO patient as in Chapter 25 of the Code.

The Mental Health Act Administrator will send a reminder to the RC to undertake a review to determine if the patient still satisfies all the criteria for CTO, whilst the patient remains on the ward.

39. PROCEDURE FOR RECALL OF CTO PATIENTS TO HOSPITAL

The power to recall includes circumstances when the community patient is already in hospital at the time the power of recall is exercised. The RC may recall a community patient if s/he is of the opinion that:

- The patient requires medical treatment for his mental disorder in hospital; and
- There would be a risk of harm to the health or safety of the patient or to other persons if the patient was not recalled to hospital for that purpose.

Failure to comply with the conditions of attending for medical examination as required will result in the RC recalling a community patient. The notice in writing to recall the community patient to a named hospital shall be sufficient authority for the managers of that hospital to detain the patient in hospital.

All patients on CTO have a hospital which is responsible for oversight of their case while they are in the community. The Act referred to this hospital as the "responsible hospital''. There is no special procedure to follow if the CTO patient is re-assigned to another hospital which is under the same managers.

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The RC may recall a patient to a hospital other than the responsible hospital. In such instances, the RC has responsibility for coordinating the recall process, unless agreed with someone else. The power of recall will be carried out by notice in writing to the patient. The RC will complete Form CP5 to recall a community patient. Two copies of the completed Form CP5 must be taken. One copy is to be kept on the patient's records and the original faxed and forwarded to the Mental Health Act administrator.

It will not usually be appropriate to post a notice of recall to the CTO patient. It is important that, whenever possible, the notice should be handed to the patient personally. When the need for recall is urgent, it will be important that there is certainty as to the timing of the delivery of the notice. When such a notice of recall is handed to the patient, it is effective immediately. This may not be possible if the patient's whereabouts are unknown, or if the patient is unavailable or simply refuses to accept the notice.

Regulation 3 of the Mental Health (Hospital, Guardianship, Community Treatment and Consent to Treatment) (Wales) Regulations 2008 states that a notice of recall may be served by delivery to the patient's usual or last known address. Delivery of the recall notice relating to CTO is secured by delivery in person or by pre-paid post.

SERVING THE NOTICE – WHEN NOT HANDED TO CTO PATIENT

- If it is urgent, the notice should be delivered **by hand** to the patient's usual or last known address. The notice is then **deemed to be served** (even though it may not actually be received by the patient) on the **day after it is delivered**. That is, the day beginning immediately after midnight following delivery.
- First class post can be used. The notice is deemed to be served on the second working day after posting. Sufficient time must be allowed, as detailed above, for the patient to receive the notice before any action is taken to ensure compliance.

Once the notice of recall is duly served the patient can be treated as absent without leave if that is necessary and taken and conveyed to hospital. Should the police be informed, the care coordinator would inform the police that the CTO patient has been duly recalled and is now absent without leave.

There may be cases whereby the patient's whereabouts are known but access to the patient cannot be obtained. In such cases, it may be necessary to consider whether a warrant issued under section 135 (2) is needed.

40. COMMUNITY PATIENTS WHO ARE ABSENT WITHOUT LEAVE

Patients on CTO are considered to be absent without leave (AWOL) if:

- They fail to return to hospital when they are recalled; or
- They abscond from hospital following recall.

Hence, such a patient, who is AWOL, may be taken into custody by an AMHP, an officer on the staff of the responsible hospital, a constable or anyone authorised in writing by the RC or the Hospital Managers, and returned to the hospital to which they were recalled.

That may only be done before:

- The time at which the CTO is due to expire (assuming it were not to be extended); or

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- The end of the six months beginning with the first day of the absence without leave, if that is later.

If patients are taken into custody, or come to the hospital voluntarily, before the end of the period during which they could be taken into custody, the 72 hours for which they can be detained effectively starts again on their arrival at the hospital, even if they had already been detained for part of that period before they went AWOL.

Special arrangements apply if a patient is AWOL at any point during the week which ends on the day their CTO is due to expire, and an extension report has yet to be made. The arrangements are equivalent to those of Part 2 detained patients.

If a patient is taken into custody, or comes to the hospital voluntarily, within 28 days, an examination and the report under section 20A may be furnished to the managers to extend the CTO.

If patients are taken into custody, or come to the hospital voluntarily, after being absent for more than 28 days, their CTO expires at the end of the week starting on the day of their arrival at the hospital unless the relevant practitioner furnishes a report to the managers within that time to extend the CTO using Form CP 4. The CTO may also be revoked under section 21B(4)(a).

41. POWERS IN RESPECT OF RECALLED PATIENTS

The community patient may be recalled to a hospital other than the responsible hospital.

- The recalled patient may be transferred to another hospital.
- Subject to meeting the necessary conditions and written agreement of an AMHP, the RC may by order in writing revoke the CTO.
- The RC may at any time release the patient but not after the CTO has been revoked.
- If the CTO has not been revoked or the recalled patient released at the end of 72 hours, the patient shall be released from hospital. However, a released patient remains subject to the CTO. The ‘‘holding powers’’ of section 5 may not be used to keep the patient in hospital after the end of the 72-hour period.

The period of 72 hours begins at the time the detention in hospital begins by virtue of the notice of recall.

Section 5(6) makes it clear that a patient subject to CTO is not to be held on either section 5(2) or section 5(4) of the Act.

42. POWER OF RECALL TO A HOSPITAL OTHER THAN THE RESPONSIBLE HOSPITAL

The hospital managers (or a person authorised by them) from the hospital from which the patient is to transferred must use Form TC6 to authorise the transfer to the managers of the hospital to which the patient is being transferred.

A copy of the duly completed Form CP5 to recall the patient will be provided to the managers of the hospital to which the patient is recalled as soon as possible after it is served to the patient. This will provide sufficient authority for the managers of the named hospital to detain the patient.

The legislation allows a recalled patient to be transferred to another hospital provided it is done within the 72-hour period.

A transfer between hospitals while a patient is recalled does not change the responsible hospital.

43. TRANSFER OF A RECALLED PATIENT

A CTO patient who has been duly recalled may be transferred to another hospital managed by the same hospital managers. There is only the transfer arrangement, as an internal issue, to be carried out so as not to negatively affect the continuity of care. This can only be done within the same 72-hour period. The nurse in charge of the receiving unit must know the time at which the 72 hours started and must ensure that the Form CP5 is duly completed and returned to the MHA Administrator.

44. TRANSFER OF A RECALLED CTO PATIENT TO A HOSPITAL UNDER DIFFERENT MANAGERS

A recalled CTO patient may also be transferred to another hospital under different managers. In such cases the transfer must be effectuated within the 72-hour period. The Ward Manager / On-call Manager or the MHA Administrator, on behalf of the hospital managers, must complete Part 1 of Form TC5. Part 2 of the form must be completed by someone authorised by the managers of the receiving hospital.

When Part 2 is duly completed, a photocopy of the completed Form TC5 must be obtained and sent to the MHA Administrator.

45. ASSIGNMENT OF RESPONSIBILITY FOR CTO PATIENTS

Responsibility for a CTO patient may be assigned to another hospital managed by different hospital managers other than Cardiff and Vale University Health Board.

If the hospital is satisfied that arrangements have been made for the assignment of responsibility of the CTO patient to the hospital to which responsibility for the CTO patient is being assigned, the Shift Coordinator or MHA Administrator, on behalf of the managers, must complete Part 1 of Form TC5.

On assignment the managers of the hospital to which responsibility for the CTO patient is being assigned must record the assignment in the form set out in Part 2 of Form TC5. When Part 2 is duly completed, a photocopy of the completed Form TC5 must be obtained and sent to our MHA Administrator.

In the event of assignment, the MHA Administrator on behalf of the hospital managers of the hospital to which responsibility has been assigned must notify:

- The patient, in writing, of the name and address of the responsible hospital and the details of the hospital managers; and
- The patient's nearest relative of the name and address of the responsible hospital and the details of the hospital managers of that hospital (if the patient does not object).

46. RECORDS TO BE KEPT FOR RECALLED PATIENT

The MHA Administrator, on behalf of the hospital managers, will keep a record of the time and date of the patient's detention as a result of the notice of recall given by the RC. The start time and date will be the time and date of the patient's arrival on the inpatient unit.

The nurse in charge must record the start date and time of the recall and also the release of the recalled patient using Form CP6 to and also record this in the patient's clinical record.

When completed the Form CP6 must be faxed and the original sent to the MHA Administrator who will keep a record of these times and dates on behalf of managers of the responsible hospital. A copy will be retained on the ward to be filed in the patient's notes.

Prior to the release, the care coordinator and anyone else involved must be informed of the CTO patient's release.

47. MEDICAL TREATMENT FOR MENTAL DISORDER – RECALLED PATIENTS

Though the CTO patient has been recalled to a hospital, the required treatment may be given on an outpatient basis when appropriate. CTO patients who have been recalled to hospital are subject to the same rules on medical treatment (with certain exceptions) as other detained patients and are subject to Part 4 of the Act.

Part 4A does not apply to the treatment of CTO patients who have been recalled to hospital, unless or until they are released from detention in hospital.

Part 4 applies to such patients instead, but with three differences.

First, treatment which would otherwise require a certificate under section 58 or 58A can be given without such a certificate if it is expressly approved instead by the patient's Part 4A certificate (if the patient has one). It is expressly approved if the SOAD states in the certificate that the treatment in question may be given to a patient who has been recalled. The certificate may contain conditions. The conditions may, for example, be different for the patient who is not recalled. However, the Part 4A certificate cannot authorise section 58A treatment for which there would be no authority under Part 4A itself.

Second, medication which would otherwise require a certificate under section 58 can be given without such a certificate if the certificate requirement in Part 4A would not yet apply to the treatment because less than one month has passed since the making of the patient's CTO. In other words, no certificate is required for the administration of most medications to a patient who has been a CTO patient for less than a month.

Third, treatment that was already being given on the basis of a Part 4A certificate before the patient was recalled to hospital may be continued temporarily, even though it is not authorised for administration on recall on the Part 4A certificate, if the person in charge of the treatment in question considers that withdrawing the treatment would cause serious suffering to the patient. However, this exception only applies pending a new certificate being obtained.

SOADs providing Part 4A certificates need to consider what treatments (if any) to approve, should the patient be recalled to hospital.

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These exceptions also apply to CTO patients who's CTOs have been revoked except that, for section 58 type treatments, continuance with medication will continue pending compliance with section 58 requirements.

Part 4A does apply to CTO patients who are in hospital, either voluntarily or when complying with a condition of their CTO without having been recalled.

HIW may at any time notify the AC in charge of the treatment in question that a Part 4A certificate will cease to apply from a certain date.

48. REVOKING A COMMUNITY TREATMENT ORDER

A CTO may only be revoked while the patient is detained in a hospital as a result of being recalled. The RC may by order revoke the CTO if:

- In their opinion the patient again needs to be admitted to hospital for medical treatment under the Act; and
- The AMHP agrees in writing with the RC and that it is appropriate to revoke the CTO.

The RC's order revoking the CTO will be in the form of a duly completed Form CP7. The RC will complete Part 1 and the AMHP will complete Part 2 of the Form CP7. Again, as soon as practicable the RC will furnish the MHA Administrator with that form. The original Form CP7 will be sent by post to the MHA Administrator. The nurse in charge at the time will have a photocopy made and the copy will be filed in the patient's notes.

The MHA Administrator, on behalf of the managers of the hospital, must refer the patient's case to the MHRT as soon as practicable after the revocation of the CTO. As soon as practicable, the care coordinator and the relevant CMHT must be informed of the revocation of the CTO.

If the AMHP does not agree that the CTO should be revoked then the patient cannot be detained in hospital after the end of the maximum recall period of 72 hours. The patient will remain on CTO. The AMHP's decision and full reasons should be recorded in the patient's notes.

49. EFFECT OF REVOKING A COMMUNITY TREATMENT ORDER

Below is the effect of revoking the CTO in respect of the patient.

- Section 6(2) shall have effect as if the patient has never been discharged from hospital on a CTO. The patient's detention under their original treatment order will be re-instated from the date of revocation.
- The provision of this or any other Act relating to patients being liable to be detained (or detained) in pursuance to an application for admission for treatment shall apply to the patient as was prior to the CTO being made.
- When the patient is being detained in a hospital other than the responsible hospital, the provisions of this Act will have the effect as if the application for admission for treatment were made to that other hospital and he had been admitted to that other hospital at the time when the patient was originally admitted in pursuance of that application.

In any case of a patient being revoked, section 20 shall have the effect as if the patient had been admitted to hospital in pursuance of the application for admission for treatment on the day

14.1

on which the order is revoked. The detention will last for six months and the RC will be able to renew the detention order, if appropriate, two months prior to the last day of the detention order.

Where the CTO patient has been recalled to a hospital which is not the responsible hospital, the RC / MHA Administrator must furnish the managers of that hospital with a copy of the order.

50. MEDICAL TREATMENT FOR MENTAL DISORDER – ON REVOCATION OF A CTO

Upon revocation of the CTO, the patient would be detained on a treatment order. As such the patient will be subject to Part 4 of the Act as far as medical treatment for mental disorder is concerned. The period of time spent receiving treatment on section 2 and section 3 and CTO will count as being continuous.

51. DUTY TO INFORM NEAREST RELATIVE

The MHA Administrator on behalf of the hospital managers will inform the nearest relative that a detained patient is to be discharged from hospital, unless that patient or the relative has asked that such information should not be given. This duty applies equally where patients are to be discharged from hospital by means of a CTO.

52. EXTENSION OF COMMUNITY TREATMENT PERIOD

Within two months ending on the day on which the CTO would cease to be in force, it shall be the duty of the RC to examine the patient and, if it appears to him that the conditions are satisfied and that the AMHP has agreed in writing, the RC must furnish the managers of the responsible hospital a report on the prescribed Form CP3. However, before providing the report the RC must consult one or more other persons who have been professionally involved with the patient's medical treatment.

The report, duly furnished, would extend the CTO for the prescribed period. Unless the hospital managers discharge the patient under section 23, the care coordinator as delegated by the hospital managers would inform the community patient of the renewal.

53. CONSULTATION BY RC PRIOR TO EXTENSION OF COMMUNITY TREATMENT PERIOD

Before furnishing the above CTO Form to the hospital managers, the RC must consult one or more other persons who have been professionally concerned with the patient's medical treatment. The RC will need to complete Part 3 of Form CP3 with details such as the name and profession of the person consulted. Ideally, it may be the care coordinator, an Occupational Therapist, a Community Psychiatric Nurse (CPN) or a chartered psychologist who has been professionally concerned with the patient's medical treatment.

14.1

54. HOW CAN A COMMUNITY PATIENT BE DISCHARGED FROM CTO?

A community patient ought to be discharged from a CTO if the patient no longer meets the grounds for CTO. Such a patient can be discharged from CTO in the following ways:

- Discharge by the RC at any time;
- By the hospital managers under section 23 of the Act;

- For Part 2 patients following application by their Nearest Relative (NR) giving 72 hours' notice;
- By the MHRT;
- Following the patient's reception under guardianship.

55. EFFECT OF EXPIRY OF A COMMUNITY TREATMENT ORDER

A patient will be absolutely discharged from CTO and liability to be recalled to hospital and the application for admission for treatment will similarly cease to have any effect when the CTO expires.

56. SAFEGUARDS FOR CTO PATIENTS

Patients on CTO will be entitled to similar safeguards to patients detained in hospital including nearest relative rights and the right to apply to an MHRT. All patients on CTO will also have their treatment (if it involves giving medicines) reviewed and certified by a second opinion appointed doctor after three months from when medication was first given or one month from discharge from hospital onto CTO, whichever is later. CTO patients will have their case reviewed regularly and will be discharged when they no longer meet the criteria.

57. MONITORING

Following recall, the hospital managers are responsible for ensuring no patient is detained for longer than 72 hours unless the CTO is revoked. The relevant statutory form must be completed on the patients arrival at hospital. Arrangements should be put in place to ensure the patients length of stay following the time of detention after recall, as recorded on the form, is carefully monitored.

The hospital managers should also ensure there are clear guidelines and procedures in place to cover any necessary transfers of responsibility between responsible clinicians in the community and in hospital and the procedure to be followed when a patient is receiving inpatient services from a private provider and a community treatment order is appropriate.

58. TRAINING

The Health Board will provide ongoing training for staff who are involved with the care and treatment of patients subject to Community Treatment Orders. Details of training available can be found by contacting the Mental Health Act Department.

59. IMPLEMENTATION

This document will be widely disseminated to staff across Cardiff and Vale University Health Board. It will be published on the organisations intranet site and referred to during training relevant to the Act.

14.1

60. RESPONSIBILITIES

60.1 Chief Executive

The Chief Executive Officer has overarching responsibility for ensuring that Cardiff and Vale University Health Board is compliant with the law in relation to the Mental Health Act.

60.2 Chief Operating Officer

The Chief Operating Officer is the Executive Lead for Mental Health. He has overarching responsibility for ensuring compliance with the contents of this procedure.

60.3 Community Team Managers/Service Managers

It is the responsibility of all clinical managers to:

- Ensure that this procedure is brought to the attention of all their staff, and that they understand and adhere to the guidance/procedure contained within.
- Ensure that all staff involved in the care and treatment of CTO patients have received adequate training and are competent to carry out these guidelines.

61. REFERENCES

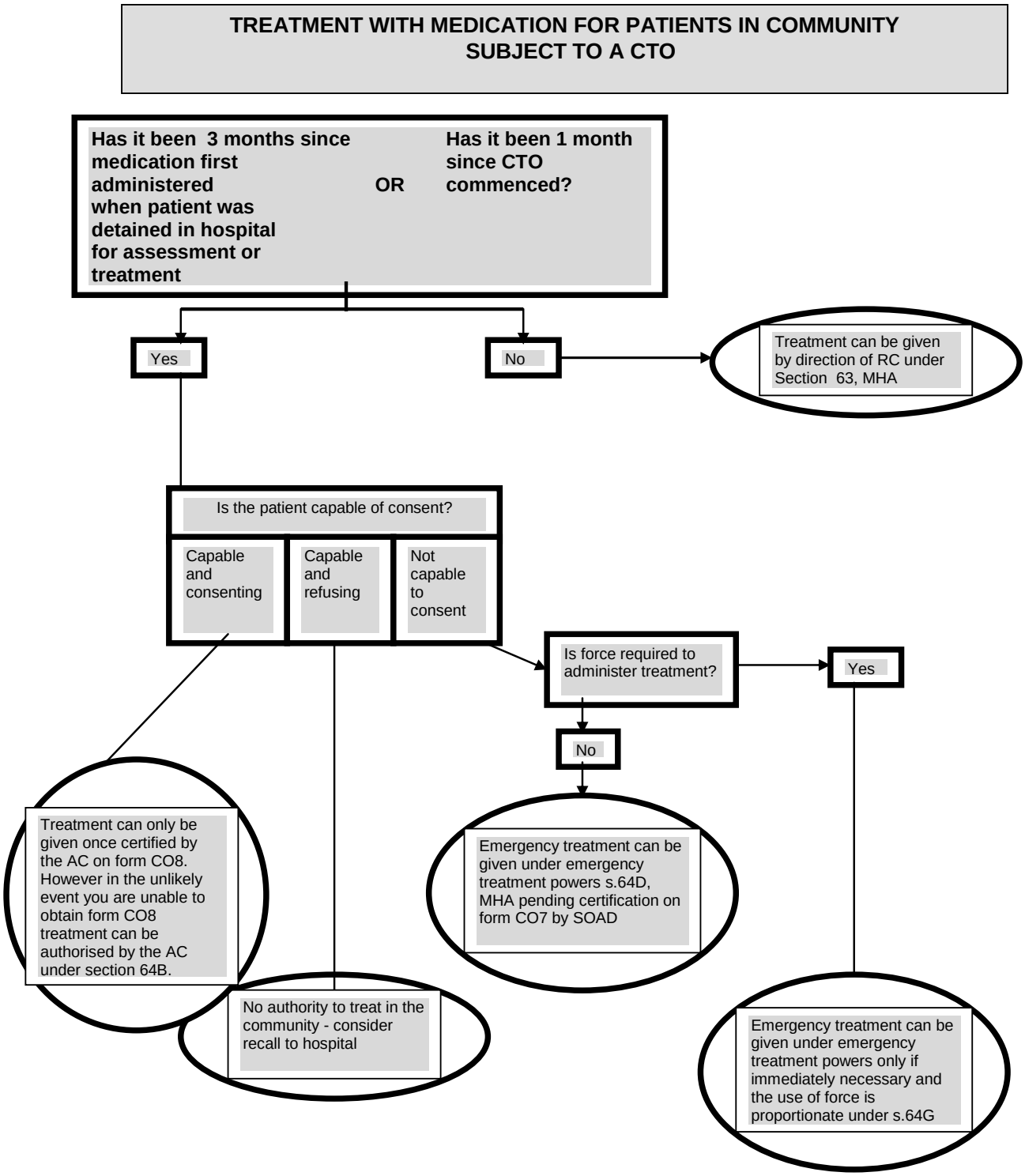
All staff will work within the Mental Health Act 1983 and in accordance with the Code of Practice for Wales 2007, Mental Capacity Act 2005, and Human Rights Act 1998.

Mental Health Act 1983 - www.legislation.gov.uk/ukpga/1983/20/contents
Mental Capacity Act 2005 - www.legislation.gov.uk/ukpga/2005/9/schedule/7
Mental Health Review Tribunal for Wales - www.justice.gov.uk/tribunals/mental-health
Human Rights Act 1998 - www.legislation.gov.uk/ukpga/1998/42/contents
Domestic Violence, Crime and Victims Act 2004
Mental Health (Hospital, Guardianship, Community Treatment and Consent to Treatment) (Wales) Regulations 2008

62. APPENDICIES

Appendix A – Treatment with medication for patients subject to a Community Treatment Order.

Appendix A



14.1

KEY:

s.63, MHA	Treatment not requiring consent
s.64B, MHA	Adult community patients
s.64D, MHA	Adult community patients lacking capacity
s.64G, MHA	Emergency treatment for patients lacking capacity or competence
CO7	Certificate of appropriateness of treatment to be given to a community patient (Part 4A certificate)
CO8	Certificate of consent to treatment for community patient (Approved Clinician Part 4A certificate)

APPROVAL OF HOSPTAL MANAGERS' SCHEME OF DELEGATION POLICY
Name of Meeting: Mental Health and Capacity Legislation Committee **Date of Meeting:** 26 June 2018

Executive Lead : Chief Operating Officer
Author : Mental Health Act Manager, sunni.webb@wales.nhs.uk
Caring for People, Keeping People Well: This report underpins the Health Board's "Sustainability" and "Values" elements of the Health Board's Strategy.
Financial impact : None
Quality, Safety, Patient Experience impact: Patients subject to the Mental Health Act must be treated only in compliance with the legal framework.
Health and Care Standard Number: 3 (Effective Care), 4 (Dignified Care), 6 (Individual Care)
CRAF Reference Number: 8.1.2
Equality and Health Impact Assessment Completed: Yes

ASSURANCE/RECOMMENDATION

ASSURANCE is provided by:

The review of this document and the consultation identified below, has taken place to ensure that it reflects the law and assists staff to comply with it.

- All Wales Mental Health Act Administrators Policy Group
- Mental Health Policy Group
- Mental Health Quality and Safety Sub Committee
- Internet consultation

The Mental Health and Capacity Legislation Committee is asked to:

- **APPROVE** the Scheme of Delegation policy and procedure

and

- **APPROVE** the full publication of the Scheme of Delegation Policy and procedure in accordance with the UHB Publication Scheme

14.2

SITUATION

It is essential that compliance with the legal requirements of the Mental Health Act 1983 and the Mental Health Act 1983 Code of Practice for Wales, Revised 2016 are monitored. Local Health Boards and Local Authorities should have agreed governance processes for ensuring the appropriate policies and procedures in place are regularly reviewed. A non exhaustive list of relevant

policies required are detailed in the Mental Health Act 1983 Code of Practice for Wales, Revised 2016.

The Scheme of Delegation Policy sets out the requirements for provision of the scheme of delegation to the practitioners and agencies involved in the management of patients subject to detention/liability to detention under the Mental Health Act 1983 (as amended by the Mental Health Act 2007).

BACKGROUND

In February 2010 the Committee received and noted the Hospital Managers' Scheme of Delegation after being advised that the document is a legal requirement upon the organisation to ensure compliance with the Mental Health Act 1983. A review of this document has taken place to ensure that it reflects the law and assists staff to comply with it.

This document provides clear direction which will be easily accessible on our internet/intranet sites to particular individuals including registered medical practitioners ('doctors'), approved clinicians, managers and staff of hospitals in relation to their legal responsibilities under the Mental Health Act (MHA)1983 as amended by the MHA 2007.

ASSESSMENT

Wide consultation has taken place to ensure that the policy meets the needs of our stakeholder and the Health Board. The consultation undertaken specific to this document was as follows:-

- The document was added to the Policy Consultation pages on the intranet between 06 November 2017 and 01 December 2017;
- The document was shared with the Mental Health Policy Group, Adult Directorate Medics, Cardiff Local Authority, Vale of Glamorgan Local Authority, the Mental Health Clinical Board Quality and Safety Sub Committee and the All Wales Mental Health Act Administrators Policy Group;
- Comments were invited via individual e-mails from the Mental Health Policy Group, the Equality Manager, the Principal Health Promotion Specialist

Where appropriate comments were taken on board and incorporated within the document.

The primary source for dissemination of this document the Hospital Managers' Scheme of Delegation Policy within the UHB will be via the intranet and clinical portal. It will also be made available to the wider community and our partners via the UHB internet site.

Reference Number: *TBA* **Version Number:** 1	**Date of Next Review:** *To be included when document approved* **Previous Trust/LHB Reference Number:**

Hospital Managers' Scheme of Delegation Policy
Mental Health Act, 1983

Policy Statement

The Health Board is responsible for ensuring that the Mental Health Act is used lawfully and fairly, in accordance with the principles of the Mental Health Act Code of Practice for Wales, including ensuring all paperwork is scrutinised for validity, that detained patients are informed of their rights, and that patients are referred to the Tribunal within the timeframes set out in the Mental Health Act. The Health Board also have various powers, to discharge patients from detention, transfer detained patients to other hospitals in accordance with regulations, as well as withholding a patient's outgoing correspondence where the law permits.

To ensure the Health Board delivers its aims, objectives, responsibilities and legal requirements transparently and consistently, we will ensure staff are aware of their delegated functions under the Mental Health Act.

The arrangements for authorising people to exercise delegated functions are set out in a scheme of delegation.

People taking decisions under the Act must recognise and respect the diverse needs, values and circumstances of each patient, including their age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion, or belief, sex and sexual orientation and culture, or any combination of these. There must be no unlawful discrimination and reasonable adjustments must be made. Individuals' protected characteristics should be taken into account and good practice followed in all aspects of care and treatment planning and implementation.

Policy Commitment

We will set out the requirements for provision of the Scheme of Delegation to the practitioners and agencies involved in the management of patients subject to detention/liability to detention under the Mental Health Act 1983 (as amended by the Mental Health Act 2007).

We will ensure statutory requirements under the Mental Health Act 1983 are met by providing clear direction and guidance which will be easily accessible on our internet/intranet sites to particular individuals including registered medical practitioners ('doctors'), approved clinicians, managers and staff of hospitals in relation to their legal responsibilities under the Mental Health Act 1983 as amended by the MHA 2007.

Document Title: Hospital Managers' Scheme of Delegation Policy	2 of 37	Approval Date: dd mmm yyyy
Reference Number:		Next Review Date: dd mmm yyyy
Version Number:		Date of Publication: dd mmm yyyy
Approved By:		

Supporting Procedures and Written Control Documents

This Policy and the Hospital Managers' Scheme of Delegation Procedure describe the following with regard to *:*

- the purpose of a scheme of delegation
- informing the organisation of the arrangements for authorising people to exercise delegated functions as set out in the Scheme of Delegation
- ensuring that all staff authorised for the receipt and scrutiny of Mental Health Act documentation are aware of their responsibilities and requirements both individually and collectively in relation to the delegated duties of Hospital Managers

Other supporting documents are:

- The Mental Health Act 1983 (as amended by the Mental Health Act 2007)
- Mental Health (hospital, guardianship, community treatment and consent to treatment)(Wales) regulations 2008
- The Mental Capacity Act 2005 (including the Deprivation of Liberty Safeguards delegated to this Act under the Mental Health Act 2007)
- The respective Codes of Practice of the above Acts of Parliament
- The Human Rights Act 1998 (and the European Convention on Human Rights)
- Domestic Violence, Crime and Victims Act, 2004

Scope

This policy is applicable to all people authorised to exercise delegated functions to be carried out day to day required by the Mental Health Act, 1983 (MHA) on behalf of Cardiff and Vale University Health Board within all Mental Health inpatient settings, community settings and general hospital settings where patients are detained under the MHA.

Equality and Health Impact Assessment	There is potential for both positive and negative impact. The procedure is aimed at improving services and meeting diverse needs. Mitigation actions are already in place to offset any potential negative outcome, e.g. through the monitoring of the procedure. There is nothing, at this time, to stop the procedure from being implemented.

Policy Approved by	Pending - Mental Health and Capacity Legislation Committee
Group with authority to approve procedures written to explain how this policy will be implemented	Mental Health and Capacity Legislation Committee
Accountable Executive	Chief Operating Officer

14.2

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Version Number:		Date of Publication: dd mmm yyyy
Approved By:		

or Clinical Board Director	

Disclaimer

If the review date of this document has passed please ensure that the version you are using is the most up to date either by contacting the document author or the Governance Directorate.

Summary of reviews/amendments

Version Number	Date Review Approved	Date Published	Summary of Amendments
1	Date approved by Board/Committee/Sub Committee dd/mm/yyyy	TBA *[To be inserted by the Gov. Dept]*	*New document*
2			

14.2

Equality & Health Impact Assessment for

HOSPITAL MANAGERS' SCHEME OF DELEGATION POLICY

1.	For service change, provide the title of the Project Outline Document or Business Case and Reference Number	HOSPITAL MANAGERS' SCHEME OF DELEGATION POLICY
2.	Name of Clinical Board / Corporate Directorate and title of lead member of staff, including contact details	Mental Health Clinical Board Sunni Webb, Mental Health Act Manager 029 21824745 Sunni.webb@wales.nhs.uk
3.	Objectives of strategy/ policy/ plan/ procedure/ service	This policy should ensure that all staff authorised for the receipt and scrutiny of Mental Health Act documentation are aware of their responsibilities and requirements both individually and collectively in relation to the delegated duties of Hospital Managers. It is the responsibility of the Mental Health Act administration team to maintain records of all original documentation and record this information on the Mental Health computerised information system The principle objectives of this policy are to inform the organisation the arrangements for authorising people to exercise delegated functions as set out in the scheme of delegation. Unless the Act or regulations say otherwise, organisations may delegate their functions under the Act to any one and in any way their constitutions allows or in the case of the HB in line with NHS legislation.
4.	Evidence and background information considered. For example • population data	**Related policies/information -** Mental Health Act 1983, Code of Practice for Wales (Revised 2016), Welsh Language Act 2016, Mental Health Wales Measure 2010, Deprivation of Liberty Safeguards,

Document Title: EHIA *Hospital Managers' Scheme of Delegation Policy*	5 of 37	Approval Date: dd mmm yyyy
Reference Number:		Next Review Date: dd mmm yyyy
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	• staff and service users data, as applicable • needs assessment • engagement and involvement findings • research • good practice guidelines • participant knowledge • list of stakeholders and how stakeholders have engaged in the development stages • comments from those involved in the designing and development stages Population pyramids are available from Public Health Wales Observatory[1] and the UHB's 'Shaping Our Future Wellbeing' Strategy provides an overview of health need[2].	Equality Act 2010 **Stakeholders -** Service Users, Nursing Staff, Responsible Clinicians, Approved Clinicians, Mental Health Act Administrators, Approved Mental Health Professionals, Qualified nursing staff and other professionals working within mental health services. **Age -** 20 per cent of children have a mental health problem in any given year, and about 10 per cent at any one time. A quarter of older people in the community have symptoms of depression that require an intervention, and this increases to 40 per cent of care home residents (Mind "Our Communities, Our Mental Health) Older people (aged 60 and above) are more vulnerable to mental health problems, depression is a common disorder amongst this population and it has been estimated that 7% of older people suffer with uni-polar depression (World Health Organisation, 2016). Further Older people are more likely to experience a combination of physical and mental health issues (WHO, 2016). Younger adults are susceptible to mental health issues, with 6.2% of 16-24 year olds attempting suicide in their lifetime and 16.4% experiencing neurotic symptoms (Young Minds, 2016). Further, student populations are disproportionately affected by mental health issues, with an estimated 1 in 4 reporting mental health problems. Poor mental health amongst young people can lead to reduced life chances and impact on their education, social participation and ability to find and sustain employment. Results of Welsh Health Survey 2015 – reported in Mental Health

[1] http://nww2.nphs.wales.nhs.uk:8080/PubHObservatoryProjDocs.nsf
[2] http://www.cardiffandvaleuhb.wales.nhs.uk/the-challenges-we-face

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		Foundation Fundamental Facts 2016:- Results from the 2015 survey found that 13% of adults (aged 16 and older) living in Wales were reported to have received treatment for a mental health problem, an increase from 12% reported in 2014. Unlike other illnesses, the percentage who reported being treated for mental ill health did not increase with age, however trends suggest that an increase in treatment towards middle age before decreasing in retirement age. These rates have not significantly changed since the 2014 health survey. The total number of CAMHS referrals to treatment in Wales doubled between April 2010 (1,204) and July 2014 (2,342). Young people awaiting outpatient's treatment has the highest numbers (2,410) compared to adults (1,291) and those in later life. The Mental Health Act relates to all patients suffering from a mental disorder who meet the criteria for detention, irrespective of age. **Disability -** Physical illness more than doubles the risk of depression, and between 30 per cent and 50 per cent of adults with learning disability in the UK have mental health problems. (Mind "Our Communities, Our Mental Health) Sensory loss: Sensory loss currently affects 1 in 5 people in Wales, with 1 in 6 people affected by hearing loss and an estimated 115,000 people living with sight loss which has a significant impact on their daily lives (Sensory Loss in the Adult population in Wales, 2012). Those affected by sensory loss are more susceptible to the development of mental health issues, especially older people. Older people with sight loss are three times more likely to experience depression than people with good vision (Depression and Anxiety in Visually Impaired Older People, 2007)

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		with the British Medical Journal reporting that sight loss is one of the top three causes of suicide among older people The proposed policy will apply to all patients detained regardless of disability, as the policy is reference to the scrutiny of the documents completed by staff rather than the processes. All documents will have been completed in conjunction with consideration of the Mental Health Act, Mental Capacity Act, DoLS and the Mental Health Wales Measure. **Gender -** There are clear differences in the way women and men experience mental health problems. Women are more likely to report common mental health problems. Girls are also more likely than boys to self-harm, and eating disorders are more common in young women compared to young men. Men are more likely to have undiagnosed depression, be detained under the Mental Health Act and take their own life compared to women. (Mind, "Our Communities, Our Mental Health") Results of Welsh Health Survey 2015 – reported in Mental Health Foundation Fundamental Facts 2016:- A higher percentage of women report being treated for a mental health problem than men (16% vs 10%). Treatment figures show an increase of 1% for both men and women from 2014 statistics. Health (and social care) services have a duty to treat people fairly and equally. However, the Stonewall **Unhealthy Attitudes 2015** report highlights some major gaps in the knowledge and training of staff relating to lesbian, gay, bisexual and trans (LGBT) people, which is resulting in unfair treatment of both LGBT patients and colleagues. Gay and Bisexual Men's Health Survey With 6,861 respondents from across Britain, the 2013 report is the largest survey ever conducted of gay and bisexual men's health needs

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		in the world. However, it demonstrates that many of those needs are not being met and that there are areas of significant concern – most particularly in mental health and drug use – that have been overlooked by health services which too often focus solely on gay men's sexual health. This report also provides hard evidence that gay and bisexual men nationwide are more likely to attempt suicide, self-harm and have depression than their straight peers. This policy will apply regardless of gender. **Gender Reassignment -** Trans people are at increased risk of depression and self-harm, and a third of trans people have attempted to take their own life.(Mind, "Our Communities, Our Mental Health") This policy will apply regardless of whether patients have transitioned or not. Health (and social care) services have a duty to treat people fairly and equally. However, the Stonewall **Unhealthy Attitudes 2015** report highlights some major gaps in the knowledge and training of staff relating to lesbian, gay, bisexual and trans (LGBT) people, which is resulting in unfair treatment of both LGBT patients and colleagues. The NHS Centre for Equality and Human Rights (CEHR) has published a new guide for all staff in NHS Wales. *"It's Just Good Care – A guide for health staff caring for people who are trans*"* aims to help health staff provide trans* people with the respectful and appropriate care they are entitled to. The document is available for downloading from the staff intranet. Also available on the intranet is a Top Tips for Making your Service Inclusive and Welcoming for Trans People **Human Rights -** The proposed policy promotes human rights in

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		ensuring that all patients are detained lawfully. **Pregnancy and Maternity -** Mental health problems affect between 10 and 20 per cent of women at some point during the perinatal period (pregnancy and one year after birth). Poor maternal health can also increase the risk of mental health in children. Within the Mind report the following issues are also identified as contributory risk factors:- Trauma and stressful events, poverty, unemployment and housing insecurity, social isolation and loneliness, discrimination and inequality. (Mind, "Our Communities, Our Mental Health") Results of Welsh Health Survey 2015 – reported in Mental Health Foundation Fundamental Facts 2016 Mental health problems affect more than 1 in 10 women during pregnancy and the first year after childbirth, and can have a devastating impact on new mothers and their families. According to a 2014 report from the London School of Economics and the Centre for Mental Health, in the UK, 20% of women are affected by mental health problems during the perinatal period. In Wales, 70% of people have no access to specialist perinatal mental health services; a figure significantly higher than the UK average of 40%. According to NHS Choices website If you have had in the past, or now have, severe mental health problems, you are more likely to become ill during pregnancy or in the first year after giving birth than at other times in your life. Severe mental health problems include bipolar affective disorder, severe depression and psychosis. After giving birth, severe mental illness may progress more quickly and be more serious than at other times. This policy will apply regardless of whether patients are pregnant at the

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		time of being detained. In relation to staff there are no changes to be made in relation to applying holding powers. Wards will have completed risk assessments in relation to staff. **Race/ Ethnicity or nationality –** A disproportionate number of people admitted as inpatients in mental health services come from BAME groups. In 2010, 23 per cent of inpatient admissions were from a BAME background. According to the mental health organisation 'Mind', the admission rate for 'other black' groups is six times higher than average, suggesting discrimination within the mental health system. Black African and Caribbean people living in the UK have lower reported rates of common mental health problems compared to other ethnic groups, however they are more likely to be diagnosed with severe mental health problems. Black African and Caribbean people are also much more likely to be detained under the Mental Health Act compared to other ethnic groups. According to Black Mental Health UK, people of African or Caribbean descent are 50 per cent more likely to be referred to mental health services via the police than their white counterparts.Young women from ethnic minorities are much more likely to take their own life than White British women. (Mind, "Our Communities, Our Mental Health") The proposed policy will apply regardless of the race / ethnicity of patients or staff. Health inequalities are further linked to unequal access to healthcare. Some BAME groups face considerable barriers to healthcare. In 2009 the Department for Communities and Local Government noted that Gypsies and Travellers face particular difficulties accessing

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		healthcare. Many of them felt that health workers and doctors misunderstood their needs and circumstances. Additionally, Gypsy and Traveller access to healthcare can also difficult if there is an inability to provide proof of identity. The West Midlands Strategic Health Partnership noted, in 2010, that migrant populations faced significant barriers accessing healthcare including difficulties that were related to registering, contracting and commissioning processes as well as a lack of knowledge about services available. Other common difficulties included poor continuity of care and the experience of not having the same doctor in the practice. A Cultural Competency Toolkit, was developed by Diverse Cymru, with assistance from UHB staff. Its aim is to help staff better interact with clients with mental ill health who are from different cultures A proportion of patients first language may not be English or Welsh. The statutory documents in relation to the Mental Health Act are provided by Welsh Government are only available in English and Welsh. Within the explanation of rights this now details if the information has been given in the patients preferred language and will be reported on. Access to an interpreter is available and translation of written information can be obtained as and when required. **Religion or Belief -** Spiritual awareness, practices and beliefs (of any religion or for those engaging in spiritual practices without a particular faith) is associated with psychological benefits, including subjective wellbeing (Mind, Our Communities, Our Mental Health").

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		There are religious beliefs and practices that have been shown, across all the cultures studied, to have some salutary effects on well-being. Other ways in which culture may impact on the relations between religion and well-being have been less consistently documented. The recent growth of interest in positive psychology, and in the relations between religion and spirituality, and maturity, morality and virtue has not yet incorporated a marked focus on cultural issues. Religious beliefs and practices supported in one culture may appear disturbed to people (including mental health professionals) from another, affecting diagnosis and treatment. Many commonly held ideas about the role of religion in shame, guilt and anxiety (including obsessive-compulsive disorder), voices, visions and spirit possession require closer examination in the light of evidence from different cultural groups. Clinical practitioners are keen to reach a better understanding of the roles played by religious factors in different cultures, in affecting mental health. The proposed policy will apply regardless of the religion or belief of patients or staff. **Sexual Orientation -** Lesbian, gay and bisexual people are at increased risk of mental health problems, including self-harm and attempted suicide. Lesbian, gay and bisexual people have a 1.5 fold increased risk of depression and anxiety. (Mind "Our Communities, Our Mental Health"). Health (and social care) services have a duty to treat people fairly and equally. However, the Stonewall **Unhealthy Attitudes 2015** report highlights some major gaps in the knowledge and training of staff relating to lesbian, gay, bisexual and trans (LGBT) people, which is resulting in unfair treatment of both LGBT patients and colleagues. Gay and Bisexual Men's Health Survey

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		With 6,861 respondents from across Britain, the 2013 report is the largest survey ever conducted of gay and bisexual men's health needs in the world. However, it demonstrates that many of those needs are not being met and that there are areas of significant concern – most particularly in mental health and drug use – that have been overlooked by health services which too often focus solely on gay men's sexual health. This report also provides hard evidence that gay and bisexual men nationwide are more likely to attempt suicide, self-harm and have depression than their straight peers. The proposed policy will apply regardless of the sexual orientation of the patients or staff. **Welsh Language -** No evidence of disproportional representation to date, but a proportion of service users may be Welsh speakers **Welsh Language and its use in Cardiff & Vale of Glamorgan** The latest census statistics available indicate that 16% of the population of Cardiff have one or more skills in the Welsh Language (ability to read, write or/and understand Welsh). 32,000 or 11% of Cardiff's population are fluent Welsh speakers. 24.5% are within the 3-15 age group, and 12.1% within the 16-24 age groups. When the results of previous Censuses are consulted, a significant increase in the incidence of Welsh speakers amongst the youngest age groups is noticed. For the 5-15 year age group, the proportion of Cardiff's residents able to speak Welsh has increased from 6.8% in 1971 to 7.5% in 1981 and 12.7% in 1991. By 2001 this figure had increased to 24.5%. In the Vale of Glamorgan 13,189 of 122,018 people, which is 10.8% of the population, are fluent Welsh speakers.

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		As the statutory documents in relation to the Mental Health Act are provided by Welsh Government these are in English on the Website. Information leaflets for the patients are available in both English and Welsh. Within the explanation of rights this now details if the information has been given in the patients preferred language and will be reported on. Welsh Language Act is a consideration. **The impact of mental ill health on employment rates** A national household survey in Great Britain conducted in 2000 found that 57% of people who have a common mental disorder are working, compared with 69% of people who do not have a common mental disorder7. Just 9% of people with a probable psychotic disorder, which includes most people with a severe mental disorder, are working fulltime and a further 19% parttime (Meltzer et al., 2002)8. An earlier survey reported that 70% of those with a common mental disorder, who are unemployed and seeking work, have been unemployed for a year or more (that is 7% of all people with a common mental disorder) and are unlikely to return to work (Meltzer et al., 1995). Those who have a common mental disorder are four to five times more likely than those who have not to be permanently unable to work and three times more likely to be receiving benefits payments (Meltzer et al., 1995 and 2002). Between 30% and 50% of people with schizophrenia are capable of work but only between 10% and 20% are in employment (Marwaha and Johnson, 2004; Schneider, 1998). Although some are in managerial or senior official positions, most are in 'elementary' jobs, for example cleaning and labouring, or are in skilled trade occupations such as plumbing or metal work. The rate of employment in people with schizophrenia seems to have fallen from before 1990 when surveys reported that between 20% and 30% were in work. Several studies conducted at two time points seem to confirm this reduction (e.g. Rinaldi

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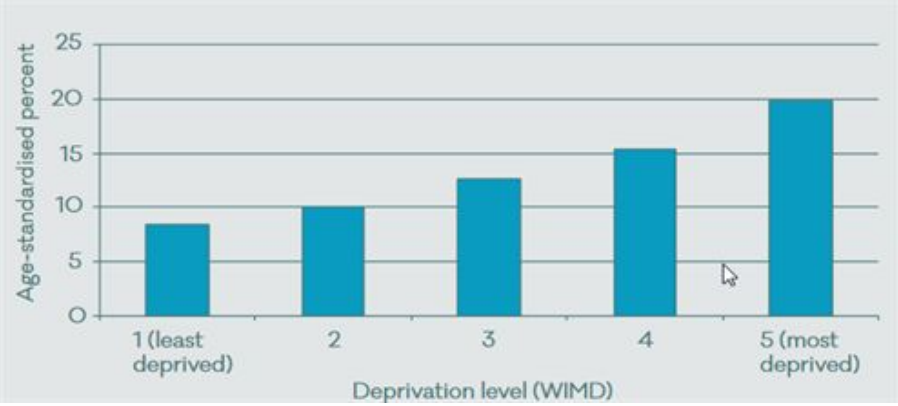
		and Perkins, 2007). The reason for this is unknown but one factor might be a reduction in the number of sheltered employment schemes. For those who present to services for the first time, the likelihood of being in employment falls markedly over the subsequent year or two (Birchwood et al., 1992; Johnstone et al., 1986). For people with Schizophrenia, premorbid social and occupational history are associated with employment and some types of psychotic symptoms and the presence of negative symptoms are associated with unemployment. The desire to have a job is one of the best predictors of future employment (Marwaha and Jonhson, 2004). **People according to where they live**  Findings from the 2015 survey found, that there was poorer mental health in more deprived areas. The percentage of adults that reported currently being treated for any mental health condition by area deprivation showed 8 per cent in the least deprived fifth in receipt of mental health treatment which rose steadily with higher levels of deprivation to 20 per cent in the most deprived fifth.

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		There is a wealth of evidence that mental health influences a very wide range of outcomes for individuals and communities. These include healthier lifestyles; better physical health; improved recovery from illness; fewer limitations in daily living; higher educational attainment; greater productivity, employment and earnings; better relationships with adults and with children; more social cohesion and engagement and improved quality of life. These outcomes are not just or necessarily a consequence of the absence of mental illness, but are associated with the presence of positive mental health, sometimes referred to as 'wellbeing'. Improving mental health is a worthwhile goal in itself: most people value a sense of emotional and social wellbeing; in addition, good mental health has many other far reaching benefits. Mental health is a fundamental element of the resilience, health assets, capabilities and positive adaptation that enable people both to cope with adversity and to reach their full potential and humanity. Mental health is also the key to understanding the impact of inequalities on health and other outcomes. It is abundantly clear that the chronic stress of struggling with material disadvantage is intensified to a very considerable degree by doing so in more unequal societies. An extensive body of research confirms the relationship between inequality and poorer outcomes, a relationship which is evident at every position on the social hierarchy and is not confined to developed nations. The emotional and cognitive effects of high levels of social status differentiation are profound and far reaching: greater inequality heightens status competition and status insecurity across all income groups and among both adults and children. It is the *distribution* of economic and social resources that explains health and other outcomes in the vast majority of studies. The importance of the social and psychological dimensions of material deprivation is gaining greater recognition in the international literature on poverty and informs current

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		efforts to develop indicators that capture the missing dimensions of poverty. Both health-damaging behaviours and violence, for example, may be survival strategies in the face of multiple problems, anger and despair related to occupational insecurity, poverty, debt, poor housing, exclusion and other indicators of low status. These problems impact on intimate relationships, the care of children and care of the self. In the United Kingdom, the 20% - 25% of people who are obese or continue to smoke are concentrated among the 26% of the population living in poverty, measured in terms of low income and multiple deprivation of necessities. This is also the population with the highest prevalence of anxiety and depression. It is already well established that mental illness, across the spectrum of disorders, is both a direct cause of mortality and morbidity and a significant risk factor for poorer economic, health and social outcomes, although these adverse outcomes vary by type of disorder and socioeconomic status (WHO 2005; 2006).[3] However, it is now becoming clear that the presence or absence of positive mental health or 'wellbeing' *also* influences outcomes across a wide range of domains. These include healthier lifestyles, better physical health, improved recovery, fewer limitations in daily living, higher educational attainment, greater productivity, employment and earnings, better relationships, greater social cohesion and engagement and improved quality of life (WHO 2004b; Barry and Jenkins 2007; Jane-Llopis et al 2004). This policy will apply regardless of where a person lives. (From: http://www.euro.who.int/__data/assets/pdf_file/0012/100821/E92227.pdf

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		Homeless Affordable and safe accommodation brings stability and security; provides a gateway to access health services like GPs; enhances social and community inclusion; and provides the basis for the right to private and family life. Put simply, a home is vital for good mental and physical health, allowing people to live in safety, security, peace and dignity. Whilst there is no such 'right to housing' in itself, the right to an adequate standard of living, including housing, is recognised in the UN Covenant on Economic, Social and Cultural Rights. Of course, there are numerous factors which can cause people to become homeless, many of which are beyond individual control, such as lack of affordable housing, disability and poverty. But what really needs to be highlighted is the two-way relationship between homelessness and mental health. Homelessness and mental health often go hand in hand, and can be a self-fulfilling prophecy. Having a mental health problem can create the circumstances which can cause a person to become homeless in the first place. Yet poor housing or homelessness can also increase the chances of developing a mental health problem, or exacerbate an existing condition. In turn, this can make it even harder for that person to recover – to develop good mental health, to secure stable housing, to find and maintain a job, to stay physically healthy and to maintain relationships. It is a fundamental fact that single homeless people are much more likely to have mental health problems compared to the general population. In 2015, 32% of single homeless people reported a mental

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		health problem, and depression rates, for example, are over 10 times higher in the homeless population. Unfortunately, other psychological issues such as complex trauma, substance misuse and social exclusion are also common This policy will apply regardless of where a person lives. **Asylum Seekers** Some asylum seekers will have been subjected to torture, as well as witnessing the consequences of societal breakdown of their home country – with consequences for their mental health. Culturally, mental illness may not be expressed or may manifest as physical complaints. Stigma may also be attached to mental ill-health. Furthermore, Western psychological concepts are not universally applicable to asylum seekers. Mental health problems such as depression and anxiety are common, but post-traumatic stress disorder is greatly underestimated and underdiagnosed and may be contested by healthcare professionals. Children are particularly neglected in this area. A shortage of mental health services for asylum seekers has been recognised. http://www.fph.org.uk/uploads/bs_aslym_seeker_health.pdf **Prisoners** 10% of men and 30% of women have had a previous psychiatric admission before they entered prison. A more recent study found that 25% of women and 15% of men in prison reported symptoms indicative of psychosis. The rate among the general public is about 4%. 26% of women and 16% of men said they had received treatment for a mental health problem in the year before custody. Personality disorders are particularly prevalent among people in prison.

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		62% of male and 57% of female sentenced prisoners have a personality disorder. 49% of women and 23% of male prisoners in a Ministry of Justice study were assessed as suffering from anxiety and depression. 16% of the general UK population (12% of men and 19% of women) are estimated to be suffering from different types of anxiety and depression. 46% of women prisoners reported having attempted suicide at some point in their lives. This is more than twice the rate of male prisoners (21%) and higher than in the general UK population amongst whom around 6% report having ever attempted suicide. http://www.prisonreformtrust.org.uk/ProjectsResearch/Mentalhealth
5.	Who will be affected by the strategy/ policy/ plan/ procedure/ service	Mental health issues affect the whole population, though some protected groups are disproportionately represented among service users**.** The policy addresses administrative issues and responsibilities rather than the direct care and treatment of patients, although decisions made have an impact on the clinical pathways of patients. The Hospital Managers' Scheme of delegation policy applies to mental health patients admitted to inpatient mental health wards. Hospital managers must ensure that those acting on their behalf are competent to do so and receive suitable training to ensure they exercise their functions appropriately to ensure the functions are carried out on a day to day basis.

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6. EQIA / How will the strategy, policy, plan, procedure and/or service impact on people?

Questions in this section relate to the impact on people on the basis of their 'protected characteristics'. Specific alignment with the 7 goals of the Well-being of Future Generations (Wales) Act 2015 is included against the relevant sections.

How will the strategy, policy, plan, procedure and/or service impact on:-	**Potential positive and/or negative impacts**	**Recommendations for improvement/ mitigation**	**Action taken by Clinical Board / Corporate Directorate.** Make reference to where the mitigation is included in the document, as appropriate
6.1 Age For most purposes, the main categories are: • under 18; • between 18 and 65; and • over 65	There is potential for a positive impact in that there is an awareness of this protected characteristic.	N/A	Under Policy Statement section.
6.2 Persons with a disability as defined in the Equality Act 2010 Those with physical impairments, learning disability, sensory loss or impairment, mental health conditions, long-term medical conditions such as diabetes	Disabled people with enduring mental health problems of all types are much less likely to be economically active than those with physical or sensory impairments. There is potential for a positive impact in that there is an awareness of this protected characteristic and staff have to take into account the diverse needs of the	A key duty is that the Doctor must be fully aware of the diverse needs of the patient when considering detention and must take them in to account at all times. They must ensure the patient fully understands what is happening to them in a language and format which	Under Policy Statement section.

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How will the strategy, policy, plan, procedure and/or service impact on:-	**Potential positive and/or negative impacts**	**Recommendations for improvement/ mitigation**	**Action taken by Clinical Board / Corporate Directorate.** Make reference to where the mitigation is included in the document, as appropriate
	individual patient.	they are able to understand, this will include sensory and cognitive abilities and physical impairment. Where necessary, an interpreter should be obtained.	
6.3 People of different genders: Consider men, women, people undergoing gender reassignment **NB** Gender-reassignment is anyone who proposes to, starts, is going through or who has completed a process to change his or her gender with or without going through any medical procedures. Sometimes referred to as Trans or	There is potential for a positive impact in that there is an awareness of this protected characteristic and staff have to take into account the diverse needs of the individual patient.	*"It's Just Good Care – A guide for health staff caring for people who are trans*" is made available to staff*	Under Policy Statement section.

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How will the strategy, policy, plan, procedure and/or service impact on:-	**Potential positive and/or negative impacts**	**Recommendations for improvement/ mitigation**	**Action taken by Clinical Board / Corporate Directorate.** Make reference to where the mitigation is included in the document, as appropriate
Transgender			
6.4 People who are married or who have a civil partner.	We are aware of potential negative impact in terms of the LGBT+ communities and access to health care services as noted elsewhere within the EHIA.	*"It's Just Good Care – A guide for health staff caring for people who are trans*" is made available to staff.*	Under Policy Statement section.
6.5 Women who are expecting a baby, who are on a break from work after having a baby, or who are breastfeeding. They are protected for 26 weeks after having a baby whether or not they are on maternity leave.	No impact anticipated. However staff have to take into account the diverse needs of the individual patient.	N/A	Under Policy Statement section.
6.6 People of a different race, nationality, colour, culture or ethnic origin including non-English speakers,	There is a potential for a negative impact as there is a lot of well documented evidence to suggest that.	A key duty is that the Doctor must be fully aware of the diverse needs of the patient when considering	Under Policy Statement section.

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How will the strategy, policy, plan, procedure and/or service impact on:-	**Potential positive and/or negative impacts**	**Recommendations for improvement/ mitigation**	**Action taken by Clinical Board / Corporate Directorate.** Make reference to where the mitigation is included in the document, as appropriate
gypsies/travellers, migrant workers	However staff have to take into account the diverse needs of the individual patient.	detention and must take them in to account at all times. They must ensure the patient fully understands what is happening to them in a language and format which they are able to understand, this will include sensory and cognitive abilities and physical impairment. Where necessary, an interpreter should be obtained.	A Cultural Competency Toolkit, was developed by Diverse Cymru, with assistance from UHB staff. Its aim is to help staff better interact with clients with mental ill health who are from different cultures.
6.7 People with a religion or belief or with no religion or belief. The term 'religion' includes a religious or philosophical	There is the potential for impact as suggested by the evidence above. However staff have to take into account the diverse needs of		A Cultural Competency Toolkit, was developed by Diverse Cymru, with assistance from UHB staff. Its aim is to help staff better interact with clients

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How will the strategy, policy, plan, procedure and/or service impact on:-	**Potential positive and/or negative impacts**	**Recommendations for improvement/ mitigation**	**Action taken by Clinical Board / Corporate Directorate.** Make reference to where the mitigation is included in the document, as appropriate
belief	the individual patient. .		with mental ill health who are from different cultures.
6.8 People who are attracted to other people of: • the opposite sex (heterosexual); • the same sex (lesbian or gay); • both sexes (bisexual)	We know from evidence that there are potential negative issues in terms of these protected characteristics. However staff have to take into account the diverse needs of the individual patient.	N/A	N/A
6.9 People who communicate using the Welsh language in terms of correspondence, information leaflets, or service plans and design Well-being Goal – A Wales of vibrant culture and thriving Welsh language	There is the potential for a negative impact. However staff have to take into account the diverse needs of the individual patient.	A key duty is that the Doctor must be fully aware of the diverse needs of the patient when considering detention and must take them in to account at all times. They must ensure the patient fully understands what is happening to them in a language and format which	Under Policy Statement section. Staff are made aware of the translation and interpretation policy.

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How will the strategy, policy, plan, procedure and/or service impact on:-	**Potential positive and/or negative impacts**	**Recommendations for improvement/ mitigation**	**Action taken by Clinical Board / Corporate Directorate.** Make reference to where the mitigation is included in the document, as appropriate
		they are able to understand, this will include sensory and cognitive abilities and physical impairment. Where necessary, an interpreter should be obtained.	
6.10 People according to their income related group: Consider people on low income, economically inactive, unemployed/workless, people who are unable to work due to ill-health	There is awareness that mental health problems have a greater impact on people's ability to work than any other group of disorders. However staff have to take into account the diverse needs of the individual patient. Disabled people with enduring mental health problems of all types are much less likely to be economically active than	N/A	Under Policy Statement section.

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How will the strategy, policy, plan, procedure and/or service impact on:-	**Potential positive and/or negative impacts**	**Recommendations for improvement/ mitigation**	**Action taken by Clinical Board / Corporate Directorate.** Make reference to where the mitigation is included in the document, as appropriate
	those with physical or sensory impairments.		
6.11 People according to where they live: Consider people living in areas known to exhibit poor economic and/or health indicators, people unable to access services and facilities	No impact identified at this time, though it is recognised that there is poorer mental health in more deprived areas. However staff have to take into account the diverse needs of the individual patient.	N/A	Under Policy Statement section.
6.12 Consider any other groups and risk factors relevant to this strategy, policy, plan, procedure and/or service	Staff will respect the rights and needs of carers alongside the person's right to confidentiality. A Review of the person's consent to share information with family members, carers and other services will take place during the inpatient stay.	A key duty is that the Doctor must be fully aware of the diverse needs of the patient when considering detention and must take them in to account at all times. They must ensure the patient fully understands what is happening to them in a	Under Policy Statement section.

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How will the strategy, policy, plan, procedure and/or service impact on:-	**Potential positive and/or negative impacts**	**Recommendations for improvement/ mitigation**	**Action taken by Clinical Board / Corporate Directorate.** Make reference to where the mitigation is included in the document, as appropriate
	No impact has been identified at this time in relation to the homeless, asylum seekers and prisoners , though it is recognised that there is sometimes poorer mental health issues due to their circumstances and that there consequences for their mental health. However staff have to take into account the diverse needs of the individual patient.	language and format which they are able to understand, this will include sensory and cognitive abilities and physical impairment. Where necessary, an interpreter should be obtained.	

7. HIA / How will the strategy, policy, plan, procedure and/or service impact on the health and well-being of our population and help address inequalities in health?

Questions in this section relate to the impact on the overall health of individual people and on the impact on our population. Specific alignment with the 7 goals of the Well-being of Future Generations (Wales) Act 2015 is included against the relevant sections.

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How will the strategy, policy, plan, procedure and/or service impact on:-	**Potential positive and/or negative impacts and any particular groups affected**	**Recommendations for improvement/ mitigation**	**Action taken by Clinical Board / Corporate Directorate** Make reference to where the mitigation is included in the document, as appropriate
7.1 People being able to access the service offered: Consider access for those living in areas of deprivation and/or those experiencing health inequalities Well-being Goal - A more equal Wales	No Impact identified at this time, though it is recognised that there is poorer mental health in more deprived areas. However staff have to take into account the diverse needs of the individual patient.	N/A	Under Policy Statement section.
7.2 People being able to improve /maintain healthy lifestyles: Consider the impact on healthy lifestyles, including healthy eating, being active, no smoking /smoking cessation, reducing the harm caused by alcohol and /or non-prescribed drugs plus access to services that support disease prevention (eg immunisation and vaccination, falls prevention). Also consider impact on access to supportive services	No impact identified at this time, though it is recognised that healthy lifestyles can have a positive impact on mental health and well-being. Staff have to take into account the diverse needs of the individual patient.	N/A	Under Policy Statement section.

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How will the strategy, policy, plan, procedure and/or service impact on:-	**Potential positive and/or negative impacts and any particular groups affected**	**Recommendations for improvement/ mitigation**	**Action taken by Clinical Board / Corporate Directorate** Make reference to where the mitigation is included in the document, as appropriate
including smoking cessation services, weight management services etc Well-being Goal – A healthier Wales			
7.3 People in terms of their income and employment status: Consider the impact on the availability and accessibility of work, paid/ unpaid employment, wage levels, job security, working conditions Well-being Goal – A prosperous Wales	No impact identified at this time, though it is recognised that being employed can have a positive impact on mental health and well-being. Staff have to take into account the diverse needs of the individual patient.	N/A	Under Policy Statement section.
7.4 People in terms of their use of the physical environment: Consider the impact on the availability and accessibility of transport, healthy food, leisure activities, green	No impact identified at this time, though it is recognised that environmental issues can have a positive impact on mental health and well-being. Staff have to take into	N/A	Under Policy Statement section.

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How will the strategy, policy, plan, procedure and/or service impact on:-	**Potential positive and/or negative impacts and any particular groups affected**	**Recommendations for improvement/ mitigation**	**Action taken by Clinical Board / Corporate Directorate** Make reference to where the mitigation is included in the document, as appropriate
spaces; of the design of the built environment on the physical and mental health of patients, staff and visitors; on air quality, exposure to pollutants; safety of neighbourhoods, exposure to crime; road safety and preventing injuries/accidents; quality and safety of play areas and open spaces Well-being Goal – A resilient Wales	account the diverse needs of the individual patient.		
7.5 People in terms of social and community influences on their health: Consider the impact on family organisation and roles; social support and social networks; neighbourliness and sense of belonging; social isolation; peer pressure; community identity; cultural and spiritual ethos	No impact identified at this time, though it is recognised that social and community influences and related issues can have a positive impact on mental health and well-being. Staff have to take into account the diverse needs of the individual patient.	N/A	Under Policy Statement section.

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How will the strategy, policy, plan, procedure and/or service impact on:-	**Potential positive and/or negative impacts and any particular groups affected**	**Recommendations for improvement/ mitigation**	**Action taken by Clinical Board / Corporate Directorate** Make reference to where the mitigation is included in the document, as appropriate
Well-being Goal – A Wales of cohesive communities			
7.6 People in terms of macro-economic, environmental and sustainability factors: Consider the impact of government policies; gross domestic product; economic development; biological diversity; climate Well-being Goal – A globally responsible Wales	No impact identified at this time, though it is recognised that macro-economic, environmental and sustainability factors social and community influences and related issues can have a positive impact on mental health and well-being. Staff have to take into account the diverse needs of the individual patient.	N/A	Under Policy Statement section.

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Please answer question 8.1 following the completion of the EHIA and complete the action plan

8.1 Please summarise the potential positive and/or negative impacts of the strategy, policy, plan or service	This policy is a technical document identifying the duties under the MHA of Hospital Managers and a formal scheme of delegation of these powers to UHB officers and is a legislative requirement under Mental Health Act. This is an updated policy. Changes made were in line with current legislation and will not impact adversely on any protected group/s. A search of similar policies elsewhere indicated a positive or neutral impact on protected group/s https://www.google.co.uk/search?site=&source=hp&q=hospital+managers+scheme+of+delegation+mental+health+equality+impact+assessment+&oq=hospital+managers+scheme+of+delegation+mental+health+equality+impact+assessment+&gs_l=psyab.12...991.25263.0.27458.107.67.7.0.0.0.556.10945.2j2j12j11j7j1.35.0....0...1.1.64.psyab..68.24.6267...0j0i131k1j0i22i30k1j33i21k1j33i160k1.GkgOkLRlha4

Action Plan for Mitigation / Improvement and Implementation

	Action	Lead	Timescale	Action taken by Clinical Board / Corporate Directorate

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	Action	Lead	Timescale	Action taken by Clinical Board / Corporate Directorate
8.2 What are the key actions identified as a result of completing the EHIA?	To ensure that an interpreter/translation is requested immediately to avoid delay and ensure patients are provided with information in their preferred language in a timely manner.	All appropriate staff	As and When required/requested	Staff will be/are made aware of our Interpretation and Translation policy and its use with service users.
8.3 Is a more comprehensive Equalities Impact Assessment or Health Impact Assessment required? This means thinking about relevance and proportionality to the Equality Act and asking: is the impact significant enough that a more formal and full consultation is required?	Not required	N/A	N/A	No action

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	Action	Lead	Timescale	Action taken by Clinical Board / Corporate Directorate
8.4 What are the next steps? Some suggestions:- • Decide whether the strategy, policy, plan, procedure and/or service proposal: o continues unchanged as there are no significant negative impacts o adjusts to account for the negative impacts o continues despite potential for adverse impact or missed opportunities to advance equality (set out the justifications for doing so) o stops. • Have your strategy, policy, plan, procedure and/or service proposal approved • Publish your report of this impact assessment • Monitor and review	No significant negative Impact. The policy will be submitted to the Health Systems Management Board for consideration and the Mental Health and Capacity Legislation Committee for approval. Once the policy has been approved the documentation will be placed on the intranet and internet. The EHIA and Policy will be reviewed three years after approval unless changes to terms and conditions, legislation or best practice determine that an earlier review is required.	N/A	N/A	N/A • The health board's Mental Health and Capacity Legislation Committee is responsible for providing assurance to the health board hospital managers that those functions of the Act , as which they have delegated to officers and staff are being carried out correctly; and that the wider operation of the Act in relation to the health board's area is operating properly.

14.2

Reference Number: *TBA* **Version Number:** 1	**Date of Next Review:** *To be included when document approved* **Previous Trust/LHB Reference Number:** *Any reference number this document has been previously known as*

Hospital Managers' Scheme of Delegation Procedure
Mental Health Act, 1983

Introduction and Aim

This document supports the Hospital Managers' Scheme of Delegation Policy, Mental Health Act, 1983.

To ensure individuals are aware of their delegated functions under the Mental Health Act.

To Provide clear direction and guidance to staff in relation to the arrangements for authorising people to exercise delegated functions on behalf of the Hospital Managers.

To Ensure that statutory requirements under the Mental Health Act 1983 are met.

Objectives

The principle objectives of this Procedure are to inform the organisation of the arrangements for authorising people to exercise delegated functions as set out in the scheme of delegation. Unless the Act or regulations say otherwise, organisations may delegate their functions under the Act to any one and in any way their constitutions allow or in the case of the Health Board, in line with NHS legislation.

This Procedure describes the following with regard to the Hospital Managers' Scheme of Delegation:

- The purpose of a Scheme of Delegation
- Who is authorised to exercise delegated functions on behalf of the Hospital Managers
- Responsibilities and requirements of individuals in relation to the delegated duties of Hospital Managers

Scope

This procedure is applicable to all people authorised to exercise delegated functions to be carried out day to day required by the Mental Health Act, 1983 (MHA) on behalf of Cardiff and Vale University Health Board within all Mental Health inpatient settings, community settings and general hospital settings where patients are detained under the MHA.

Equality and Health Impact Assessment	There is potential for both positive and negative impact. The procedure is aimed at improving services and meeting diverse needs. Mitigation actions are already in place to offset any potential negative outcome, e.g. through the monitoring of the procedure. There is nothing, at this time, to stop the procedure from being implemented.

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Documents to read alongside this Procedure	• The Mental Health Act 1983 (as amended by the Mental Health Act 2007) • Mental Health (hospital, guardianship, community treatment and consent to treatment)(Wales) regulations 2008 • The Mental Capacity Act 2005 (including the Deprivation of Liberty Safeguards delegated to this Act under the Mental Health Act 2007) • The respective Codes of Practice of the above Acts of Parliament • The Human Rights Act 1998 (and the European Convention on Human Rights) • Domestic Violence, Crime and Victims Act, 2004 All Cardiff and Vale policies on the Mental Health Act 1983 as appropriate including: Hospital Managers' Scheme of Delegation Policy Section 5(4) Nurses' Holding Power Policy Section 5(4) Nurses' Holding Power Procedure Section 5(2) Doctors' Holding Power Policy Section 5(2) Doctors' Holding Power Procedure Community Treatment Order Policy Community Treatment Order Procedure
Approved by	Pending – Mental Health and Capacity Legislation Committee

Accountable Executive or Clinical Board Director	*Chief Operating Officer*
Author(s)	*Mental Health Act Manager*

Disclaimer

If the review date of this document has passed please ensure that the version you are using is the most up to date either by contacting the document author or the Governance Directorate.

14.2

Summary of reviews/amendments			
Version Number	**Date of Review Approved**	**Date Published**	**Summary of Amendments**
1	*Date of Committee or Group*	*TBA*	*New document*

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	Approval		

Glossary of terms

Term	Definition
RC	Responsible Clinician - The approved clinician with overall responsibility for the patient's case
CTO	Community Treatment Order – Written authorisation on a prescribed form for the discharge of a patient from detention in a Hospital onto supervised community treatment
SOAD	Second Opinion Approved Doctor – An independent doctor appointed by Healthcare Inspectorate Wales who gives a second opinion on whether certain types of medical treatment for mental disorder should be given without the patient's consent
MHRTfW	Mental Health Review Tribunal for Wales – A judicial body that has the power to discharge patients from detention, community treatment orders, guardianship and conditional discharge
AC	Approved Clinician – A mental health professional approved by the Welsh Ministers to act as an approved clinician for the purposes of the Act. In practice, Health Boards take these decisions on behalf of the Welsh Ministers
IMHA	Independent Mental Health Advocate – An advocate independent of the team involved in patient care available to offer support to patients.
HIW	Healthcare Inspectorate Wales – The independent body which is responsible for monitoring the operation of the Act in Wales.
Section 4	Section 4 of the MHA allows a period of detention for assessment that lasts up to 72 hours based on one medical recommendation.
Section 5	The powers in Section 5 allow hospital inpatients to be detained temporarily so that a decision can be made about whether an application for detention should be made.
Section 15	Rectification of applications and recommendations.
Section 7	Guardianship – An application to a local authority for a patient to become subject to Guardianship

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Section 25	Restrictions on discharge by nearest relatives
Section 62	Urgent treatment given to detained patients
Section 133	The duty of hospital managers to information nearest relatives of a patients discharge
Section 134(1)(a)	The withholding of postal packages
Form CP6	Form used by nursing staff to record the recall of a CTO patient to hospital
Form HO14	Record of admission to hospital – completed by nursing staff for relevant sections of the MHA
Keywords	Scheme of Delegation, Mental Health Act, 1983, Hospital Managers

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1. INTRODUCTION

Associate Hospital Managers as appointed by the Health Board have the authority to detain patients under the Mental Health Act 1983 (Act). The Health Board is defined as the 'Hospital Managers' for the purposes of the Act.

Hospital Managers have a range of responsibilities, including:

- Ensuring that patient's care and treatment complies with the Act;
- Authority to detain patients admitted under the Act; and
- Power to discharge certain patients (sec 23 of the Act) - which can only be exercised by three or more members of a committee formed for that purpose.

There are many other responsibilities and duties which are carried out on the Health Boards behalf by 'authorised officers' (staff) of our hospitals. These include receipt, scrutiny and amendment of detention documents, ensuring patients' rights are made known to them, referral for and arranging Mental Health Review Tribunals, ensuring compliance with renewal/extension, consent treatment and second opinion dates. This is not an exhaustive list as there are many other duties. These roles and responsibilities will be given in more detail below and in the scheme of delegation at **Appendix A**.

It is the hospital managers who have the authority to detain patients under the Act and have equivalent responsibilities towards patients subject to Community Treatment Orders (CTO), where the patient was detained at the "responsible hospital" immediately before becoming subject to the community treatment order (CTO), even if those patients are not being treated at one of their hospitals. The procedure provides assurance that the health board as a detaining authority has formally delegated specific statutory duties and powers to specific individuals (or groups of individuals).

The health board's Mental Health and Capacity Legislation Committee is responsible for providing assurance to the health board hospital managers that those functions of the Act , as which they have delegated to officers and staff are being carried out correctly; and that the wider operation of the Act in relation to the health board's area is operating properly.

2. PROCEDURE STATEMENT

The Health Board is responsible for ensuring that the Mental Health Act is used lawfully and fairly, in accordance with the principles of the Mental Health Act Code of Practice for Wales, including ensuring all paperwork is scrutinised for validity, that detained patients are informed of their rights, and that patients are referred to the Tribunal within the timeframes set out in the Mental Health Act. They also have various powers, to discharge patients from detention, transfer detained patients to other hospitals in accordance with regulations, as well as withholding a patient's outgoing correspondence where the law permits.

People taking decisions under the Act must recognise and respect the diverse needs, values and circumstances of each patient, including their age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion, or belief, sex and sexual orientation and culture, or any combination of these. There must be no unlawful discrimination

and reasonable adjustments must be made. Individuals' protected characteristics should be taken into account and good practice followed in all aspects of care and treatment planning and implementation.

3. SCOPE

The Health Board has in place appropriate governance arrangements to monitor and review the exercise of functions under the Act on its behalf. The Mental Health and Capacity Legislation Committee are specifically for this purpose.

The scheme of delegation covers mental health patients across community, outpatient and inpatient settings. Hospital managers must ensure that those acting on their behalf are competent to do so and receive suitable training to ensure they exercise their functions appropriately to ensure the functions are carried out on a day to day basis.

4. THE STATUTORY FUNCTIONS OF HOSPITAL MANAGERS

The statutory functions of the hospital managers are as follows:

6.1. Receipt, Scrutiny and Recording of Documentation

Hospital Managers should formally delegate their duties to receive and scrutinise 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 whenever patients may be admitted to the hospital. A manager of appropriate seniority should take overall responsibility on behalf of the hospital managers for the proper receipt and scrutiny of documents. (Code of Practice for Wales, 35.8).

It is necessary that all detention papers undergo both administrative and medical scrutiny to ensure that they are technically correct and that the clinical reasons given are sufficient for detaining the patient under the Act. The Mental Health Act administrator will carry out the administrative scrutiny and a consultant who is not involved with the patient concerned will carry out the medical scrutiny in accordance with local practice.

The MHA Administration team provides the Mental Health and Capacity Legislation Committee with details of defective admission documents and of any subsequent action on a regular basis.

Authority for checking that detention documents are in order and receiving papers authorising a patients' detention can only be undertaken by:

- The Mental Health Act Department
- Shift Coordinator
- Night Site Manager

All of the above staff should receive regular training and instruction in the receipt of admission documentation.

Section 15 of the Act describes the types of errors that may be rectified in the statutory documents. The person who signed the document in question must complete the rectification and that must take place within 14 days of the date of the Form HO14 (record of receipt of admission). Further guidance on the subject of rectification may be found in Part II of the Act.

If admission documents reveal a defect which fundamentally invalidates the application and which cannot, therefore, be rectified under section 15, the patient can no longer be detained on the basis of the application. Authority for detention can only be obtained through a new application. The hospital managers should use their power under section 25 to discharge the patient. The patient should be informed both verbally and in writing.

Responsibility for coordinating this at Cardiff and Vale UHB rests with the Mental Health Act Department

6.2. Report on hospital in-patient (section 5, MHA)

Hospital Managers should monitor the use of section 5 including:

- How quickly patient are assessed for detention and discharged from the holding power
- The attendance times of doctors and approved clinicians following the use of section 5(4)
- The proportion of cases in which applications for detention are, in fact, made following use of section 5

Hospital managers should ensure suitably qualified, experienced and competent nurses are available where there is a possibility of section 5(4) being invoked.

The role of monitoring is provided by the Mental Health and Capacity Legislation Committee who will be informed via the Mental Health Act Department

6.3. Emergency admission (section 4, MHA)

Hospital managers should monitor the use of section 4 and ensure that second doctors are available to visit a patient within a reasonable time after being requested. This will also be monitored by Healthcare Inspectorate Wales (HIW).

The role of monitoring is provided by the Mental Health and Capacity Legislation Committee who will be informed via the Mental Health Act Department

6.4. Allocation of a Responsible Clinician

Every patient must have an allocated Responsible Clinician (RC). (Code of Practice for Wales, Chapter 36) The RC is the approved clinician who will have overall responsibility for the patient's care and treatment. The patient should be informed of the identity of the RC and of any change. Chapter 36 of the Code of Practice for Wales outlines the functions of responsible clinicians and approved clinicians and steps to be followed to ensure that:

- The patient's RC is the available Approved Clinician (AC) with the most appropriate expertise to meet the patient's main assessment and treatment needs;

- A patient's RC can be easily determined;
- Cover arrangements are in place when the RC is not available;
- There is a system for keeping the appropriateness of the RC is under review.

The allocation of the Responsible Clinician is delegated to the Clinical Team and the Clinical Director. A list of Approved Clinicians in Wales and those employed by the Health Board is held by Betsi Cadwaladr University Health Board.

6.5. Transfer between hospitals (section 19, MHA)

Section 19 of the Act allows hospital managers to authorise the transfer of most detained patients from one hospital to another. Decisions on transfers may be delegated to a person who could, but need not be the patient's responsible clinician. For restricted patients, the consent of the Secretary of State for Justice is also required.

The Mental Health Act Department, Shift Coordinator or Night Site Manager will perform this role on behalf of the Hospital managers.

6.6. Transfers into/from guardianship (section 7, MHA)

Section 19 allows hospital managers to authorise the transfer of most detained patients into guardianship with the agreement of the relevant local authority. This procedure avoids the need to discharge the patient from detention and making a separate guardianship application. There should be good reasons for any transfer into guardianship and the needs and interest of the patient must be central to decision making.

The Mental Health Act Department, Shift Coordinator or Night Site Manager will perform this role on behalf of the Hospital managers.

6.7. Transfer and assignment of responsibility for CTO patients (sec 19A, MHA)

The managers of a hospital to which a CTO patient has been recalled may authorise the patient's transfer to another hospital during the 72 hour maximum period of recall. With the agreement of the hospital to which the patient is being transferred, the hospital managers may also reassign responsibility for CTO patients so that a different hospital will become the patient's responsible hospital.

The Mental Health Act Department, Shift Coordinator or Night Site Manager will perform this role on behalf of the Hospital managers.

14.2

6.8. Removal and return of patients (section 86)

Part 6 of the Act enables the transfer between the United Kingdom jurisdictions, Channel Islands or Isle of Man of detained patients (otherwise than under s.35, s.36 or s.38), patients subject to guardianship or to compulsion in the community where the patient concerned needs to remain subject to detention, guardianship or the equivalent CTO on arrival in Wales.

Following approval by Welsh Ministers this role is performed on behalf of the Hospital managers by the Mental Health Act Department.

6.9. Responsibilities under Community Treatment Order

There is a duty on the hospital managers to take steps to ensure patients understand what a CTO means for them and their rights to apply for discharge. A copy of this information must also be provided to the nearest relative, where practicable, if the patient does not object. (Code of Practice for Wales, Chapter 4)

The RC, Care Coordinator or qualified nurses will perform this role on behalf of the hospital managers.

6.10. Recall to hospital for CTO patients (sec 17E)

Following recall, the hospital managers are responsible for ensuring no patient is detained for longer than 72 hours unless the CTO is revoked. The relevant statutory form must be completed on the patient's arrival at hospital. Arrangements should be put in place to ensure the patient's length of stay following the time of detention after recall, as recorded on the form, is carefully monitored.

The completion of form CP6 will be undertaken by Mental Health Act Department or Shift Coordinator on behalf of the hospital managers.

6.11. Duty to provide information to patients

Section 132 and 132A of the Act require hospital managers to take such steps as are practicable to ensure that patients who are detained in hospital under the Act, or who are subject to a community treatment order (CTO), understand important information about how the Act applies to them. This must be done as soon as practicable after the start of the patient's detention or the CTO. (Code of Practice for Wales, Chapter 4)

Information should be given to the patient both verbally and in writing, in accessible formats, appropriate to the patient's needs, e.g. Braille, Moon, easy read, and in a language the patient understands. It would not be sufficient to repeat what is already written on an information leaflet as a way of providing information verbally.

Patients should be given all relevant information, which includes how to make a complaint, how to access advocacy services, legal advice and the role of the Inspectorates.

Those with responsibility for the care and treatment of patients should be aware of the most effective way to community with each individual and their family, carers and relevant others. Everything possible should be done to overcome barriers to effective communication.

Under section 133 of the Act, the hospital managers must inform the nearest relative (as defined in section 26 of the 1983 Act) when a patient is released from detention, including a patient who is to be discharged from hospital under CTO. It need not be provided, if either the patient or nearest relative have requested that this information should not be given.

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The role for ensuring that the patient and nearest relative are informed in line with the above requirements rests with the Mental Health Act Department or suitably experienced nursing staff.

6.12. Correspondence of patients

Section 134(1)(a) of the Act allows hospital managers to withhold outgoing post from detained patient if the person it is addressed to has requested in writing that they do so and the procedure to be followed in the event of the hospital managers receiving a written request for outgoing mail to be withheld.

The role of monitoring is provided by the Mental Health and Capacity Legislation Committee who will be informed via the Mental Health Act Department.

6.13. Information about Independent Mental Health Advocates

Section 130D places a duty on hospital managers (and in certain cases RCs) to provide qualifying patients with information that advocacy services are available and how to obtain that help.

This role will be provided on behalf of the hospital managers by ward nursing staff, community staff or the Mental Health Act department in accordance with (Code of Practice for Wales 37.15)

6.14. Duty to refer cases to the Mental Health Review Tribunal for Wales (sec 68, MHA)

Hospital Managers must refer a patient's case to the MHRT for Wales in the circumstances set out in section 68 of the Act below:

- Who has not exercised their right to apply (or been referred by Welsh Ministers or the hospital managers as set out in section 68;
- Who has been transferred from guardianship under regulations under section 19 and has not applied for a tribunal;
- Who has not had an application made on his behalf by the nearest relative or by virtue of a referral by Welsh Ministers;
- If the authority for detention is renewed and the patient has not had a MHRT for more than three years, or a patient under 18 years of age, for one year ; or
- On the revocation of a Community Treatment Order (CTO)

14.2

The responsibility for ensuring that systems are in place to make a reference to the MHRTfW within the timescales will be performed by the Mental Health Act Department on behalf of the hospital managers.

6.15. Referrals to the Mental Health Review Tribunal for Wales by Welsh Ministers

Hospital managers should consider asking Welsh Ministers to exercise their power of referral for a patient (whose rights under Article 5(4) may be at risk of being violated) to have their case considered by the MHRT for Wales (Chapter 37.40 of the Code refers).

The hospital managers should normally seek such a reference in any cases where:

- A patient's detention under section has been extended under section 29 of the Act pending the outcome of an application to the county court for the displacement of their nearest relative
- The patient lacks the capacity to request a reference
- The patient's case has never been considered by the MHRT for Wales or a significant period has passed since it was last considered

The Mental Health Act Department will perform this duty on behalf of the hospital managers.

6.16. Renewal of authority to detain (section 20, MHA)

The hospital managers should consider a report made under section 20(3) or section 20A (4) before the current period of detention or community treatment expires. If a responsible clinician does not hold a review before the period of detention or CTO expires, this should be considered a very serious matter to be urgently reviewed. The hospital managers should have processes in place to ensure that this does not happen.

The Responsible Clinician has responsibility for completing the report to renew a patient's detention or community treatment order. The Mental Health Act Department receives the report on behalf of the hospital managers and arranges a hearing for the hospital managers to sit and consider the renewal of detention.

6.17. Report barring discharge by nearest relative (section 25, MHA)

The nearest relative may order the discharge of a patient detained under section 3, or CTO by giving 72 hours notice to the hospital managers in writing. The person receiving the notice must note the time and date received.

The receiving of this notification of intent to discharge the patient is delegated to the Mental Health Act Department; any qualified nursing staff or any Approved Clinician.

14.2

The responsible clinician may within the 72-hour period furnish Form NR1 barring the discharge by the nearest relative.

The duty of informing the nearest relative in writing of the decision on behalf of the hospital managers is delegated to the Mental Health Act Department.

6.18. Duties in respect of victims

The Domestic Violence, Crime & Victims Act 2004 (DVCVA) 2004 places a number of duties on hospital managers in relation to certain patients who have committed sexual or violent crimes together with guidance on the exercise of these.

The duties include the following information is communicated to victims:

- When authority to detain a patient expires
- When the patient is discharged, including allowing the victim to make representations about discharge conditions and whether a CTO is to be made
- What conditions of discharge relate to the victim, and when these cease
- The victim's entitlement to make representations on the need for a CTO and allowing representation concerning the conditions attached to the CTO
- Any conditions on the CTO relating to the victim or their family, and any variation of the conditions
- When the CTO ceases

Responsible Clinicians will perform this role on behalf of the hospital managers.

6.19. Discharge from MHA detention and CTO (section 23, MHA)

Hospital Managers have the power to discharge certain patients from detention (sec 23 of the Act) which can only be exercised by three or more members of a Committee formed for that purpose. Although the function is delegated to a Committee of three or more lay members, the Health Board remains responsible for this statutory function. A panel of three or more members drawn from the Hospital Managers Power of Discharge Sub-Committee (a Sub-Committee of the Mental Health Legislation Assurance Committee) hear individual cases where patients or their nearest relative have applied for discharge. The panels also sit on renewal hearings; these are collectively known as hospital managers reviews.

Section 23 of the Act (the power to discharge certain patients from detention) is delegated to three or more members of the Hospital Managers Power of Discharge Sub-Committee and the Responsible Clinician.

6.20. Consent to Treatment

The hospital managers should ensure that robust procedures are in place to notify the approved clinician in charge of the patient's treatment, of the expiry of the three-month rule set by section 58 and Part 4A certificates for community patients, and they should check that action has been taken.

14.2

This is delegated to the Mental Health Act Department on behalf of the hospital managers.

The same reminder system should ensure that patients are asked whether they consent to continued medication.

Responsibility for this task is delegated to the Mental Health Act Department in conjunction with qualified nursing staff and community staff.

If the patient is unwilling to consent or incapable of doing so, the approved clinician in charge of the patient's treatment must ask Healthcare Inspectorate Wales to arrange for a second opinion appointed doctor (SOAD) to visit the patient and review the proposed treatment.

When a second opinion is required, the hospital managers should ensure that the patient, statutory consultees (one of which is neither a doctor nor a nurse), and any other relevant people, are available to consult with the SOAD, and that the statutory documents are in order and readily available for inspection.

Responsibility for this is delegated to the Responsible Clinicians and Mental Health Act Department in conjunction with qualified nursing staff and community staff.

6.21. Emergency Treatment

The Hospital Managers should monitor the giving of 'urgent treatment' under section 62 and 64 of the 1983 Act, and they should ensure that a form is provided for completion by the responsible clinician, or the approved clinician in charge of the patient's treatment, can record details of:

- the proposed treatment
- why it is immediately necessary to give the treatment
- The length of time for which the treatment was or will be given.

The use of section 62 and 64 will be monitored by the Mental Health Act administration team on behalf of the hospital managers.

6.22. Hospital accommodation for children

Section 131A of the Act puts a duty on hospital managers to ensure any children receiving in-patient care for mental disorder in their hospitals are accommodated in an environment which is suitable for their age and in line with their needs. This duty will apply to children admitted informally to hospitals, as well as those detained under the Act.

The admission of children and young people onto psychiatric wards is monitored by the child and adolescent mental health services on behalf of the hospital managers.

7. TRAINING

The health board will provide ongoing training for staff that have a delegated duty under the scheme of delegation. Details of training courses available can be found by contacting the Mental Health Act Department.

8. IMPLEMENTATION

This document will be widely disseminated to staff in Cardiff and Vale University Health Board. It will be published on the organisations intranet sites and referred to during training relevant to the Act.

9. RESPONSIBILITIES

9.1. Chief Executive

The Chief Executive Officer has overarching responsibility for ensuring that Cardiff and Vale University Health Board is compliant with the law in relation to the Mental Health Act.

9.2. Chief Operating Officer

The Chief Operating Officer is the Executive Lead for Mental Health. He has overarching responsibility for ensuring compliance with the contents of this procedure.

9.3 Designated Individuals

The procedure states which individuals are responsible for certain sections of the Mental Health Act under the Scheme of Delegation at Appendix A

10. REVIEW

This Procedure will be reviewed following any changes in legislation to the Mental Health Act, 1983.

11. REFERENCES

All staff will work within the Mental Health Act 1983 and in accordance with the Code of Practice for Wales 2007, Mental Capacity Act 2005, and Human Rights Act 1998.

Mental Health Act 1983 - www.legislation.gov.uk/ukpga/1983/20/contents
Mental Capacity Act 2005 - www.legislation.gov.uk/ukpga/2005/9/schedule/7
Mental Health Review Tribunal for Wales - www.justice.gov.uk/tribunals/mental-health
Human Rights Act 1998 - www.legislation.gov.uk/ukpga/1998/42/contents

12. APPENDICES

Hospital Managers' Scheme of Delegation.

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APPENDIX A: Hospital Managers' Scheme of Delegation

The arrangements for authorising decisions should be set out in a scheme of delegation approved by the resolution of the body itself. (Code of Practice for Wales, chapter 37.8)

Page	Legislative Reference	Function	Delegated to
6	Section 15	Receipt, scrutiny and recording of documentation	MHA Administration Team, Shift Coordinator, Night Site Manager
7	Section 5	Report on hospital in-patient	MHA Administration Team, Shift Coordinator, Night Site Manager
7	Section 4	Emergency admission (Monitoring)	MHA Administration Team, Shift Coordinator, Night Site Manager
7	Code of Practice for Wales - Chapter 36	Allocation of Responsible Clinician	Clinical Director, Integrated Team Manager
8	Section 19	Transfer between hospitals	MHA Administration Team, Shift Coordinator, Night Site Manager, Responsible Clinician
8	Section 7	Transfers into/from guardianship	MHA Administration Team, Shift Coordinator, Night Site Manager
8	Section 19A	Transfer and assignment of responsibility for CTO patients	MHA Administration Team, Shift Coordinator, Night Site Manager, Responsible Clinician
8	Section 86	Removal and return of patients	MHA Administration Team
9	Section 17E	Recall of CTO patient to hospital	Responsible Clinician, Mental Health Act Administration Team, Shift Coordinator, Night Site Manager
9	132, 132A and 133	Duty to provide Information to patients	MHA Administration Team,Ward Manager, Shift Coordinator, Night Site Manager,

Page	Legislative Reference	Function	Delegated to
			Community Staff, Responsible Clinician
9	Section 134(1)	Correspondence of patients	MHA Administration Team
9	Section 130D	Independent Mental Health Act Advocates – duty to provide information	MHA Administration Team, ward staff, community staff,
10	Section 68	Referral to MHRT for Wales	MHA Administration Team
10	Section 67	Referrals by Welsh Ministers to MHRT	MHA Administration Team
10	Section 20 and 20A	Renewal of authority to detain	MHA Administration Team
11	Section 25	Report barring discharge by nearest relative	MHA Administration Team, Ward Manager, Responsible Clinician
11	Domestic Violence, Crime & Victims Act 2004	Victims Right to be informed of discharge and conditions attached to that discharge	Responsible Clinician
11	Section 23	Discharge from MHA detention or CTO	Responsible Clinician Hospital Managers - who have the power to discharge certain patients from detention which can only be exercised by three or more members of a Committee formed for that purpose. The UHB Board remains responsible for this statutory function.
11	Part IV and Part IVA Section 58 – Section 63	Consent to Treatment	MHA Administration Team, Nursing Staff, Community Staff, Approved Clinicians and Responsible Clinician
12	Section 62	Emergency Treatment (Monitoring)	MHA Administration Team, Responsible Clinician
12	Section 131A	Hospital accommodation for children and young people (Monitoring)	MHA Administration Team, CAMHS

APPROVAL OF SECTION 5(2) DOCTORS HOLDING POWER POLICY AND PROCEDURE
Name of Meeting: Mental Health and Capacity Legislation Committee **Date of Meeting:** 26 June 2018

Executive Lead : Chief Operating Officer
Author : Mental Health Act Manager, sunni.webb@wales.nhs.uk
Caring for People, Keeping People Well: This report underpins the Health Board's "Sustainability" and "Values" elements of the Health Board's Strategy.
Financial impact : None
Quality, Safety, Patient Experience impact: Patients subject to the Mental Health Act must be treated only in compliance with the legal framework.
Health and Care Standard Number: 3 (Effective Care), 4 (Dignified Care), 6 (Individual Care)
CRAF Reference Number: 8.1.2
Equality and Health Impact Assessment Completed: Yes

ASSURANCE/RECOMMENDATION

ASSURANCE is provided by:

- All Wales MHAA Policy Group
- Mental Health Policy Group
- Mental Health Quality and Safety Sub Committee
- Internet consultation

The Mental Health and Capacity Legislation Committee is asked to:

- **APPROVE** the Section 5(2) Doctors Holding Power Policy and Procedure

and

- **APPROVE** the full publication of the Section 5(2) Doctors Holding Power Policy and procedure in accordance with the UHB Publication Scheme

14.3

SITUATION

It is essential that compliance with the legal requirements of the Mental Health Act 1983 and the Mental Health Act 1983 Code of Practice for Wales, Revised 2016 are monitored. Local Health Boards and Local Authorities should have agreed governance processes for ensuring the appropriate policies and procedures in place are regularly reviewed. A non exhaustive list of relevant

policies required are detailed in the Mental Health Act 1983 Code of Practice for Wales, Revised 2016.

The Section 5(2) Doctors Holding Power Policy sets out the requirements for provision of the doctors holding power under section 5(2) of the Mental Health Act 1983 (as amended by the MHA 2007) to the practitioners and agencies involved in the management of patients subject to a doctors holding power**.**

BACKGROUND

There is currently no policy to ensure statutory requirements under the Mental Health Act 1983 are met

This document provides clear guidance which will be easily accessible on our internet/intranet sites to particular individuals including registered medical practitioners (‘doctors’), approved clinicians, managers and staff of hospitals in relation to their legal responsibilities under the Mental Health Act 1983 as amended by the MHA 2007.

ASSESSMENT

Wide consultation has taken place to ensure that the policy and procedure meets the needs of our stakeholder and the Health Board. The consultation undertaken specific to this document was as follows:-

- The document was added to the Policy Consultation pages on the intranet between 06 November 2017 and 01 December 2017;
- The document was shared with the Mental Health Policy Group, Adult Directorate Medics, Cardiff Local Authority, Vale of Glamorgan Local Authority, the Mental Health Clinical Board Quality and Safety Sub Committee and the All Wales Mental Health Act Administrators Policy Group;
- Comments were invited via individual e-mails from the Mental Health Policy Group, the Equality Manager, the Principal Health Promotion Specialist

Where appropriate comments were taken on board and incorporated within the document.

The primary source for dissemination of this document the Section 5(2) Doctors Holding Power Policy within the UHB will be via the intranet and clinical portal. It will also be made available to the wider community and our partners via the UHB internet site.

Reference Number: *TBA* **Version Number:** 1	**Date of Next Review:** *To be included when document approved* **Previous Trust/LHB Reference Number:**

Section 5(2) Doctors' Holding Power Policy
Mental Health Act, 1983

Policy Statement

To ensure the Health Board delivers its aims, objectives, responsibilities and legal requirements transparently and consistently, we will ensure staff are aware of their individual and collective responsibilities when considering use of the doctors' holding power under section 5(2).

Section 5(2) allows a doctor to detain an inpatient for a maximum period of up to 72 hours in order for assessment under the Mental Health Act.

Practitioners will have due regard to the Mental Health Act Code of Practice generally and specifically to the Guiding Principles when they are considering the use of Section 5(2). This will ensure that considerations are given as to whether the objectives can be met in a less restrictive way.

The Responsible Clinician must be fully aware of the diverse needs of the patient when considering use of section 5(2) and must take them in to account at all times. They must ensure the patient fully understands what is happening to them in a language and format which they are able to understand, this will include sensory and cognitive abilities and physical impairment. Where necessary, an interpreter should be obtained.

Policy Commitment

To set out the requirements for provision of the doctors' holding power under section 5(2) of the Mental Health Act 1983 (as amended by the MHA 2007) to the practitioners and agencies involved in the management of patients subject to a doctors' holding power**.**

We will ensure statutory requirements under the Mental Health Act 1983 are met by providing clear direction and guidance which will be easily accessible on our internet/intranet sites to particular individuals including registered medical practitioners ('doctors'), approved clinicians, managers and staff of hospitals in relation to their legal responsibilities under the Mental Health Act 1983 (as amended by the MHA 2007).

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Supporting Procedures and Written Control Documents

This Policy and the Section 5(2) Doctors' Holding Power Procedure describe the following with regard to the use of a doctors' holding power:

- The purpose of a doctors' holding power
- The process for assessing the suitability for the use of a doctors' holding power
- The duties of the practitioners and agencies involved in the management of patients subject to a doctors' holding power

Other supporting documents are:

- The Mental Health Act 1983 (as amended by the Mental Health Act 2007)
- Mental Health (hospital, guardianship, community treatment and consent to treatment)(Wales) regulations 2008
- The Mental Capacity Act 2005 (including the Deprivation of Liberty Safeguards delegated to this Act under the Mental Health Act 2007)
- The respective Codes of Practice of the above Acts of Parliament
- The Human Rights Act 1998 (and the European Convention on Human Rights)
- Domestic Violence, Crime and Victims Act, 2004

Scope

This policy applies to all of our staff in any inpatient setting where a person is receiving inpatient treatment in hospital and is not already liable to be detained or who is subject to a community treatment order (CTO).

Patients who are in hospital by virtue of a deprivation of liberty authorisation under the Mental Capacity Act 2005 (MCA) may be detained under section 5(2). It does not matter whether the patient was originally admitted for treatment primarily for either a mental disorder or a physical condition.

Equality and Health Impact Assessment	There is potential for both positive and negative impact. The procedure is aimed at improving services and meeting diverse needs. Mitigation actions are already in place to offset any potential negative outcome, e.g. through the monitoring of the procedure. There is nothing, at this time, to stop the procedure from being implemented.

14.3

Policy Approved by	Pending - Mental Health and Capacity Legislation Committee
Group with authority to approve procedures written to explain how this policy will be	Mental Health and Capacity Legislation Committee

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implemented	
Accountable Executive or Clinical Board Director	Mental Health Clinical Board Director of Operations

Disclaimer

If the review date of this document has passed please ensure that the version you are using is the most up to date either by contacting the document author or the Governance Directorate.

Summary of reviews/amendments

Version Number	Date Review Approved	Date Published	Summary of Amendments
1	Date approved by Board/Committee/Sub Committee dd/mm/yyyy	TBA *[To be inserted by the Gov. Dept]*	*New document*
2			

14.3

Equality & Health Impact Assessment for

SECTION 5(2) DOCTORS' HOLDING POWER POLICY

1.	For service change, provide the title of the Project Outline Document or Business Case and Reference Number	SECTION 5(2) DOCTORS' HOLDING POWER POLICY
2.	Name of Clinical Board / Corporate Directorate and title of lead member of staff, including contact details	Mental Health Clinical Board Sunni Webb, Mental Health Act Manager 029 21824745 Sunni.webb@wales.nhs.uk
3.	Objectives of strategy/ policy/ plan/ procedure/ service	The aim of this policy is to ensure doctors' are aware of their individual and collective responsibilities when considering implementing holding powers. Provide clear guidance to staff in relation to their legal responsibilities under the Mental Health Act 1983 as amended by the MHA 2007. Ensure that statutory requirements under the Mental Health Act 1983 are met. Practitioners should have due regard to the Mental Health Act Code of Practice generally and specifically to the Guiding Principles when they are considering the use of Doctors' holding powers. This would ensure that considerations are given as to whether the objectives can be met in

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		a less restrictive way.
4.	Evidence and background information considered. For example • population data • staff and service users data, as applicable • needs assessment • engagement and involvement findings • research • good practice guidelines • participant knowledge • list of stakeholders and how stakeholders have engaged in the development stages • comments from those involved in the designing and development stages Population pyramids are available from Public Health Wales Observatory[1] and the UHB's 'Shaping Our Future Wellbeing' Strategy provides an overview of health need[2].	**Related policies/information -** Mental Health Act 1983, Code of Practice for Wales (Revised 2016), Welsh Language Act 2016, Mental Health Wales Measure 2010, Deprivation of Liberty Safeguards, Equality Act 2010 **Stakeholders -** Service Users, Nursing Staff, Responsible Clinicians, Approved Clinicians, Mental Health Act Administrators, Approved Mental Health Professionals, Qualified nursing staff and other professionals working within mental health services. **Age -** 20 per cent of children have a mental health problem in any given year, and about 10 per cent at any one time. A quarter of older people in the community have symptoms of depression that require an intervention, and this increases to 40 per cent of care home residents (Mind "Our Communities, Our Mental Health) Older people (aged 60 and above) are more vulnerable to mental health problems, depression is a common disorder amongst this population and it has been estimated that 7% of older people suffer with uni-polar depression (World Health Organisation, 2016). Further Older people are more likely to experience a combination of physical and mental health issues (WHO, 2016). Younger adults are susceptible to mental health issues, with 6.2% of 16-24 year olds attempting suicide in their lifetime and 16.4% experiencing neurotic symptoms (Young Minds, 2016). Further, student

[1] http://nww2.nphs.wales.nhs.uk:8080/PubHObservatoryProjDocs.nsf
[2] http://www.cardiffandvaleuhb.wales.nhs.uk/the-challenges-we-face

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		populations are disproportionately affected by mental health issues, with an estimated 1 in 4 reporting mental health problems. Poor mental health amongst young people can lead to reduced life chances and impact on their education, social participation and ability to find and sustain employment. Results of Welsh Health Survey 2015 – reported in Mental Health Foundation Fundamental Facts 2016:- Results from the 2015 survey found that 13% of adults (aged 16 and older) living in Wales were reported to have received treatment for a mental health problem, an increase from 12% reported in 2014. Unlike other illnesses, the percentage who reported being treated for mental ill health did not increase with age, however trends suggest that an increase in treatment towards middle age before decreasing in retirement age. These rates have not significantly changed since the 2014 health survey. The total number of CAMHS referrals to treatment in Wales doubled between April 2010 (1,204) and July 2014 (2,342). Young people awaiting outpatient's treatment has the highest numbers (2,410) compared to adults (1,291) and those in later life. The Mental Health Act relates to all patients suffering from a mental disorder who meet the criteria for detention, irrespective of age. **Disability -** Physical illness more than doubles the risk of depression, and between 30 per cent and 50 per cent of adults with learning disability in the UK have mental health problems. (Mind "Our Communities, Our Mental Health)

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		Sensory loss: Sensory loss currently affects 1 in 5 people in Wales, with 1 in 6 people affected by hearing loss and an estimated 115,000 people living with sight loss which has a significant impact on their daily lives (Sensory Loss in the Adult population in Wales, 2012). Those affected by sensory loss are more susceptible to the development of mental health issues, especially older people. Older people with sight loss are three times more likely to experience depression than people with good vision (Depression and Anxiety in Visually Impaired Older People, 2007) with the British Medical Journal reporting that sight loss is one of the top three causes of suicide among older people The proposed policy will apply to all patients detained regardless of disability, as the policy is reference to the scrutiny of the documents completed by staff rather than the processes. All documents will have been completed in conjunction with consideration of the Mental Health Act, Mental Capacity Act, DoLS and the Mental Health Wales Measure. **Gender -** There are clear differences in the way women and men experience mental health problems. Women are more likely to report common mental health problems. Girls are also more likely than boys to self-harm, and eating disorders are more common in young women compared to young men. Men are more likely to have undiagnosed depression, be detained under the Mental Health Act and take their own life compared to women. (Mind, “Our Communities, Our Mental Health”) Results of Welsh Health Survey 2015 – reported in Mental Health Foundation Fundamental Facts 2016:- A higher percentage of women report being treated for a mental health problem than men (16% vs 10%). Treatment figures show an increase

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		of 1% for both men and women from 2014 statistics. Health (and social care) services have a duty to treat people fairly and equally. However, the Stonewall **Unhealthy Attitudes 2015** report highlights some major gaps in the knowledge and training of staff relating to lesbian, gay, bisexual and trans (LGBT) people, which is resulting in unfair treatment of both LGBT patients and colleagues. Gay and Bisexual Men's Health Survey With 6,861 respondents from across Britain, the 2013 report is the largest survey ever conducted of gay and bisexual men's health needs in the world. However, it demonstrates that many of those needs are not being met and that there are areas of significant concern – most particularly in mental health and drug use – that have been overlooked by health services which too often focus solely on gay men's sexual health. This report also provides hard evidence that gay and bisexual men nationwide are more likely to attempt suicide, self-harm and have depression than their straight peers. This policy will apply regardless of gender. **Gender Reassignment -** Trans people are at increased risk of depression and self-harm, and a third of trans people have attempted to take their own life.(Mind, "Our Communities, Our Mental Health") This policy will apply regardless of whether patients have transitioned or not. Health (and social care) services have a duty to treat people fairly and equally. However, the Stonewall **Unhealthy Attitudes 2015** report

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		highlights some major gaps in the knowledge and training of staff relating to lesbian, gay, bisexual and trans (LGBT) people, which is resulting in unfair treatment of both LGBT patients and colleagues. The NHS Centre for Equality and Human Rights (CEHR) has published a new guide for all staff in NHS Wales. *"It's Just Good Care – A guide for health staff caring for people who are trans*"* aims to help health staff provide trans* people with the respectful and appropriate care they are entitled to. The document is available for downloading from the staff intranet. Also available on the intranet is a Top Tips for Making your Service Inclusive and Welcoming for Trans People **Human Rights -** The proposed policy promotes human rights in ensuring that all patients are detained lawfully. **Pregnancy and Maternity -** Mental health problems affect between 10 and 20 per cent of women at some point during the perinatal period (pregnancy and one year after birth). Poor maternal health can also increase the risk of mental health in children. Within the Mind report the following issues are also identified as contributory risk factors:- Trauma and stressful events, poverty, unemployment and housing insecurity, social isolation and loneliness, discrimination and inequality. (Mind, "Our Communities, Our Mental Health") Results of Welsh Health Survey 2015 – reported in Mental Health Foundation Fundamental Facts 2016 Mental health problems affect more than 1 in 10 women during pregnancy and the first year after childbirth, and can have a devastating impact on new mothers and their families. According to a 2014 report

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		from the London School of Economics and the Centre for Mental Health, in the UK, 20% of women are affected by mental health problems during the perinatal period. In Wales, 70% of people have no access to specialist perinatal mental health services; a figure significantly higher than the UK average of 40%. According to NHS Choices website If you have had in the past, or now have, severe mental health problems, you are more likely to become ill during pregnancy or in the first year after giving birth than at other times in your life. Severe mental health problems include bipolar affective disorder, severe depression and psychosis. After giving birth, severe mental illness may progress more quickly and be more serious than at other times. This policy will apply regardless of whether patients are pregnant at the time of being detained. In relation to staff there are no changes to be made in relation to applying holding powers. Wards will have completed risk assessments in relation to staff. **Race/ Ethnicity or nationality –** A disproportionate number of people admitted as inpatients in mental health services come from BAME groups. In 2010, 23 per cent of inpatient admissions were from a BAME background. According to the mental health organisation ‘Mind’, the admission rate for ‘other black’ groups is six times higher than average, suggesting discrimination within the mental health system. Black African and Caribbean people living in the UK have lower reported rates of common mental health problems compared to other ethnic groups, however they are more likely to be diagnosed with

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		severe mental health problems. Black African and Caribbean people are also much more likely to be detained under the Mental Health Act compared to other ethnic groups. According to Black Mental Health UK, people of African or Caribbean descent are 50 per cent more likely to be referred to mental health services via the police than their white counterparts.Young women from ethnic minorities are much more likely to take their own life than White British women. (Mind, “Our Communities, Our Mental Health”) The proposed policy will apply regardless of the race / ethnicity of patients or staff. Health inequalities are further linked to unequal access to healthcare. Some BAME groups face considerable barriers to healthcare. In 2009 the Department for Communities and Local Government noted that Gypsies and Travellers face particular difficulties accessing healthcare. Many of them felt that health workers and doctors’ misunderstood their needs and circumstances. Additionally, Gypsy and Traveller access to healthcare can also difficult if there is an inability to provide proof of identity. The West Midlands Strategic Health Partnership noted, in 2010, that migrant populations faced significant barriers accessing healthcare including difficulties that were related to registering, contracting and commissioning processes as well as a lack of knowledge about services available. Other common difficulties included poor continuity of care and the experience of not having the same doctor in the practice.

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		A Cultural Competency Toolkit, was developed by Diverse Cymru, with assistance from UHB staff. Its aim is to help staff better interact with clients with mental ill health who are from different cultures A proportion of patients first language may not be English or Welsh. The statutory documents in relation to the Mental Health Act are provided by Welsh Government are only available in English and Welsh. Within the explanation of rights this now details if the information has been given in the patients preferred language and will be reported on. Access to an interpreter is available and translation of written information can be obtained as and when required. **Religion or Belief -** Spiritual awareness, practices and beliefs (of any religion or for those engaging in spiritual practices without a particular faith) is associated with psychological benefits, including subjective wellbeing (Mind, Our Communities, Our Mental Health”). There are religious beliefs and practices that have been shown, across all the cultures studied, to have some salutary effects on well-being. Other ways in which culture may impact on the relations between religion and well-being have been less consistently documented. The recent growth of interest in positive psychology, and in the relations between religion and spirituality, and maturity, morality and virtue has not yet incorporated a marked focus on cultural issues. Religious beliefs and practices supported in one culture may appear disturbed to people (including mental health professionals) from another, affecting diagnosis and treatment. Many commonly held ideas about the role of religion in

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		shame, guilt and anxiety (including obsessive-compulsive disorder), voices, visions and spirit possession require closer examination in the light of evidence from different cultural groups. Clinical practitioners are keen to reach a better understanding of the roles played by religious factors in different cultures, in affecting mental health. The proposed policy will apply regardless of the religion or belief of patients or staff. **Sexual Orientation -** Lesbian, gay and bisexual people are at increased risk of mental health problems, including self-harm and attempted suicide. Lesbian, gay and bisexual people have a 1.5 fold increased risk of depression and anxiety. (Mind “Our Communities, Our Mental Health”). Health (and social care) services have a duty to treat people fairly and equally. However, the Stonewall **Unhealthy Attitudes 2015** report highlights some major gaps in the knowledge and training of staff relating to lesbian, gay, bisexual and trans (LGBT) people, which is resulting in unfair treatment of both LGBT patients and colleagues. Gay and Bisexual Men’s Health Survey. With 6,861 respondents from across Britain, the 2013 report is the largest survey ever conducted of gay and bisexual men’s health needs in the world. However, it demonstrates that many of those needs are not being met and that there are areas of significant concern – most particularly in mental health and drug use – that have been overlooked by health services which too often focus solely on gay men’s sexual health. This report also provides hard evidence that gay and bisexual men

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		nationwide are more likely to attempt suicide, self-harm and have depression than their straight peers. The proposed policy will apply regardless of the sexual orientation of the patients or staff. **Welsh Language -** No evidence of disproportional representation to date, but a proportion of service users may be Welsh speakers **Welsh Language and its use in Cardiff & Vale of Glamorgan** The latest census statistics available indicate that 16% of the population of Cardiff have one or more skills in the Welsh Language (ability to read, write or/and understand Welsh). 32,000 or 11% of Cardiff's population are fluent Welsh speakers. 24.5% are within the 3-15 age group, and 12.1% within the 16-24 age groups. When the results of previous Censuses are consulted, a significant increase in the incidence of Welsh speakers amongst the youngest age groups is noticed. For the 5-15 year age group, the proportion of Cardiff's residents able to speak Welsh has increased from 6.8% in 1971 to 7.5% in 1981 and 12.7% in 1991. By 2001 this figure had increased to 24.5%. In the Vale of Glamorgan 13,189 of 122,018 people, which is 10.8% of the population, are fluent Welsh speakers. As the statutory documents in relation to the Mental Health Act are provided by Welsh Government these are in English on the Website. Information leaflets for the patients are available in both English and Welsh. Within the explanation of rights this now details if the information has been given in the patients preferred language and will

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		be reported on. Welsh Language Act is a consideration. **The impact of mental ill health on employment rates** A national household survey in Great Britain conducted in 2000 found that 57% of people who have a common mental disorder are working, compared with 69% of people who do not have a common mental disorder. Just 9% of people with a probable psychotic disorder, which includes most people with a severe mental disorder, are working fulltime and a further 19% part-time (Meltzer et al., 2002)8. An earlier survey reported that 70% of those with a common mental disorder, who are unemployed and seeking work, have been unemployed for a year or more (that is 7% of all people with a common mental disorder) and are unlikely to return to work (Meltzer et al., 1995). Those who have a common mental disorder are four to five times more likely than those who have not to be permanently unable to work and three times more likely to be receiving benefits payments (Meltzer et al., 1995 and 2002). Between 30% and 50% of people with schizophrenia are capable of work but only between 10% and 20% are in employment (Marwaha and Johnson, 2004; Schneider, 1998). Although some are in managerial or senior official positions, most are in 'elementary' jobs, for example cleaning and labouring, or are in skilled trade occupations such as plumbing or metal work. The rate of employment in people with schizophrenia seems to have fallen from before 1990 when surveys reported that between 20% and 30% were in work. Several studies conducted at two time points seem to confirm this reduction (e.g. Rinaldi and Perkins, 2007). The reason for this is unknown but one factor might be a reduction in the number of sheltered employment schemes. For those who present to services for the first time, the likelihood of being in employment falls markedly over the subsequent year or two (Birchwood

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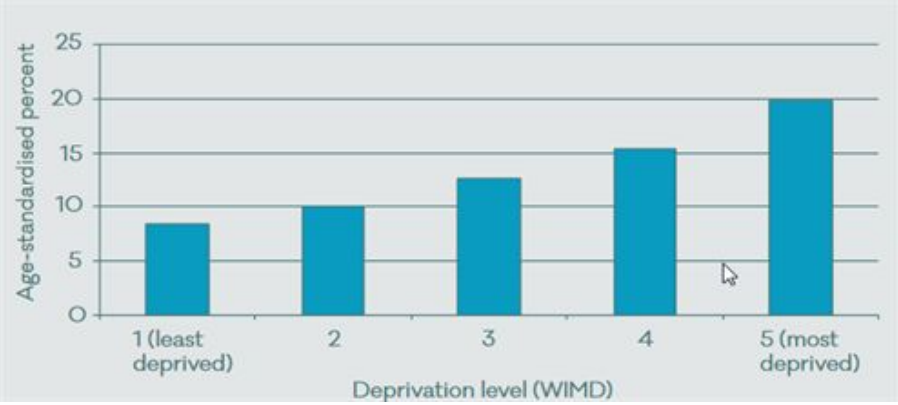
et al., 1992; Johnstone et al., 1986). For people with Schizophrenia, premorbid social and occupational history are associated with employment and some types of psychotic symptoms and the presence of negative symptoms are associated with unemployment. The desire to have a job is one of the best predictors of future employment (Marwaha and Jonhson, 2004).

People according to where they live



Findings from the 2015 survey found, that there was poorer mental health in more deprived areas. The percentage of adults that reported currently being treated for any mental health condition by area deprivation showed 8 per cent in the least deprived fifth in receipt of mental health treatment which rose steadily with higher levels of deprivation to 20 per cent in the most deprived fifth.

There is a wealth of evidence that mental health influences a very wide

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		range of outcomes for individuals and communities. These include healthier lifestyles; better physical health; improved recovery from illness; fewer limitations in daily living; higher educational attainment; greater productivity, employment and earnings; better relationships with adults and with children; more social cohesion and engagement and improved quality of life. These outcomes are not just or necessarily a consequence of the absence of mental illness, but are associated with the presence of positive mental health, sometimes referred to as 'wellbeing'. Improving mental health is a worthwhile goal in itself: most people value a sense of emotional and social wellbeing; in addition, good mental health has many other far reaching benefits. Mental health is a fundamental element of the resilience, health assets, capabilities and positive adaptation that enable people both to cope with adversity and to reach their full potential and humanity. Mental health is also the key to understanding the impact of inequalities on health and other outcomes. It is abundantly clear that the chronic stress of struggling with material disadvantage is intensified to a very considerable degree by doing so in more unequal societies. An extensive body of research confirms the relationship between inequality and poorer outcomes, a relationship which is evident at every position on the social hierarchy and is not confined to developed nations. The emotional and cognitive effects of high levels of social status differentiation are profound and far reaching: greater inequality heightens status competition and status insecurity across all income groups and among both adults and children. It is the *distribution* of economic and social resources that explains health and other outcomes in the vast majority of studies. The importance of the social and psychological dimensions of material deprivation is gaining greater recognition in the international literature on poverty and informs current

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		efforts to develop indicators that capture the missing dimensions of poverty. Both health-damaging behaviours and violence, for example, may be survival strategies in the face of multiple problems, anger and despair related to occupational insecurity, poverty, debt, poor housing, exclusion and other indicators of low status. These problems impact on intimate relationships, the care of children and care of the self. In the United Kingdom, the 20% - 25% of people who are obese or continue to smoke are concentrated among the 26% of the population living in poverty, measured in terms of low income and multiple deprivation of necessities. This is also the population with the highest prevalence of anxiety and depression. It is already well established that mental illness, across the spectrum of disorders, is both a direct cause of mortality and morbidity and a significant risk factor for poorer economic, health and social outcomes, although these adverse outcomes vary by type of disorder and socioeconomic status (WHO 2005; 2006).[3] However, it is now becoming clear that the presence or absence of positive mental health or 'wellbeing' *also* influences outcomes across a wide range of domains. These include healthier lifestyles, better physical health, improved recovery, fewer limitations in daily living, higher educational attainment, greater productivity, employment and earnings, better relationships, greater social cohesion and engagement and improved quality of life (WHO 2004b; Barry and Jenkins 2007; Jane-Llopis et al 2004). This policy will apply regardless of where a person lives. (From:

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		http://www.euro.who.int/__data/assets/pdf_file/0012/100821/E92227.pdf **Homeless** Affordable and safe accommodation brings stability and security; provides a gateway to access health services like GPs; enhances social and community inclusion; and provides the basis for the right to private and family life. Put simply, a home is vital for good mental and physical health, allowing people to live in safety, security, peace and dignity. Whilst there is no such 'right to housing' in itself, the right to an adequate standard of living, including housing, is recognised in the UN Covenant on Economic, Social and Cultural Rights. Of course, there are numerous factors which can cause people to become homeless, many of which are beyond individual control, such as lack of affordable housing, disability and poverty. But what really needs to be highlighted is the two-way relationship between homelessness and mental health. Homelessness and mental health often go hand in hand, and can be a self-fulfilling prophecy. Having a mental health problem can create the circumstances which can cause a person to become homeless in the first place. Yet poor housing or homelessness can also increase the chances of developing a mental health problem, or exacerbate an existing condition. In turn, this can make it even harder for that person to recover – to develop good mental health, to secure stable housing, to find and maintain a job, to stay physically healthy and to maintain

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		relationships. It is a fundamental fact that single homeless people are much more likely to have mental health problems compared to the general population. In 2015, 32% of single homeless people reported a mental health problem, and depression rates, for example, are over 10 times higher in the homeless population. Unfortunately, other psychological issues such as complex trauma, substance misuse and social exclusion are also common This policy will apply regardless of where a person lives. **Asylum Seekers** Some asylum seekers will have been subjected to torture, as well as witnessing the consequences of societal breakdown of their home country – with consequences for their mental health. Culturally, mental illness may not be expressed or may manifest as physical Complaints. Stigma may also be attached to mental ill-health. Furthermore, Western psychological concepts are not universally applicable to asylum seekers. Mental health problems such as depression and anxiety are common, but post-traumatic stress disorder is greatly underestimated and under diagnosed and may be contested by healthcare professionals. Children are particularly neglected in this area. A shortage of mental health services for asylum seekers has been recognised. http://www.fph.org.uk/uploads/bs_aslym_seeker_health.pdf **Prisoners** 10% of men and 30% of women have had a previous psychiatric admission before they entered prison. A more recent study found that

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		25% of women and 15% of men in prison reported symptoms indicative of psychosis. The rate among the general public is about 4%. 26% of women and 16% of men said they had received treatment for a mental health problem in the year before custody. Personality disorders are particularly prevalent among people in prison. 62% of male and 57% of female sentenced prisoners have a personality disorder. 49% of women and 23% of male prisoners in a Ministry of Justice study were assessed as suffering from anxiety and depression. 16% of the general UK population (12% of men and 19% of women) are estimated to be suffering from different types of anxiety and depression. 46% of women prisoners reported having attempted suicide at some point in their lives. This is more than twice the rate of male prisoners (21%) and higher than in the general UK population amongst whom around 6% report having ever attempted suicide. http://www.prisonreformtrust.org.uk/ProjectsResearch/Mentalhealth **Information in relation to multiple protected characteristics -** Mental health issues can affect anyone among the population at any stage of life. However, national statistics show that that there are higher incidences of mental health issues among certain protected groups. Mind's report "Our Communities, Our Mental Health" identified the following contributory risk factors:-

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		Trauma and stressful events, poverty, unemployment and housing insecurity, social isolation and loneliness, discrimination and inequality. These risk factors may be present in any protected group.
5.	Who will be affected by the strategy/ policy/ plan/ procedure/ service	Mental health issues affect the whole population, though some protected groups are disproportionately represented among service users**.** The policy addresses administrative issues and responsibilities in relation to the direct care and treatment of patients. The section 5(2) policy applies to informal inpatients. Hospital managers must ensure that those acting on their behalf are competent to do so and receive suitable training to ensure they exercise their functions appropriately to ensure the functions are carried out on a day to day basis.

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6. EQIA / How will the strategy, policy, plan, procedure and/or service impact on people?

Questions in this section relate to the impact on people on the basis of their 'protected characteristics'. Specific alignment with the 7 goals of the Well-being of Future Generations (Wales) Act 2015 is included against the relevant sections.

How will the strategy, policy, plan, procedure and/or service impact on:-	**Potential positive and/or negative impacts**	**Recommendations for improvement/ mitigation**	**Action taken by Clinical Board / Corporate Directorate.** Make reference to where the mitigation is included in the document, as appropriate
6.1 Age For most purposes, the main categories are: • under 18; • between 18 and 65; and • over 65	There is potential for a positive impact in that there is an awareness of this protected characteristic.	N/A	Under Policy Statement
6.2 Persons with a disability as defined in the Equality Act 2010 Those with physical impairments, learning disability, sensory loss or impairment, mental health conditions, long-term medical conditions such as diabetes	Disabled people with enduring mental health problems of all types are much less likely to be economically active than those with physical or sensory impairments. There is potential for a positive impact in that there is an awareness of this protected	A key duty is that the Doctor must be fully aware of the diverse needs of the patient when considering detention and must take them in to account at all times. They must ensure the patient fully	Under Policy Statement

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How will the strategy, policy, plan, procedure and/or service impact on:-	**Potential positive and/or negative impacts**	**Recommendations for improvement/ mitigation**	**Action taken by Clinical Board / Corporate Directorate.** Make reference to where the mitigation is included in the document, as appropriate
	characteristic and staff have to take into account the diverse needs of the individual patient.	understands what is happening to them in a language and format which they are able to understand, this will include sensory and cognitive abilities and physical impairment. Where necessary, an interpreter should be obtained.	
6.3 People of different genders: Consider men, women, people undergoing gender reassignment **NB** Gender-reassignment is anyone who proposes to, starts, is going through or	There is potential for a positive impact in that there is an awareness of this protected characteristic and staff have to take into account the diverse needs of the individual patient.	*"It's Just Good Care – A guide for health staff caring for people who are trans*" is made available to staff*	Under Policy Statement

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How will the strategy, policy, plan, procedure and/or service impact on:-	**Potential positive and/or negative impacts**	**Recommendations for improvement/ mitigation**	**Action taken by Clinical Board / Corporate Directorate.** Make reference to where the mitigation is included in the document, as appropriate
who has completed a process to change his or her gender with or without going through any medical procedures. Sometimes referred to as Trans or Transgender			
6.4 People who are married or who have a civil partner.	We are aware of potential negative impact in terms of the LGBT+ communities and access to health care services as noted elsewhere within the EHIA.	*"It's Just Good Care – A guide for health staff caring for people who are trans*" is made available to staff.*	Under Policy Statement
6.5 Women who are expecting a baby, who are on a break from work after having a baby, or who are breastfeeding. They are protected for 26 weeks after having a baby whether or not	No impact anticipated. However staff have to take into account the diverse needs of the individual patient.	N/A	Under Policy Statement

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How will the strategy, policy, plan, procedure and/or service impact on:-	**Potential positive and/or negative impacts**	**Recommendations for improvement/ mitigation**	**Action taken by Clinical Board / Corporate Directorate.** Make reference to where the mitigation is included in the document, as appropriate
they are on maternity leave.			
6.6 People of a different race, nationality, colour, culture or ethnic origin including non-English speakers, gypsies/travellers, migrant workers	There is a potential for a negative impact as there is a lot of well documented evidence to suggest that. However staff have to take into account the diverse needs of the individual patient.	A key duty is that the Doctor must be fully aware of the diverse needs of the patient when considering detention and must take them in to account at all times. They must ensure the patient fully understands what is happening to them in a language and format which they are able to understand, this will include sensory and cognitive abilities and physical impairment. Where necessary, an	Under Policy Statement A Cultural Competency Toolkit, was developed by Diverse Cymru, with assistance from UHB staff. Its aim is to help staff better interact with clients with mental ill health who are from different cultures.

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How will the strategy, policy, plan, procedure and/or service impact on:-	**Potential positive and/or negative impacts**	**Recommendations for improvement/ mitigation**	**Action taken by Clinical Board / Corporate Directorate.** Make reference to where the mitigation is included in the document, as appropriate
		interpreter should be obtained.	
6.7 People with a religion or belief or with no religion or belief. The term 'religion' includes a religious or philosophical belief	There is the potential for impact as suggested by the evidence above. However staff have to take into account the diverse needs of the individual patient. .		A Cultural Competency Toolkit, was developed by Diverse Cymru, with assistance from UHB staff. Its aim is to help staff better interact with clients with mental ill health who are from different cultures.
6.8 People who are attracted to other people of: • the opposite sex (heterosexual); • the same sex (lesbian or gay); • both sexes (bisexual)	We know from evidence that there are potential negative issues in terms of these protected characteristics. However staff have to take into account the diverse needs of the individual	N/A	N/A

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How will the strategy, policy, plan, procedure and/or service impact on:-	**Potential positive and/or negative impacts**	**Recommendations for improvement/ mitigation**	**Action taken by Clinical Board / Corporate Directorate.** Make reference to where the mitigation is included in the document, as appropriate
	patient.		
6.9 People who communicate using the Welsh language in terms of correspondence, information leaflets, or service plans and design Well-being Goal – A Wales of vibrant culture and thriving Welsh language	There is the potential for a negative impact. However staff have to take into account the diverse needs of the individual patient.	A key duty is that the Doctor must be fully aware of the diverse needs of the patient when considering detention and must take them in to account at all times. They must ensure the patient fully understands what is happening to them in a language and format which they are able to understand, this will include sensory and cognitive abilities and physical impairment. Where necessary, an interpreter should be	Under Policy Statement Staff are made aware of the translation and interpretation policy.

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How will the strategy, policy, plan, procedure and/or service impact on:-	**Potential positive and/or negative impacts**	**Recommendations for improvement/ mitigation**	**Action taken by Clinical Board / Corporate Directorate.** Make reference to where the mitigation is included in the document, as appropriate
		obtained.	
6.10 People according to their income related group: Consider people on low income, economically inactive, unemployed/workless, people who are unable to work due to ill-health	There is awareness that mental health problems have a greater impact on people's ability to work than any other group of disorders. However staff have to take into account the diverse needs of the individual patient. Disabled people with enduring mental health problems of all types are much less likely to be economically active than those with physical or sensory impairments.	N/A	Under Policy Statement

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How will the strategy, policy, plan, procedure and/or service impact on:-	**Potential positive and/or negative impacts**	**Recommendations for improvement/ mitigation**	**Action taken by Clinical Board / Corporate Directorate.** Make reference to where the mitigation is included in the document, as appropriate
6.11 People according to where they live: Consider people living in areas known to exhibit poor economic and/or health indicators, people unable to access services and facilities	No impact identified at this time, though it is recognised that there is poorer mental health in more deprived areas. However staff have to take into account the diverse needs of the individual patient.	N/A	Under Policy Statement
6.12 Consider any other groups and risk factors relevant to this strategy, policy, plan, procedure and/or service	Staff will respect the rights and needs of carers alongside the person's right to confidentiality. A Review of the person's consent to share information with family members, carers and other services will take place during the inpatient stay.	A key duty is that the Doctor must be fully aware of the diverse needs of the patient when considering detention and must take them in to account at all times. They must ensure the patient fully understands what is happening to them in a	Under Policy Statement

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How will the strategy, policy, plan, procedure and/or service impact on:-	**Potential positive and/or negative impacts**	**Recommendations for improvement/ mitigation**	**Action taken by Clinical Board / Corporate Directorate.** Make reference to where the mitigation is included in the document, as appropriate
	No impact has been identified at this time in relation to the homeless, asylum seekers and prisoners, though it is recognised that there is sometimes poorer mental health issues due to their circumstances and that there consequences for their mental health. However staff have to take into account the diverse needs of the individual patient.	language and format which they are able to understand, this will include sensory and cognitive abilities and physical impairment. Where necessary, an interpreter should be obtained.	

7. HIA / How will the strategy, policy, plan, procedure and/or service impact on the health and well-being of our population and help address inequalities in health?

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Questions in this section relate to the impact on the overall health of individual people and on the impact on our population. Specific alignment with the 7 goals of the Well-being of Future Generations (Wales) Act 2015 is included against the relevant sections.

How will the strategy, policy, plan, procedure and/or service impact on:-	**Potential positive and/or negative impacts and any particular groups affected**	**Recommendations for improvement/ mitigation**	**Action taken by Clinical Board / Corporate Directorate** Make reference to where the mitigation is included in the document, as appropriate
7.1 People being able to access the service offered: Consider access for those living in areas of deprivation and/or those experiencing health inequalities Well-being Goal - A more equal Wales	No Impact identified at this time, though it is recognised that there is poorer mental health in more deprived areas. However staff have to take into account the diverse needs of the individual patient.	N/A	Under Policy Statement
7.2 People being able to improve /maintain healthy lifestyles: Consider the impact on healthy lifestyles, including healthy eating, being active, no smoking /smoking cessation, reducing the harm caused by alcohol and /or	No impact identified at this time, though it is recognised that healthy lifestyles can have a positive impact on mental health and well-being. Staff have to take into account the diverse needs of the individual patient.	N/A	Under Policy Statement

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How will the strategy, policy, plan, procedure and/or service impact on:-	**Potential positive and/or negative impacts and any particular groups affected**	**Recommendations for improvement/ mitigation**	**Action taken by Clinical Board / Corporate Directorate** Make reference to where the mitigation is included in the document, as appropriate
non-prescribed drugs plus access to services that support disease prevention (e.g. immunisation and vaccination, falls prevention). Also consider impact on access to supportive services including smoking cessation services, weight management services etc Well-being Goal – A healthier Wales			
7.3 People in terms of their income and employment status: Consider the impact on the availability and accessibility of work, paid/ unpaid employment, wage levels, job security, working conditions	No impact identified at this time, though it is recognised that being employed can have a positive impact on mental health and well-being. Staff have to take into account the diverse needs of the individual patient.	N/A	Under Policy Statement

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How will the strategy, policy, plan, procedure and/or service impact on:-	**Potential positive and/or negative impacts and any particular groups affected**	**Recommendations for improvement/ mitigation**	**Action taken by Clinical Board / Corporate Directorate** Make reference to where the mitigation is included in the document, as appropriate
Well-being Goal – A prosperous Wales			
7.4 People in terms of their use of the physical environment: Consider the impact on the availability and accessibility of transport, healthy food, leisure activities, green spaces; of the design of the built environment on the physical and mental health of patients, staff and visitors; on air quality, exposure to pollutants; safety of neighbourhoods, exposure to crime; road safety and preventing injuries/accidents; quality and safety of play areas and open spaces Well-being Goal – A resilient Wales	No impact identified at this time, though it is recognised that environmental issues can have a positive impact on mental health and well-being. Staff have to take into account the diverse needs of the individual patient.	N/A	Under Policy Statement

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How will the strategy, policy, plan, procedure and/or service impact on:-	**Potential positive and/or negative impacts and any particular groups affected**	**Recommendations for improvement/ mitigation**	**Action taken by Clinical Board / Corporate Directorate** Make reference to where the mitigation is included in the document, as appropriate
7.5 People in terms of social and community influences on their health: Consider the impact on family organisation and roles; social support and social networks; neighbourliness and sense of belonging; social isolation; peer pressure; community identity; cultural and spiritual ethos Well-being Goal – A Wales of cohesive communities	No impact identified at this time, though it is recognised that social and community influences and related issues can have a positive impact on mental health and well-being. Staff have to take into account the diverse needs of the individual patient.	N/A	Under Policy Statement
7.6 People in terms of macro-economic, environmental and sustainability factors: Consider the impact of	No impact identified at this time, though it is recognised that macro-economic, environmental and sustainability factors social	N/A	Under Policy Statement

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How will the strategy, policy, plan, procedure and/or service impact on:-	**Potential positive and/or negative impacts and any particular groups affected**	**Recommendations for improvement/ mitigation**	**Action taken by Clinical Board / Corporate Directorate** Make reference to where the mitigation is included in the document, as appropriate
government policies; gross domestic product; economic development; biological diversity; climate Well-being Goal – A globally responsible Wales	and community influences and related issues can have a positive impact on mental health and well-being. Staff have to take into account the diverse needs of the individual patient.		

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Please answer question 8.1 following the completion of the EHIA and complete the action plan

8.1 Please summarise the potential positive and/or negative impacts of the strategy, policy, plan or service	This policy aligns with legislative requirements. All relevant persons are required to comply with this document and must demonstrate sensitivity and competence in relation to the nine protected characteristics as defined by the Equality Act 2010. It will be the responsibility of each person enacting this policy to ensure that it is implemented fairly and equitably, with dignity and respect. A search of similar policies elsewhere indicated a neutral or positive impact in relation to protected groups:- https://www.google.co.uk/search?site=&source=hp&q=doctors'+holding+power+policy+equality+impact+assessment+&oq=doctors'+holding+power+policy+equality+impact+assessment+&gs_l=psyab.12...2021.16849.0.19472.76.52.5.0.0.0.606.9184.0j3j12j5j5j3.28.0....0...1.1.64.psyab..45.28.7940...0j0i10k1j0i131k1j0i22i30k1j0i13k1j0i13i30k1j33i22i29i30k1j33i160k1j33i21k1.0el4ViGQVWM

Action Plan for Mitigation / Improvement and Implementation

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	Action	Lead	Timescale	Action taken by Clinical Board / Corporate Directorate
8.2 What are the key actions identified as a result of completing the EHIA?	To ensure that an interpreter/translation is requested immediately to avoid delay and ensure patients are provided with information in their preferred language in a timely manner.	All appropriate staff	As and When required/requested	Staff will be/are made aware of our Interpretation and Translation policy and its use with service users.
8.3 Is a more comprehensive Equalities Impact Assessment or Health Impact Assessment required? This means thinking about relevance and proportionality to the Equality Act and asking: is the impact significant enough that a more formal and full consultation is required?	Not required	N/A	N/A	No action

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	Action	Lead	Timescale	Action taken by Clinical Board / Corporate Directorate
8.4 What are the next steps? Some suggestions:- • Decide whether the strategy, policy, plan, procedure and/or service proposal: ○ continues unchanged as there are no significant negative impacts ○ adjusts to account for the negative impacts ○ continues despite potential for adverse impact or missed opportunities to advance equality (set out the justifications for doing so) stops. • Have your strategy, policy, plan, procedure and/or service proposal approved • Publish your report of this impact assessment • Monitor and review	No significant negative Impact. The policy will be submitted to the Mental Health and Capacity Legislation Committee for approval. Once the policy has been approved the documentation will be placed on the intranet and internet. The EHIA and Policy will be reviewed three years after approval unless changes to terms and conditions, legislation or best practice determine that an earlier review is required.	N/A	N/A	N/A Hospital managers should monitor the use of section 5(2), including: • How quickly patients are assessed for detention and discharged from the holding power. • The proportion of cases in which applications for detention are, in fact, made following use of section 5(2).

14.3

Reference Number: *TBA* **Version Number:** 1	**Date of Next Review:** *To be included when document approved* **Previous Trust/LHB Reference Number:** *Any reference number this document has been previously known as*

Section 5(2) Doctors' Holding Power Procedure
Mental Health Act, 1983

Introduction and Aim

This document supports the Section 5(2) Doctors' Holding Power Policy, Mental Health Act, 1983.

To ensure staff are aware of their individual and collective responsibilities when considering use of the doctors' holding power under section 5(2).

To Provide clear direction and guidance to staff in relation to their legal responsibilities under the Mental Health Act 1983 as amended by the MHA 2007.

To Ensure that statutory requirements under the Mental Health Act 1983 are met.

Objectives

This Procedure describes the following with regard to a doctors' holding power:

- The purpose of a doctors' holding power
- The process for assessing the suitability for the use of a doctors' holding power
- The duties of the practitioners and agencies involved in the management of patients subject to a doctors' holding power

Practitioners must have due regard to the Mental Health Act Code of Practice generally and specifically to the Guiding Principles when they are considering the use of a doctors' holding power. This will ensure that considerations are given as to whether the objectives can be met in a less restrictive way.

Scope

This procedure applies to all of our staff in any inpatient setting where a person is receiving inpatient treatment in hospital and is not already liable to be detained or who is subject to a community treatment order (CTO).

Patients who are in hospital by virtue of a deprivation of liberty authorisation under the Mental Capacity Act 2005 (MCA) may be detained under section 5(2). It does not matter whether the patient was originally admitted for treatment primarily for either a mental disorder or a physical condition.

Equality and Health Impact Assessment	There is potential for both positive and negative impact. The procedure is aimed at improving services and meeting diverse needs. Mitigation actions are already in place to offset any potential negative

	outcome, e.g. through the monitoring of the procedure. There is nothing, at this time, to stop the procedure being implemented.
Documents to read alongside this Procedure	• The Mental Health Act 1983 (as amended by the Mental Health Act 2007) • Mental Health (hospital, guardianship, community treatment and consent to treatment)(Wales) regulations 2008 • The Mental Capacity Act 2005 (including the Deprivation of Liberty Safeguards delegated to this Act under the Mental Health Act 2007) • The respective Codes of Practice of the above Acts of Parliament • The Human Rights Act 1998 (and the European Convention on Human Rights) • Domestic Violence, Crime and Victims Act, 2004 All Cardiff and Vale policies on the Mental Health Act 1983 as appropriate including: Section 5(2) Doctors' Holding Power Policy Section 5(4) Nurses' Holding Power Policy Section 5(4) Nurses' Holding Power Procedure Hospital Managers' Scheme of Delegation Policy Hospital Managers' Scheme of Delegation Procedure
Approved by	Pending – Mental Health and Capacity Legislation Committee

Accountable Executive or Clinical Board Director	*Chief Operating Officer*
Author(s)	*Mental Health Act Manager*

Disclaimer

If the review date of this document has passed please ensure that the version you are using is the most up to date either by contacting the document author or the Governance Directorate.

Summary of reviews/amendments

Version Number	Date of Review Approved	Date Published	Summary of Amendments

14.3

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1	*Date of Committee or Group Approval*	*TBA*	*New document*

Glossary of terms

Term	Definition
AC	Approved Clinician – A mental health professional approved by the Welsh Ministers to act as an approved clinician for the purposes of the Act. In practice, Health Boards take these decisions on behalf of the Welsh Ministers
Community Treatment Order (CTO)	The legal authority for the discharge of a patient from detention in hospital, subject to the possibility of recall to hospital for further medical treatment if necessary. Community patients are expected to comply with the conditions specified in the community treatment order.
Form HO12	Statutory Welsh form to be completed by Doctor when implementing section 5(2)
RC	Responsible Clinician - The approved clinician with overall responsibility for the patient's case
IMHA	Independent Mental Health Advocate – An advocate independent of the team involved in patient care available to offer support to patients.
Mental Capacity Act (2005)	An Act of Parliament that governs decision-making on behalf of people who lack capacity, both where they lose capacity at some point in their lives and where the incapacitating condition has been present since birth
MHRTfW	Mental Health Review Tribunal for Wales – A judicial body that has the power to discharge patients from detention, community treatment orders, guardianship and conditional discharge
Part 4, Mental Health Act	The part of the Act which deals mainly with the medical treatment for mental disorder of detained patients (including conditionally discharged and community treatment order patients who have been recalled to hospital). In particular, it sets out when they can and cannot be treated for the mental disorder without their consent
Section 2	Compulsory admission of a patient to hospital for assessment and for detention up to 28 days
Section 3	Compulsory admission to hospital for treatment and detention for up to six months
Section 4	An application for detention for assessment of mental disorder made with only one supporting medical recommendation in cases of urgent necessity. Also known as a section 4 application

Section 17 leave	Formal permission for a patient who is detained in hospital to be absent from the hospital for a period of time; patients remain under the powers of the Act when they are on leave and can be recalled to hospital if necessary in the interests of their health or safety or for the protection of others
Section 133	The duty of hospital managers to information nearest relatives of a patients discharge
Keywords	Section 5(2), Doctors' Holding Power, Mental Health Act, 1983

CONTENTS

14.3

1. INTRODUCTION

Section 5(2) is the power under the Mental Health Act, 1983 (MHA) that allows a responsible doctor or approved clinician to detain an in-patient for a maximum period of up to 72 hours in order to make arrangements for their assessment for detention under section 2 or section 3 of the MHA. This power can only be used to detain patients who have already been informally admitted to a hospital. It can be used whether or not the patient has capacity to consent to their admission but cannot be used with out-patients, or with those attending the hospital in other capacities, e.g. as visitors.

Section 5(2) should only be used if; at the time it is not practicable or safe to take the steps necessary to make an application for detention without detaining the patient in the interim. It should not be used as an alternative to making an application, even if it is thought that the patient will only need to be detained for 72 hours or less.

2. PROCEDURE STATEMENT

This procedure has been developed to guide staff on the implementation and management of section 5(2) doctors' holding powers in accordance with the Mental Health Act 1983 as amended by MHA 2007. This guidance has been developed in line with the Mental Health Act 1983 Code of Practice for Wales 2016 (Code of Practice).

Holding powers when implemented authorises the detention of the patient in the hospital for a maximum of 72 hours so the patient can be assessed with a view to an application for detention under the Act being made.

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3. SCOPE

The Health Board has in place appropriate governance arrangements to monitor and review the exercise of functions under the Act on its behalf. The Mental Health and Capacity Legislation Committee is specifically for this purpose.

This procedure is applicable to all qualified doctors' within all Mental Health inpatient settings and general hospital settings.

4. DUTIES AND RESPONSIBILITIES OF DOCTORS' AND APPROVED CLINICIANS

Section 5(2) authorises the detention of the patient in the hospital for a maximum of 72 hours so the patient can be assessed with a view to an application for detention under the Act being made. It should only be used if, at the time, it is not practicable or safe to initiate an application for detention without also detaining the patient in the interim. That is, the patient must be unwilling to remain in hospital in order for the assessment for detention to be made and it must be necessary for the person to remain in hospital until the assessment can be undertaken.

Section 5(2) should not be used as an alternative to making an application, even if it is thought the patient will only need to be detained for 72 hours or less.

The identity of the person in charge of a patient's medical treatment at any time will depend on the particular circumstances. However, 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 receiving treatment for both a physical and a mental disorder. In such a case, the psychiatrist or approved clinician in charge of the patient's treatment for the mental disorder is the preferred person to use the power in section 5(2).

The Doctor must be fully aware of the diverse needs of the patient when considering detention and must take them in to account at all times. They must ensure the patient fully understands what is happening to them in a language and format which they are able to understand, this will include sensory and cognitive abilities and physical impairment. Where necessary, an interpreter should be obtained.

They must complete a written record of the assessment (Statutory Form HO12). As well as the completion of the statutory documentation, doctors' must make a record of the assessment including the start time of the section in the patients' clinical notes.

5. NOMINATION OF DEPUTIES

Section 5(3) allows the doctor or approved clinician in charge of an inpatient's treatment to nominate a deputy to independently exercise section 5(2) powers in their absence.

Only a doctor or approved clinician on the staff of the same hospital may be a nominated deputy. The deputy does not have to be a member of the same profession as the person nominating them. Only one deputy may be authorised at any time for any patient, and it is unlawful for a nominated deputy to nominate another.

Doctors' and approved clinicians should only be nominated as a deputy if they are competent to perform the role. Nominated deputies should report the use of section 5(2) to the person for whom they are deputising as soon as practicable.

It is permissible for deputies to be nominated by title, rather than by name e.g. the junior doctor on call for particular wards, provided there is only one nominated deputy for any patient at any time and it can be determined with certainty who that nominated deputy is.

Doctors' and approved clinicians may leave instructions with ward staff to contact them (or their nominated deputy) if a particular patient wants or tries to leave. However, they may not leave instructions for their nominated deputy to use section 5(2), nor may they complete a section 5(2) report in advance to be used in their absence. The deputy must exercise their own professional judgment. Patients should not be admitted informally with the sole intention of then using the holding power.

6. DUTIES AND RESPONSIBILITIES OF QUALIFIED NURSES

The qualified nurse should check that the doctor has completed form HO12 correctly. The form must then be faxed or emailed and the original sent immediately to the Mental Health Act administration team either by hand, internal mail for first class post delivery.

The nurse should ensure that the patient is made aware of their rights under the Act and this is documented in the patients' notes. Information and leaflets are available on the Mental Health Act page, Cardiff and Vale intranet.

7. PROCEDURE

Holding powers can only be used on a patient who has been admitted to hospital. Admission should be defined as completion of the admission process performed by nursing staff or medical staff.

Patients who are in hospital by virtue of a deprivation of liberty authorisation under the Mental Capacity Act 2005 (MCA) may be detained under section 5(2). It does not matter whether the patient was originally admitted for treatment primarily for either a mental disorder or a physical condition.

If the doctor invoking the section 5(2) power is not a psychiatrist, approved clinician or nominated deputy they should make immediate contact with a psychiatrist or an approved clinician to obtain confirmation of their opinion that the patient needs to be detained so that an application can be made.

If a patient is already detained under section 5(4) the request from a nurse to assess for detention under section 5(2) should be treated as an emergency and be responded to accordingly i.e. within 6 hours of the section 5(4) commencing.

Although section 5(2) can last up to a maximum of 72 hours, the assessment process must be put in place once the HO12 is completed.

The Approved Mental Health Practitioner (AMHP) should be contacted at this stage in order to co-ordinate a Mental Health Act assessment and for those attending to consider the need for section 2 or section 3 of the Mental Health Act.

Patients subject to section 5(2) are not subject to consent to treatment provisions contained in Part 4 of the MHA.
If the patient is mentally capable of making a decision about treatment, the common law enables him to refuse to be treated for either a physical or mental disorder. However, if the patient is assessed as being mentally incapable of making a decision about treatment, the treatment can be provided under the Mental Capacity Act 2005 if it is deemed to be in his best interests.

A record of the assessment must be made in the patient's clinical notes.

8. USE OF SECTION 5(2) IN A GENERAL HOSPITAL

Any doctor in charge of a patient's care may detain an informal patient under section 5(2), using form HO12. This includes a doctor in a non psychiatric hospital.

The non-psychiatric doctor should, wherever possible, consult with a senior psychiatrist prior to the use of section 5(2). If this is not practicable then the senior psychiatrist should see the patient as soon as possible to determine whether the patient should be detained further.

The full Mental Health Act assessment should be requested as soon as possible after the use of section 5(2).

Section 5(2) cannot be used in an Accident and Emergency Department.

9. SECTION 17 LEAVE

A patient detained on Section 5 (2) cannot receive section 17 leave. They are not detained by virtue of either an application under Section 2 or Section 3 and therefore do not have a Responsible Clinician to grant such leave.

10. COMMUNITY TREATMENT ORDER PATIENTS

Section 5(2) is not applicable to a patient subject to a Community Treatment Order (CTO). Patients can be recalled even during periods when they are in-patients. Therefore where it is considered necessary, the recall procedure must be used to detain the patient and within the 72 hours allowed a decision must be made whether to revoke the CTO.

Section 5(2) cannot be used to keep a patient in hospital after the end of the 72 hour recall period if the CTO has not been revoked.

11. SECTION 18 ABSENT WITHOUT LEAVE (AWOL)

A patient detained under section 5(2) who leaves the hospital is AWOL and can be retaken but only within the 72 hour period.

12. INAPPROPRIATE USE OF SECTION 5(2)

Section 5(2) cannot be used in the following circumstances:

- For an outpatient attending an accident and emergency department or any other out-patient facility.
- For a patient who is already liable to be detained in hospital or who is subject to a CTO.
- Is not to be used as a holding power simply for the purpose of persuading the patient to stay.

Patients should not be informally admitted with the sole intention of then using the holding power.

13. ENDING OF SECTION 5(2)

Section 5(2) holding powers last for a maximum of 72 hours and cannot be renewed.

Detention under section 5(2) will end if:-

- The result of the assessment is a decision not to make an application under section 2 or section 3.
- The power has been invoked by a nominee under section 5(3) and the doctor or approved clinician in charge decides that no assessment for possible detention needs to be carried out.
- An application under section 2 or section 3 is made.
- The patient is discharged for clinical reasons before an assessment can be undertaken.

14.3

The maximum period a patient may be held under section 5(2) is 72 hours, which will include anytime the patient is held on section 5(4) of the Act.

The patient should be informed once they are no longer held under section 5(2) and advised of the reasons why. If this is because section 2 or section 3 was not applied, the patient should be informed they are free to leave hospital.

14. MEDICALTREATMENT OF PATIENTS

The rules in Part 4 of the Act do not apply to patients detained under section 5(2) and as such there is no 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 detained under the Act.

15. TRANSFER TO OTHER HOSPITALS

Patients detained under section 5(2) cannot be transferred to another hospital under section 19, because they are not detained by virtue of an application made under Part 2 of the Act. This includes transfer between hospitals managed by the same hospital managers.

A patient who is subject to section 5(2) of the Act but needs to go to another hospital urgently for treatment, security or other exceptional reasons, can only be taken there if they consent to the transfer. If the patient lacks capacity to consent to the transfer, any transfer must be carried out in accordance with the MCA.

If, following transfer, the patient tries to leave the receiving hospital, a new situation will have arisen. In this circumstance, the receiving hospital may need to use section 5(2) to provide authority to detain the patient in that hospital.

In all cases, if the conditions are met, an emergency application for detention under section 4 of the Act could be made by the sending hospital. The patient could then be transferred to the receiving hospital under section 19. Alternatively, an emergency application under section 4 could be submitted to the managers of the receiving hospital.

16. APPEALS

A patient detained under section 5(2) cannot make an application to the Mental Health Review Tribunal for Wales or appeal to the hospital managers.

17. MONITORING

Hospital managers should monitor the use of section 5(2), including:

- How quickly patients are assessed for detention and discharged from the holding power.
- The proportion of cases in which applications for detention are, in fact, made following use of section 5(2).

18. TRAINING

The health board will provide ongoing training for staff who have a delegated duty under the scheme of delegation. Details of training courses available can be found by contacting the mental health act administration team.

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Approved By:		

19. IMPLEMENTATION

This document will be widely disseminated to staff in Cardiff and Vale University Health Board. It will be published on the organisations intranet sites and referred to during training relevant to the Act.

20. RESPONSIBILITIES

20.1 Chief Executive

The Chief Executive Officer has overarching responsibility for ensuring that Cardiff and Vale University Health Board is compliant with the law in relation to the Mental Health Act.

20.2 Chief Operating officer

The Chief Operating Officer is the Executive Lead for Mental Health. He has overarching responsibility for ensuring compliance with the contents of this procedure.

20.3 Designated Individuals

This procedure applies to all doctors' who have defined responsibilities under the provisions of the Act.

21. REFERENCES

All staff will work within the Mental Health Act 1983 and in accordance with the Code of Practice for Wales 2007, Mental Capacity Act 2005, and Human Rights Act 1998.

Mental Health Act 1983 - www.legislation.gov.uk/ukpga/1983/20/contents
Mental Capacity Act 2005 - www.legislation.gov.uk/ukpga/2005/9/schedule/7
Mental Health Review Tribunal for Wales - www.justice.gov.uk/tribunals/mental-health
Human Rights Act 1998 - www.legislation.gov.uk/ukpga/1998/42/contents

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Approved By:		

APPROVAL OF SECTION 5(4) NURSES'' HOLDING POWER POLICY AND PROCEDURE
Name of Meeting: Mental Health and Capacity Legislation Committee **Date of Meeting:** 26 June 2018

Executive Lead : Chief Operating Officer
Author : Mental Health Act Manager, sunni.webb@wales.nhs.uk
Caring for People, Keeping People Well: This report underpins the Health Board's "Sustainability" and "Values" elements of the Health Board's Strategy.
Financial impact : None
Quality, Safety, Patient Experience impact: Patients subject to the Mental Health Act must be treated only in compliance with the legal framework.
Health and Care Standard Number: 3 (Effective Care), 4 (Dignified Care), 6 (Individual Care)
CRAF Reference Number: 8.1.2
Equality and Health Impact Assessment Completed: Yes

ASSURANCE/RECOMMENDATION

ASSURANCE is provided consultation with by:

- All Wales Mental Health Act Administrators Policy Group
- Mental Health Policy Group
- Mental Health Quality and Safety Sub Committee
- Internet consultation

The Mental Health and Capacity Legislation Committee is asked to:

- **APPROVE** the Section 5(4) Nurses' Holding Power Policy and Procedure

and

- **APPROVE** the full publication of the Section 5(4) Nurses' Holding Power Policy and procedure in accordance with the UHB Publication Scheme

14.4

SITUATION

It is essential that compliance with the legal requirements of the Mental Health Act 1983 and the Mental Health Act 1983 Code of Practice for Wales, Revised 2016 are monitored. Local Health Boards and Local Authorities should have agreed governance processes for ensuring the appropriate policies and procedures in place are regularly reviewed. A non exhaustive list of relevant

policies required are detailed in the Mental Health Act 1983 Code of Practice for Wales, Revised 2016.

The Section 5(4) Nurses' Holding Power Policy sets out the requirements for provision of the nurses' holding power under section 5(4) of the Mental Health Act 1983 (as amended by the MHA 2007) to the practitioners and agencies involved in the management of patients subject to a nurses' holding power**.**

BACKGROUND

This is a new policy to ensure statutory requirements under the Mental Health Act 1983 are met.

This document provides clear direction and guidance which will be easily accessible on our internet/intranet sites to particular individuals including registered medical practitioners ('doctors'), approved clinicians, managers and staff of hospitals in relation to their legal responsibilities under the Mental Health Act 1983 as amended by the MHA 2007.

ASSESSMENT

Wide consultation has taken place to ensure that the policy and procedure meet the needs of our stakeholder and the Health Board. The consultation undertaken specific to this document was as follows:-

- The document was added to the Policy Consultation pages on the intranet between 06 November 2017 and 01 December 2017;
- The document was shared with the Mental Health Policy Group, Adult Directorate Medics, Cardiff Local Authority, Vale of Glamorgan Local Authority, the Mental Health Clinical Board Quality and Safety Sub Committee and the All Wales Mental Health Act Administrators Policy Group;
- Comments were invited via individual e-mails from the Mental Health Policy Group, the Equality Manager, the Principal Health Promotion Specialist

Where appropriate comments were taken on board and incorporated within the document.

The primary source for dissemination of this document the Section 5(4) Nurses' Holding Power Policy within the UHB will be via the intranet and clinical portal. It will also be made available to the wider community and our partners via the UHB internet site.

Reference Number: *TBA* **Version Number:** 1	**Date of Next Review:** *To be included when document approved* **Previous Trust/LHB Reference Number:**

Section 5(4) Nurses' Holding Power Policy
Mental Health Act, 1983

Policy Statement

To ensure the Health Board delivers its aims, objectives, responsibilities and legal requirements transparently and consistently, we will ensure staff are aware of their individual and collective responsibilities when considering use of the nurses' holding power under section 5(4) of the Mental Health Act.

Section 5(4) allows a registered mental health or learning disability nurse to detain an inpatient for a maximum period of up to 6 hours in order for their assessment under the Mental Health Act.

Practitioners will have due regard to the Mental Health Act Code of Practice generally and specifically to the Guiding Principles when they are considering the use Section 5(4). This will ensure that considerations are given as to whether the objectives can be met in a less restrictive way.

The nurse must be fully aware of the diverse needs of the patient when considering detention and must take them in to account at all times. They must ensure the patient fully understands what is happening to them in a language and format which they are able to understand, this will include sensory and cognitive abilities and physical impairment. Where necessary, an interpreter should be obtained.

Policy Commitment

We will set out the requirements for provision of the nurses' holding power under section 5(4) of the Mental Health Act 1983 (as amended by the Mental Health Act 2007) to the practitioners and agencies involved in the management of patients subject to a nurses' holding power**.**

We will ensure statutory requirements under the Mental Health Act 1983 are met by providing clear direction and guidance which will be easily accessible on our internet/intranet sites to particular individuals including registered medical practitioners ('doctors'), approved clinicians, managers and staff of hospitals in relation to their legal responsibilities under the Mental Health Act 1983 (as amended by the MHA 2007).

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Approved By:		

Supporting Procedures and Written Control Documents

This Policy and the Section 5(4) Nurses' Holding Power Procedure describe the following with regard to the use of a nurses' holding power:

- The purpose of a nurses' holding power
- The process for assessing the suitability for the use of a nurses' holding power
- The duties of the practitioners and agencies involved in the management of patients subject to a nurses' holding power

Other supporting documents are:

- The Mental Health Act 1983 (as amended by the Mental Health Act 2007)
- Mental Health (hospital, guardianship, community treatment and consent to treatment)(Wales) regulations 2008
- The Mental Capacity Act 2005 (including the Deprivation of Liberty Safeguards delegated to this Act under the Mental Health Act 2007)
- The respective Codes of Practice of the above Acts of Parliament
- The Human Rights Act 1998 (and the European Convention on Human Rights)
- Domestic Violence, Crime and Victims Act, 2004

Scope

This policy applies to all of our staff in any inpatient setting where a person is receiving inpatient treatment in hospital and is not already liable to be detained or who is subject to a community treatment order (CTO).

Patients who are in hospital by virtue of a deprivation of liberty authorisation under the Mental Capacity Act 2005 (MCA) may be detained under section 5(4).

This power can only be used in respect of patients who are receiving hospital treatment for mental disorder; it is not sufficient for the patient to be merely suffering from a mental disorder. Although the power can be invoked in any hospital where the patient is receiving treatment for mental disorder, it is unlikely that a non-psychiatric ward will be staffed with nurses' of the "prescribed class".[1]

Equality and Health Impact Assessment	There is potential for both positive and negative impact. The procedure is aimed at improving services and meeting diverse needs. Mitigation actions are already in place to offset any potential negative outcome, e.g. through the monitoring of the procedure. There is nothing, at this time, to stop the procedure from being implemented.

14.4

[1] http://www.legislation.gov.uk/wsi/2008/2441/article/2/made

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Approved By:		

Policy Approved by	Pending - Mental Health and Capacity Legislation Committee
Group with authority to approve procedures written to explain how this policy will be implemented	Mental Health and Capacity Legislation Committee
Accountable Executive or Clinical Board Director	Mental Health Clinical Board Director of Operations

Disclaimer

If the review date of this document has passed please ensure that the version you are using is the most up to date either by contacting the document author or the Governance Directorate.

Summary of reviews/amendments

Version Number	Date Review Approved	Date Published	Summary of Amendments
1	Date approved by Board/Committee/Sub Committee dd/mm/yyyy	TBA *[To be inserted by the Gov. Dept]*	*New document*
2			

14.4

Equality & Health Impact Assessment for

SECTION 5(4) NURSES' HOLDING POWER POLICY

1.	For service change, provide the title of the Project Outline Document or Business Case and Reference Number	SECTION 5(4) NURSES' HOLDING POWER POLICY
2.	Name of Clinical Board / Corporate Directorate and title of lead member of staff, including contact details	Mental Health Clinical Board Sunni Webb, Mental Health Act Manager 029 21824745 Sunni.webb@wales.nhs.uk
3.	Objectives of strategy/ policy/ plan/ procedure/ service	Section 5(4) allows a registered mental health or learning disability nurse to detain an inpatient for a maximum period of up to six hours in order for their assessment under the Mental Health Act. The policy provides information on how and who can implement it. The aims of this policy are to: • Ensure staff are aware of their individual and collective responsibilities when considering and assessing individuals before implementing holding powers. • Provide clear guidance to staff in relation to their legal responsibilities under the Mental Health Act 1983. • Ensure that statutory requirements under the Mental Health Act 1983 are met Practitioners should have due regard to the Mental Health Act Code of

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		Practice generally and specifically to the Guiding Principles when they are considering the use of nurses' holding power. This would ensure that considerations are given as to whether the objectives can be met in a less restrictive way.
4.	Evidence and background information considered. For example • population data • staff and service users data, as applicable • needs assessment • engagement and involvement findings • research • good practice guidelines • participant knowledge • list of stakeholders and how stakeholders have engaged in the development stages • comments from those involved in the designing and development stages Population pyramids are available from Public Health Wales Observatory[2] and the UHB's 'Shaping Our Future Wellbeing' Strategy provides an overview of health need[3].	**Related policies/information -** Mental Health Act 1983, Code of Practice for Wales (Revised 2016), Welsh Language Act 2016, Mental Health Wales Measure 2010, Deprivation of Liberty Safeguards, Equality Act 2010 **Stakeholders -** Service Users, Nursing Staff, Responsible Clinicians, Approved Clinicians, Mental Health Act Administrators, Approved Mental Health Professionals, Qualified nursing staff and other professionals working within mental health services. **Age -** 20 per cent of children have a mental health problem in any given year, and about 10 per cent at any one time. A quarter of older people in the community have symptoms of depression that require an intervention, and this increases to 40 per cent of care home residents (Mind "Our Communities, Our Mental Health) Older people (aged 60 and above) are more vulnerable to mental health problems, depression is a common disorder amongst this population and it has been estimated that 7% of older people suffer with uni-polar depression (World Health Organisation, 2016). Further Older people are more likely to experience a combination of physical and mental health issues (WHO, 2016).

[2] http://nww2.nphs.wales.nhs.uk:8080/PubHObservatoryProjDocs.nsf
[3] http://www.cardiffandvaleuhb.wales.nhs.uk/the-challenges-we-face

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		Younger adults are susceptible to mental health issues, with 6.2% of 16-24 year olds attempting suicide in their lifetime and 16.4% experiencing neurotic symptoms (Young Minds, 2016). Further, student populations are disproportionately affected by mental health issues, with an estimated 1 in 4 reporting mental health problems. Poor mental health amongst young people can lead to reduced life chances and impact on their education, social participation and ability to find and sustain employment. Results of Welsh Health Survey 2015 – reported in Mental Health Foundation Fundamental Facts 2016:- Results from the 2015 survey found that 13% of adults (aged 16 and older) living in Wales were reported to have received treatment for a mental health problem, an increase from 12% reported in 2014. Unlike other illnesses, the percentage who reported being treated for mental ill health did not increase with age, however trends suggest that an increase in treatment towards middle age before decreasing in retirement age. These rates have not significantly changed since the 2014 health survey. The total number of CAMHS referrals to treatment in Wales doubled between April 2010 (1,204) and July 2014 (2,342). Young people awaiting outpatient's treatment has the highest numbers (2,410) compared to adults (1,291) and those in later life. The Mental Health Act relates to all patients suffering from a mental disorder who meet the criteria for detention, irrespective of age. **Disability -** Physical illness more than doubles the risk of depression,

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		and between 30 per cent and 50 per cent of adults with learning disability in the UK have mental health problems. (Mind "Our Communities, Our Mental Health) Sensory loss: Sensory loss currently affects 1 in 5 people in Wales, with 1 in 6 people affected by hearing loss and an estimated 115,000 people living with sight loss which has a significant impact on their daily lives (Sensory Loss in the Adult population in Wales, 2012). Those affected by sensory loss are more susceptible to the development of mental health issues, especially older people. Older people with sight loss are three times more likely to experience depression than people with good vision (Depression and Anxiety in Visually Impaired Older People, 2007) with the British Medical Journal reporting that sight loss is one of the top three causes of suicide among older people The proposed policy will apply to all patients detained regardless of disability, as the policy is reference to the scrutiny of the documents completed by staff rather than the processes. All documents will have been completed in conjunction with consideration of the Mental Health Act, Mental Capacity Act, DoLS and the Mental Health Wales Measure. **Gender -** There are clear differences in the way women and men experience mental health problems. Women are more likely to report common mental health problems. Girls are also more likely than boys to self-harm, and eating disorders are more common in young women compared to young men. Men are more likely to have undiagnosed depression, be detained under the Mental Health Act and take their own life compared to women. (Mind, "Our Communities, Our Mental Health") Results of Welsh Health Survey 2015 – reported in Mental Health Foundation Fundamental Facts 2016:-

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		A higher percentage of women report being treated for a mental health problem than men (16% vs 10%). Treatment figures show an increase of 1% for both men and women from 2014 statistics. Health (and social care) services have a duty to treat people fairly and equally. However, the Stonewall **Unhealthy Attitudes 2015** report highlights some major gaps in the knowledge and training of staff relating to lesbian, gay, bisexual and trans (LGBT) people, which is resulting in unfair treatment of both LGBT patients and colleagues. Gay and Bisexual Men's Health Survey With 6,861 respondents from across Britain, the 2013 report is the largest survey ever conducted of gay and bisexual men's health needs in the world. However, it demonstrates that many of those needs are not being met and that there are areas of significant concern – most particularly in mental health and drug use – that have been overlooked by health services which too often focus solely on gay men's sexual health. This report also provides hard evidence that gay and bisexual men nationwide are more likely to attempt suicide, self-harm and have depression than their straight peers. This policy will apply regardless of gender. **Gender Reassignment -** Trans people are at increased risk of depression and self-harm, and a third of trans people have attempted to take their own life.(Mind, "Our Communities, Our Mental Health") This policy will apply regardless of whether patients have transitioned or not.

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		Health (and social care) services have a duty to treat people fairly and equally. However, the Stonewall **Unhealthy Attitudes 2015** report highlights some major gaps in the knowledge and training of staff relating to lesbian, gay, bisexual and trans (LGBT) people, which is resulting in unfair treatment of both LGBT patients and colleagues. The NHS Centre for Equality and Human Rights (CEHR) has published a new guide for all staff in NHS Wales. *"It's Just Good Care – A guide for health staff caring for people who are trans*"* aims to help health staff provide trans* people with the respectful and appropriate care they are entitled to. The document is available for downloading from the staff intranet. Also available on the intranet is a Top Tips for Making your Service Inclusive and Welcoming for Trans People **Human Rights -** The proposed policy promotes human rights in ensuring that all patients are detained lawfully. **Pregnancy and Maternity -** Mental health problems affect between 10 and 20 per cent of women at some point during the perinatal period (pregnancy and one year after birth). Poor maternal health can also increase the risk of mental health in children. Within the Mind report the following issues are also identified as contributory risk factors:- Trauma and stressful events, poverty, unemployment and housing insecurity, social isolation and loneliness, discrimination and inequality. (Mind, "Our Communities, Our Mental Health") Results of Welsh Health Survey 2015 – reported in Mental Health Foundation Fundamental Facts 2016

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		Mental health problems affect more than 1 in 10 women during pregnancy and the first year after childbirth, and can have a devastating impact on new mothers and their families. According to a 2014 report from the London School of Economics and the Centre for Mental Health, in the UK, 20% of women are affected by mental health problems during the perinatal period. In Wales, 70% of people have no access to specialist perinatal mental health services; a figure significantly higher than the UK average of 40%. According to NHS Choices website If you have had in the past, or now have, severe mental health problems, you are more likely to become ill during pregnancy or in the first year after giving birth than at other times in your life. Severe mental health problems include bipolar affective disorder, severe depression and psychosis. After giving birth, severe mental illness may progress more quickly and be more serious than at other times. This policy will apply regardless of whether patients are pregnant at the time of being detained. In relation to staff there are no changes to be made in relation to applying holding powers. Wards will have completed risk assessments in relation to staff. **Race/ Ethnicity or nationality –** A disproportionate number of people admitted as inpatients in mental health services come from BAME groups. In 2010, 23 per cent of inpatient admissions were from a BAME background. According to the mental health organisation ‘Mind’, the admission rate for ‘other black’ groups is six times higher than average, suggesting discrimination within the mental health system.

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		Black African and Caribbean people living in the UK have lower reported rates of common mental health problems compared to other ethnic groups, however they are more likely to be diagnosed with severe mental health problems. Black African and Caribbean people are also much more likely to be detained under the Mental Health Act compared to other ethnic groups. According to Black Mental Health UK, people of African or Caribbean descent are 50 per cent more likely to be referred to mental health services via the police than their white counterparts.Young women from ethnic minorities are much more likely to take their own life than White British women. (Mind, “Our Communities, Our Mental Health”) The proposed policy will apply regardless of the race / ethnicity of patients or staff. Health inequalities are further linked to unequal access to healthcare. Some BAME groups face considerable barriers to healthcare. In 2009 the Department for Communities and Local Government noted that Gypsies and Travellers face particular difficulties accessing healthcare. Many of them felt that health workers and doctors misunderstood their needs and circumstances. Additionally, Gypsy and Traveller access to healthcare can also difficult if there is an inability to provide proof of identity. The West Midlands Strategic Health Partnership noted, in 2010, that migrant populations faced significant barriers accessing healthcare including difficulties that were related to registering, contracting and commissioning processes as well as a lack of knowledge about services

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		available. Other common difficulties included poor continuity of care and the experience of not having the same doctor in the practice. A Cultural Competency Toolkit, was developed by Diverse Cymru, with assistance from UHB staff. Its aim is to help staff better interact with clients with mental ill health who are from different cultures A proportion of patients first language may not be English or Welsh. The statutory documents in relation to the Mental Health Act are provided by Welsh Government are only available in English and Welsh. Within the explanation of rights this now details if the information has been given in the patients preferred language and will be reported on. Access to an interpreter is available and translation of written information can be obtained as and when required. **Religion or Belief -** Spiritual awareness, practices and beliefs (of any religion or for those engaging in spiritual practices without a particular faith) is associated with psychological benefits, including subjective wellbeing (Mind, Our Communities, Our Mental Health”). There are religious beliefs and practices that have been shown, across all the cultures studied, to have some salutary effects on well-being. Other ways in which culture may impact on the relations between religion and well-being have been less consistently documented. The recent growth of interest in positive psychology, and in the relations between religion and spirituality, and maturity, morality and virtue has not yet incorporated a marked focus on cultural issues. Religious beliefs

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		and practices supported in one culture may appear disturbed to people (including mental health professionals) from another, affecting diagnosis and treatment. Many commonly held ideas about the role of religion in shame, guilt and anxiety (including obsessive-compulsive disorder), voices, visions and spirit possession require closer examination in the light of evidence from different cultural groups. Clinical practitioners are keen to reach a better understanding of the roles played by religious factors in different cultures, in affecting mental health. The proposed policy will apply regardless of the religion or belief of patients or staff. **Sexual Orientation -** Lesbian, gay and bisexual people are at increased risk of mental health problems, including self-harm and attempted suicide. Lesbian, gay and bisexual people have a 1.5 fold increased risk of depression and anxiety. (Mind “Our Communities, Our Mental Health”). Health (and social care) services have a duty to treat people fairly and equally. However, the Stonewall **Unhealthy Attitudes 2015** report highlights some major gaps in the knowledge and training of staff relating to lesbian, gay, bisexual and trans (LGBT) people, which is resulting in unfair treatment of both LGBT patients and colleagues. Gay and Bisexual Men’s Health Survey. With 6,861 respondents from across Britain, the 2013 report is the largest survey ever conducted of gay and bisexual men’s health needs in the world. However, it demonstrates that many of those needs are not being met and that there are areas of significant concern – most particularly in mental health and drug use – that have been overlooked

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		by health services which too often focus solely on gay men's sexual health. This report also provides hard evidence that gay and bisexual men nationwide are more likely to attempt suicide, self-harm and have depression than their straight peers. The proposed policy will apply regardless of the sexual orientation of the patients or staff. **Welsh Language -** No evidence of disproportional representation to date, but a proportion of service users may be Welsh speakers **Welsh Language and its use in Cardiff & Vale of Glamorgan** The latest census statistics available indicate that 16% of the population of Cardiff have one or more skills in the Welsh Language (ability to read, write or/and understand Welsh). 32,000 or 11% of Cardiff's population are fluent Welsh speakers. 24.5% are within the 3-15 age group, and 12.1% within the 16-24 age groups. When the results of previous Censuses are consulted, a significant increase in the incidence of Welsh speakers amongst the youngest age groups is noticed. For the 5-15 year age group, the proportion of Cardiff's residents able to speak Welsh has increased from 6.8% in 1971 to 7.5% in 1981 and 12.7% in 1991. By 2001 this figure had increased to 24.5%. In the Vale of Glamorgan 13,189 of 122,018 people, which is 10.8% of the population, are fluent Welsh speakers. As the statutory documents in relation to the Mental Health Act are provided by Welsh Government these are in English on the Website.

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		Information leaflets for the patients are available in both English and Welsh. Within the explanation of rights this now details if the information has been given in the patients preferred language and will be reported on. Welsh Language Act is a consideration. **The impact of mental ill health on employment rates** A national household survey in Great Britain conducted in 2000 found that 57% of people who have a common mental disorder are working, compared with 69% of people who do not have a common mental disorder. Just 9% of people with a probable psychotic disorder, which includes most people with a severe mental disorder, are working fulltime and a further 19% part-time (Meltzer et al., 2002)8. An earlier survey reported that 70% of those with a common mental disorder, who are unemployed and seeking work, have been unemployed for a year or more (that is 7% of all people with a common mental disorder) and are unlikely to return to work (Meltzer et al., 1995). Those who have a common mental disorder are four to five times more likely than those who have not to be permanently unable to work and three times more likely to be receiving benefits payments (Meltzer et al., 1995 and 2002). Between 30% and 50% of people with schizophrenia are capable of work but only between 10% and 20% are in employment (Marwaha and Johnson, 2004; Schneider, 1998). Although some are in managerial or senior official positions, most are in 'elementary' jobs, for example cleaning and labouring, or are in skilled trade occupations such as plumbing or metal work. The rate of employment in people with schizophrenia seems to have fallen from before 1990 when surveys reported that between 20% and 30% were in work. Several studies conducted at two time points seem to confirm this reduction (e.g. Rinaldi and Perkins, 2007). The reason for this is unknown but one factor might

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		be a reduction in the number of sheltered employment schemes. For those who present to services for the first time, the likelihood of being in employment falls markedly over the subsequent year or two (Birchwood et al., 1992; Johnstone et al., 1986). For people with Schizophrenia, premorbid social and occupational history are associated with employment and some types of psychotic symptoms and the presence of negative symptoms are associated with unemployment. The desire to have a job is one of the best predictors of future employment (Marwaha and Jonhson, 2004). **People according to where they live**

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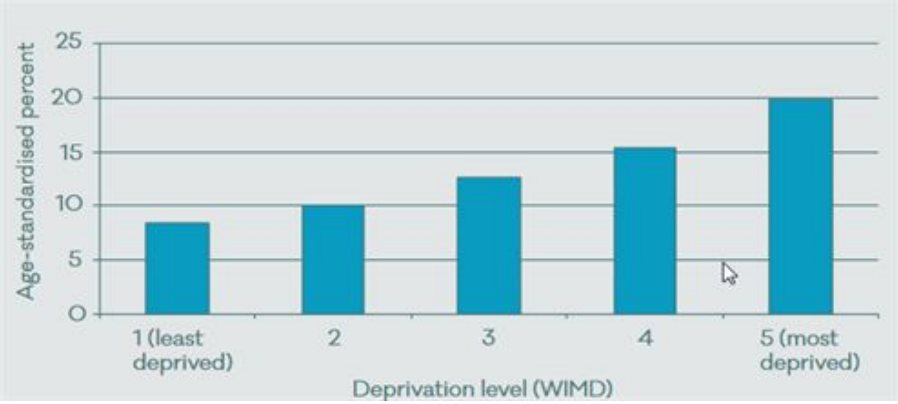

Findings from the 2015 survey found, that there was poorer mental health in more deprived areas. The percentage of adults that reported currently being treated for any mental health condition by area deprivation showed 8 per cent in the least deprived fifth in receipt of mental health treatment which rose steadily with higher levels of deprivation to 20 per cent in the most deprived fifth.

There is a wealth of evidence that mental health influences a very wide range of outcomes for individuals and communities. These include healthier lifestyles; better physical health; improved recovery from illness; fewer limitations in daily living; higher educational attainment; greater productivity, employment and earnings; better relationships with adults and with children; more social cohesion and engagement and improved quality of life. These outcomes are not just or necessarily a consequence of the absence of mental illness, but are associated with the presence of positive mental health, sometimes referred to as ‘wellbeing’. Improving mental health is a worthwhile goal in itself: most

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		people value a sense of emotional and social wellbeing; in addition, good mental health has many other far reaching benefits. Mental health is a fundamental element of the resilience, health assets, capabilities and positive adaptation that enable people both to cope with adversity and to reach their full potential and humanity. Mental health is also the key to understanding the impact of inequalities on health and other outcomes. It is abundantly clear that the chronic stress of struggling with material disadvantage is intensified to a very considerable degree by doing so in more unequal societies. An extensive body of research confirms the relationship between inequality and poorer outcomes, a relationship which is evident at every position on the social hierarchy and is not confined to developed nations. The emotional and cognitive effects of high levels of social status differentiation are profound and far reaching: greater inequality heightens status competition and status insecurity across all income groups and among both adults and children. It is the *distribution* of economic and social resources that explains health and other outcomes in the vast majority of studies. The importance of the social and psychological dimensions of material deprivation is gaining greater recognition in the international literature on poverty and informs current efforts to develop indicators that capture the missing dimensions of poverty. Both health-damaging behaviours and violence, for example, may be survival strategies in the face of multiple problems, anger and despair related to occupational insecurity, poverty, debt, poor housing, exclusion and other indicators of low status. These problems impact on intimate relationships, the care of children and care of the self. In the United Kingdom, the 20% - 25% of people who are obese or continue to

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		smoke are concentrated among the 26% of the population living in poverty, measured in terms of low income and multiple deprivation of necessities. This is also the population with the highest prevalence of anxiety and depression. It is already well established that mental illness, across the spectrum of disorders, is both a direct cause of mortality and morbidity and a significant risk factor for poorer economic, health and social outcomes, although these adverse outcomes vary by type of disorder and socioeconomic status (WHO 2005; 2006).[3] However, it is now becoming clear that the presence or absence of positive mental health or 'wellbeing' *also* influences outcomes across a wide range of domains. These include healthier lifestyles, better physical health, improved recovery, fewer limitations in daily living, higher educational attainment, greater productivity, employment and earnings, better relationships, greater social cohesion and engagement and improved quality of life (WHO 2004b; Barry and Jenkins 2007; Jane-Llopis et al 2004). This policy will apply regardless of where a person lives. (From: http://www.euro.who.int/__data/assets/pdf_file/0012/100821/E92227.pdf **Homeless** Affordable and safe accommodation brings stability and security; provides a gateway to access health services like GPs; enhances social and community inclusion; and provides the basis for the right to private

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		and family life. Put simply, a home is vital for good mental and physical health, allowing people to live in safety, security, peace and dignity. Whilst there is no such 'right to housing' in itself, the right to an adequate standard of living, including housing, is recognised in the UN Covenant on Economic, Social and Cultural Rights. Of course, there are numerous factors which can cause people to become homeless, many of which are beyond individual control, such as lack of affordable housing, disability and poverty. But what really needs to be highlighted is the two-way relationship between homelessness and mental health. Homelessness and mental health often go hand in hand, and can be a self-fulfilling prophecy. Having a mental health problem can create the circumstances which can cause a person to become homeless in the first place. Yet poor housing or homelessness can also increase the chances of developing a mental health problem, or exacerbate an existing condition. In turn, this can make it even harder for that person to recover – to develop good mental health, to secure stable housing, to find and maintain a job, to stay physically healthy and to maintain relationships. It is a fundamental fact that single homeless people are much more likely to have mental health problems compared to the general population. In 2015, 32% of single homeless people reported a mental health problem, and depression rates, for example, are over 10 times higher in the homeless population. Unfortunately, other psychological issues such as complex trauma, substance misuse and social exclusion

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		are also common This policy will apply regardless of where a person lives. **Asylum Seekers** Some asylum seekers will have been subjected to torture, as well as witnessing the consequences of societal breakdown of their home country – with consequences for their mental health. Culturally, mental illness may not be expressed or may manifest as physical Complaints. Stigma may also be attached to mental ill-health. Furthermore, Western psychological concepts are not universally applicable to asylum seekers. Mental health problems such as depression and anxiety are common, but post-traumatic stress disorder is greatly underestimated and under diagnosed and may be contested by healthcare professionals. Children are particularly neglected in this area. A shortage of mental health services for asylum seekers has been recognised. http://www.fph.org.uk/uploads/bs_aslym_seeker_health.pdf **Prisoners** 10% of men and 30% of women have had a previous psychiatric admission before they entered prison. A more recent study found that 25% of women and 15% of men in prison reported symptoms indicative of psychosis. The rate among the general public is about 4%. 26% of women and 16% of men said they had received treatment for a mental health problem in the year before custody. Personality disorders are particularly prevalent among people in prison. 62% of male and 57% of female sentenced prisoners have a personality disorder.

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		49% of women and 23% of male prisoners in a Ministry of Justice study were assessed as suffering from anxiety and depression. 16% of the general UK population (12% of men and 19% of women) are estimated to be suffering from different types of anxiety and depression. 46% of women prisoners reported having attempted suicide at some point in their lives. This is more than twice the rate of male prisoners (21%) and higher than in the general UK population amongst whom around 6% report having ever attempted suicide. http://www.prisonreformtrust.org.uk/ProjectsResearch/Mentalhealth **Information in relation to multiple protected characteristics -** Mental health issues can affect anyone among the population at any stage of life. However, national statistics show that that there are higher incidences of mental health issues among certain protected groups. Mind's report "Our Communities, Our Mental Health" identified the following contributory risk factors:- Trauma and stressful events, poverty, unemployment and housing insecurity, social isolation and loneliness, discrimination and inequality. These risk factors may be present in any protected group.
5.	Who will be affected by the strategy/ policy/ plan/ procedure/ service	Mental health issues affect the whole population, though some protected groups are disproportionately represented among service users**.**

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		The policy addresses administrative issues and responsibilities in relation to the direct care and treatment of patients. The section 5(4) policy applies to inpatients who are receiving hospital treatment for mental disorder. Hospital managers must ensure that those acting on their behalf are competent to do so and receive suitable training to ensure they exercise their functions appropriately to ensure the functions are carried out on a day to day basis.

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6. EQIA / How will the strategy, policy, plan, procedure and/or service impact on people?

Questions in this section relate to the impact on people on the basis of their 'protected characteristics'. Specific alignment with the 7 goals of the Well-being of Future Generations (Wales) Act 2015 is included against the relevant sections.

How will the strategy, policy, plan, procedure and/or service impact on:-	**Potential positive and/or negative impacts**	**Recommendations for improvement/ mitigation**	**Action taken by Clinical Board / Corporate Directorate.** Make reference to where the mitigation is included in the document, as appropriate
6.1 Age For most purposes, the main categories are: • under 18; • between 18 and 65; and • over 65	There is potential for a positive impact in that there is an awareness of this protected characteristic.	N/A	Under Policy Statement
6.2 Persons with a disability as defined in the Equality Act 2010 Those with physical impairments, learning disability, sensory loss or impairment, mental health conditions, long-term medical conditions such as diabetes	Disabled people with enduring mental health problems of all types are much less likely to be economically active than those with physical or sensory impairments. There is potential for a positive impact in that there is an awareness of this protected	A key duty is that the Doctor must be fully aware of the diverse needs of the patient when considering detention and must take them in to account at all times. They must ensure the patient fully	Under Policy Statement

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How will the strategy, policy, plan, procedure and/or service impact on:-	**Potential positive and/or negative impacts**	**Recommendations for improvement/ mitigation**	**Action taken by Clinical Board / Corporate Directorate.** Make reference to where the mitigation is included in the document, as appropriate
	characteristic and staff have to take into account the diverse needs of the individual patient.	understands what is happening to them in a language and format which they are able to understand, this will include sensory and cognitive abilities and physical impairment. Where necessary, an interpreter should be obtained.	
6.3 People of different genders: Consider men, women, people undergoing gender reassignment **NB** Gender-reassignment is anyone who proposes to, starts, is going through or	There is potential for a positive impact in that there is an awareness of this protected characteristic and staff have to take into account the diverse needs of the individual patient.	*"It's Just Good Care – A guide for health staff caring for people who are trans*" is made available to staff*	Under Policy Statement

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How will the strategy, policy, plan, procedure and/or service impact on:-	**Potential positive and/or negative impacts**	**Recommendations for improvement/ mitigation**	**Action taken by Clinical Board / Corporate Directorate.** Make reference to where the mitigation is included in the document, as appropriate
who has completed a process to change his or her gender with or without going through any medical procedures. Sometimes referred to as Trans or Transgender			
6.4 People who are married or who have a civil partner.	We are aware of potential negative impact in terms of the LGBT+ communities and access to health care services as noted elsewhere within the EHIA.	*"It's Just Good Care – A guide for health staff caring for people who are trans*" is made available to staff.*	Under Policy Statement
6.5 Women who are expecting a baby, who are on a break from work after having a baby, or who are breastfeeding. They are protected for 26 weeks after having a baby whether or not	No impact anticipated. However staff have to take into account the diverse needs of the individual patient.	N/A	Under Policy Statement

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How will the strategy, policy, plan, procedure and/or service impact on:-	**Potential positive and/or negative impacts**	**Recommendations for improvement/ mitigation**	**Action taken by Clinical Board / Corporate Directorate.** Make reference to where the mitigation is included in the document, as appropriate
they are on maternity leave.			
6.6 People of a different race, nationality, colour, culture or ethnic origin including non-English speakers, gypsies/travellers, migrant workers	There is a potential for a negative impact as there is a lot of well documented evidence to suggest that. However staff have to take into account the diverse needs of the individual patient.	A key duty is that the Doctor must be fully aware of the diverse needs of the patient when considering detention and must take them in to account at all times. They must ensure the patient fully understands what is happening to them in a language and format which they are able to understand, this will include sensory and cognitive abilities and physical impairment. Where necessary, an	Under Policy Statement A Cultural Competency Toolkit, was developed by Diverse Cymru, with assistance from UHB staff. Its aim is to help staff better interact with clients with mental ill health who are from different cultures.

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How will the strategy, policy, plan, procedure and/or service impact on:-	**Potential positive and/or negative impacts**	**Recommendations for improvement/ mitigation**	**Action taken by Clinical Board / Corporate Directorate.** Make reference to where the mitigation is included in the document, as appropriate
		interpreter should be obtained.	
6.7 People with a religion or belief or with no religion or belief. The term 'religion' includes a religious or philosophical belief	There is the potential for impact as suggested by the evidence above. However staff have to take into account the diverse needs of the individual patient. .		A Cultural Competency Toolkit, was developed by Diverse Cymru, with assistance from UHB staff. Its aim is to help staff better interact with clients with mental ill health who are from different cultures.
6.8 People who are attracted to other people of: • the opposite sex (heterosexual); • the same sex (lesbian or gay); • both sexes (bisexual)	We know from evidence that there are potential negative issues in terms of these protected characteristics. However staff have to take into account the diverse needs of the individual	N/A	N/A

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How will the strategy, policy, plan, procedure and/or service impact on:-	**Potential positive and/or negative impacts**	**Recommendations for improvement/ mitigation**	**Action taken by Clinical Board / Corporate Directorate.** Make reference to where the mitigation is included in the document, as appropriate
	patient.		
6.9 People who communicate using the Welsh language in terms of correspondence, information leaflets, or service plans and design Well-being Goal – A Wales of vibrant culture and thriving Welsh language	There is the potential for a negative impact. However staff have to take into account the diverse needs of the individual patient.	A key duty is that the Doctor must be fully aware of the diverse needs of the patient when considering detention and must take them in to account at all times. They must ensure the patient fully understands what is happening to them in a language and format which they are able to understand, this will include sensory and cognitive abilities and physical impairment. Where necessary, an interpreter should be	Under Policy Statement Staff are made aware of the translation and interpretation policy.

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How will the strategy, policy, plan, procedure and/or service impact on:-	**Potential positive and/or negative impacts**	**Recommendations for improvement/ mitigation**	**Action taken by Clinical Board / Corporate Directorate.** Make reference to where the mitigation is included in the document, as appropriate
		obtained.	
6.10 People according to their income related group: Consider people on low income, economically inactive, unemployed/workless, people who are unable to work due to ill-health	There is awareness that mental health problems have a greater impact on people's ability to work than any other group of disorders. However staff have to take into account the diverse needs of the individual patient. Disabled people with enduring mental health problems of all types are much less likely to be economically active than those with physical or sensory impairments.	N/A	Under Policy Statement

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How will the strategy, policy, plan, procedure and/or service impact on:-	**Potential positive and/or negative impacts**	**Recommendations for improvement/ mitigation**	**Action taken by Clinical Board / Corporate Directorate.** Make reference to where the mitigation is included in the document, as appropriate
6.11 People according to where they live: Consider people living in areas known to exhibit poor economic and/or health indicators, people unable to access services and facilities	No impact identified at this time, though it is recognised that there is poorer mental health in more deprived areas. However staff have to take into account the diverse needs of the individual patient.	N/A	Under Policy Statement
6.12 Consider any other groups and risk factors relevant to this strategy, policy, plan, procedure and/or service	Staff will respect the rights and needs of carers alongside the person's right to confidentiality. A Review of the person's consent to share information with family members, carers and other services will take place during the inpatient stay.	A key duty is that the Doctor must be fully aware of the diverse needs of the patient when considering detention and must take them in to account at all times. They must ensure the patient fully understands what is happening to them in a	Under Policy Statement

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How will the strategy, policy, plan, procedure and/or service impact on:-	**Potential positive and/or negative impacts**	**Recommendations for improvement/ mitigation**	**Action taken by Clinical Board / Corporate Directorate.** Make reference to where the mitigation is included in the document, as appropriate
	No impact has been identified at this time in relation to the homeless, asylum seekers and prisoners, though it is recognised that there is sometimes poorer mental health issues due to their circumstances and that there consequences for their mental health. However staff have to take into account the diverse needs of the individual patient.	language and format which they are able to understand, this will include sensory and cognitive abilities and physical impairment. Where necessary, an interpreter should be obtained.	

7. HIA / How will the strategy, policy, plan, procedure and/or service impact on the health and well-being of our population and help address inequalities in health?

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Questions in this section relate to the impact on the overall health of individual people and on the impact on our population. Specific alignment with the 7 goals of the Well-being of Future Generations (Wales) Act 2015 is included against the relevant sections.

How will the strategy, policy, plan, procedure and/or service impact on:-	**Potential positive and/or negative impacts and any particular groups affected**	**Recommendations for improvement/ mitigation**	**Action taken by Clinical Board / Corporate Directorate** Make reference to where the mitigation is included in the document, as appropriate
7.1 People being able to access the service offered: Consider access for those living in areas of deprivation and/or those experiencing health inequalities Well-being Goal - A more equal Wales	No Impact identified at this time, though it is recognised that there is poorer mental health in more deprived areas. However staff have to take into account the diverse needs of the individual patient.	N/A	Under Policy Statement
7.2 People being able to improve /maintain healthy lifestyles: Consider the impact on healthy lifestyles, including healthy eating, being active, no smoking /smoking cessation, reducing the harm caused by alcohol and /or	No impact identified at this time, though it is recognised that healthy lifestyles can have a positive impact on mental health and well-being. Staff have to take into account the diverse needs of the individual patient.	N/A	Under Policy Statement

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How will the strategy, policy, plan, procedure and/or service impact on:-	**Potential positive and/or negative impacts and any particular groups affected**	**Recommendations for improvement/ mitigation**	**Action taken by Clinical Board / Corporate Directorate** Make reference to where the mitigation is included in the document, as appropriate
non-prescribed drugs plus access to services that support disease prevention (e.g. immunisation and vaccination, falls prevention). Also consider impact on access to supportive services including smoking cessation services, weight management services etc Well-being Goal – A healthier Wales			
7.3 People in terms of their income and employment status: Consider the impact on the availability and accessibility of work, paid/ unpaid employment, wage levels, job security, working conditions	No impact identified at this time, though it is recognised that being employed can have a positive impact on mental health and well-being. Staff have to take into account the diverse needs of the individual patient.	N/A	Under Policy Statement

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How will the strategy, policy, plan, procedure and/or service impact on:-	**Potential positive and/or negative impacts and any particular groups affected**	**Recommendations for improvement/ mitigation**	**Action taken by Clinical Board / Corporate Directorate** Make reference to where the mitigation is included in the document, as appropriate
Well-being Goal – A prosperous Wales			
7.4 People in terms of their use of the physical environment: Consider the impact on the availability and accessibility of transport, healthy food, leisure activities, green spaces; of the design of the built environment on the physical and mental health of patients, staff and visitors; on air quality, exposure to pollutants; safety of neighbourhoods, exposure to crime; road safety and preventing injuries/accidents; quality and safety of play areas and open spaces Well-being Goal – A resilient Wales	No impact identified at this time, though it is recognised that environmental issues can have a positive impact on mental health and well-being. Staff have to take into account the diverse needs of the individual patient.	N/A	Under Policy Statement

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How will the strategy, policy, plan, procedure and/or service impact on:-	**Potential positive and/or negative impacts and any particular groups affected**	**Recommendations for improvement/ mitigation**	**Action taken by Clinical Board / Corporate Directorate** Make reference to where the mitigation is included in the document, as appropriate
7.5 People in terms of social and community influences on their health: Consider the impact on family organisation and roles; social support and social networks; neighbourliness and sense of belonging; social isolation; peer pressure; community identity; cultural and spiritual ethos Well-being Goal – A Wales of cohesive communities	No impact identified at this time, though it is recognised that social and community influences and related issues can have a positive impact on mental health and well-being. Staff have to take into account the diverse needs of the individual patient.	N/A	Under Policy Statement
7.6 People in terms of macro-economic, environmental and sustainability factors: Consider the impact of	No impact identified at this time, though it is recognised that macro-economic, environmental and sustainability factors social	N/A	Under Policy Statement

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How will the strategy, policy, plan, procedure and/or service impact on:-	**Potential positive and/or negative impacts and any particular groups affected**	**Recommendations for improvement/ mitigation**	**Action taken by Clinical Board / Corporate Directorate** Make reference to where the mitigation is included in the document, as appropriate
government policies; gross domestic product; economic development; biological diversity; climate Well-being Goal – A globally responsible Wales	and community influences and related issues can have a positive impact on mental health and well-being. Staff have to take into account the diverse needs of the individual patient.		

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Please answer question 8.1 following the completion of the EHIA and complete the action plan

8.1 Please summarise the potential positive and/or negative impacts of the strategy, policy, plan or service	This policy aligns with legislative requirements. All relevant persons are required to comply with this document and must demonstrate sensitivity and competence in relation to the nine protected characteristics as defined by the Equality Act 2010. It will be the responsibility of each person enacting this policy to ensure that it is implemented fairly and equitably, with dignity and respect. A search of similar policies elsewhere indicated a neutral or positive impact in relation to protected groups:- https://www.google.co.uk/search?q=section+5%284%29+policy&ie=utf-8&oe=utf-8&client=firefox-b&gfe_rd=cr&dcr=0&ei=eqPoWdTDKcqAkgX6g5TIAQ

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Action Plan for Mitigation / Improvement and Implementation

	Action	Lead	Timescale	Action taken by Clinical Board / Corporate Directorate
8.2 What are the key actions identified as a result of completing the EHIA?	To ensure that an interpreter/translation is requested immediately to avoid delay and ensure patients are provided with information in their preferred language in a timely manner.	All appropriate staff	As and When required/requested	Staff will be/are made aware of our Interpretation and Translation policy and its use with service users.
8.3 Is a more comprehensive Equalities Impact Assessment or Health Impact Assessment required? This means thinking about relevance and proportionality to the Equality Act and asking: is the impact significant enough that a more formal and full consultation is required?	Not required	N/A	N/A	No action

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	Action	**Lead**	**Timescale**	**Action taken by Clinical Board / Corporate Directorate**
8.4 What are the next steps? Some suggestions:- • Decide whether the strategy, policy, plan, procedure and/or service proposal: ○ continues unchanged as there are no significant negative impacts ○ adjusts to account for the negative impacts ○ continues despite potential for adverse impact or missed opportunities to advance equality (set out the justifications for doing so) stops. • Have your strategy, policy, plan, procedure and/or service proposal approved • Publish your report of this impact assessment • Monitor and review	No significant negative Impact. The policy will be submitted to the Mental Health and Capacity Legislation Committee for approval. Once the policy has been approved the documentation will be placed on the intranet and internet. The EHIA and Policy will be reviewed three years after approval unless changes to terms and conditions, legislation or best practice determine that an earlier review is required.	N/A	N/A	N/A Hospital managers should monitor the use of section 5(4), including: • How quickly patients are assessed for detention and discharged from the holding power • The proportion of cases in which applications for detention are, in fact, made following use of section 5(4). • Ensure the patients are made aware of their rights under section 132 of the Mental Health Act.

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Reference Number: *TBA* **Version Number:** 1	**Date of Next Review:** *To be included when document approved* **Previous Trust/LHB Reference Number:** *Any reference number this document has been previously known as*

Section 5(4) Nurses' Holding Power Procedure
Mental Health Act, 1983

Introduction and Aim

This document supports the Section 5(4) Nurses' Holding Power Policy, Mental Health Act, 1983.

To ensure staff are aware of their individual and collective responsibilities when considering use of the nurses' holding power under section 5(4).

To Provide clear guidance to staff in relation to their legal responsibilities under the Mental Health Act 1983 as amended by the MHA 2007.

To Ensure that statutory requirements under the Mental Health Act 1983 are met.

Objectives

This procedure describe the following with regard to a nurses' holding power:

- The purpose of a nurses' holding power
- The process for assessing the suitability for the use of a nurses' holding power
- The duties of the practitioners and agencies involved in the management of patients subject to a nurses' holding power

Practitioners must have due regard to the Mental Health Act Code of Practice generally and specifically to the Guiding Principles when they are considering the use of a doctors holding power. This will ensure that considerations are given as to whether the objectives can be met in a less restrictive way.

Scope

This procedure applies to all of our staff in any inpatient setting where a person is receiving inpatient treatment in hospital and is not already liable to be detained or who is subject to a community treatment order (CTO).

Patients who are in hospital by virtue of a deprivation of liberty authorisation under the Mental Capacity Act 2005 (MCA) may be detained under section 5(4).

This power can only be used in respect of patients who are receiving hospital treatment for mental disorder; it is not sufficient for the patient to be merely suffering from a mental disorder. Although the power can be invoked in any hospital where the patient is receiving treatment for mental disorder, it is unlikely that a non-psychiatric ward will be staffed with nurses' of the "prescribed class".[1]

Equality and Health Impact Assessment	There is potential for both positive and negative impact. The procedure is aimed at improving services and meeting diverse needs. Mitigation actions are already in place to

[1] https://www.legislation.gov.uk/wsi/2008/2441/article/2/made

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	offset any potential negative outcome, e.g. through the monitoring of the procedure. There is nothing, at this time, to stop the procedure from being implemented.
Documents to read alongside this Procedure	• The Mental Health Act 1983 (as amended by the Mental Health Act 2007) • Mental Health (hospital, guardianship, community treatment and consent to treatment)(Wales) regulations 2008 • The Mental Capacity Act 2005 (including the Deprivation of Liberty Safeguards delegated to this Act under the Mental Health Act 2007) • The respective Codes of Practice of the above Acts of Parliament • The Human Rights Act 1998 (and the European Convention on Human Rights) • Domestic Violence, Crime and Victims Act, 2004 All Cardiff and Vale policies on the Mental Health Act 1983 as appropriate including: Section 5(4) Nurses' Holding Power Policy Section 5(2) Doctors' Holding Power Policy Section 5(2) Doctors' Holding Power Procedure Hospital Managers' Scheme of Delegation Policy Hospital Managers' Scheme of Delegation Procedure
Approved by	Pending – Mental Health and Capacity Legislation Committee

Accountable Executive or Clinical Board Director	*Mental Health Clinical Board Director of Operations*
Author(s)	*Mental Health Act Manager*

Disclaimer

If the review date of this document has passed please ensure that the version you are using is the most up to date either by contacting the document author or the Governance Directorate.

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Summary of reviews/amendments

Version Number	Date of Review Approved	Date Published	Summary of Amendments

1	*Date of Committee or Group Approval*	*TBA*	*New document*

Glossary of terms

Term	Definition
AC	Approved Clinician – A mental health professional approved by the Welsh Ministers to act as an approved clinician for the purposes of the Act. In practice, Health Boards take these decisions on behalf of the Welsh Ministers
Community Treatment Order (CTO)	The legal authority for the discharge of a patient from detention in hospital, subject to the possibility of recall to hospital for further medical treatment if necessary. Community patients are expected to comply with the conditions specified in the community treatment order.
Form HO13	Statutory Welsh form to be completed by qualified nurser when implementing section 5(4)
RC	Responsible Clinician - The approved clinician with overall responsibility for the patient's case
IMHA	Independent Mental Health Advocate – An advocate independent of the team involved in patient care available to offer support to patients.
Mental Capacity Act (2005)	An Act of Parliament that governs decision-making on behalf of people who lack capacity, both where they lose capacity at some point in their lives and where the incapacitating condition has been present since birth.
MHRTfW	Mental Health Review Tribunal for Wales – A judicial body that has the power to discharge patients from detention, community treatment orders, guardianship and conditional discharge
Part 4, Mental Health Act	The Part of the Act which deals mainly with the medical treatment for mental disorder of detained patients (including conditionally discharged and community treatment order patients who have been recalled to hospital). In particular, it sets out when they can and cannot be treated for the mental disorder without their consent.
Section 2	Compulsory admission of a patient to hospital for assessment and treatment for detention up to 28 days
Section 3	Compulsory admission to hospital for treatment and detention for up to six months

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Section 17 leave	Formal permission for a patient who is detained in hospital to be absent from the hospital for a period of time; patients remain under the powers of the Act when they are on leave and can be recalled to hospital if necessary in the interests of their health or safety or for the protection of others.
Section 133	The duty of hospital managers to provide information nearest relatives of a patients discharge.
Keywords	Section 5(4), Nurses' Holding Power, Mental Health Act, 1983

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1. INTRODUCTION

Under section 5(4) nurses' of the prescribed class may detain a hospital inpatient who is already receiving treatment for the mental disorder for up to six hours. The decision to invoke the power is the personal decision of the nurse, who cannot be instructed to exercise the power by anyone else. This power may only be used where the nurse considers:

- The patient is suffering from mental disorder to such a degree that it is necessary for the patient to be immediately prevented from leaving the hospital, either for the patient's health or safety or the protection of other people.
- The patient is not an informal patient who is also subject to a community treatment order.
- It is not practicable to secure the attendance of a doctor or approved clinician who can submit a report under section 5(2).

2. PROCEDURE STATEMENT

This procedure has been developed to guide staff on the implementation and management of nurses' holding powers (Section 5(4)) in accordance with the Mental Health Act 1983 as amended by MHA 2007. This guidance has been developed in line with the Mental Health Act 1983 Code of Practice for Wales 2016 (Code of Practice).

Holding powers when implemented authorises the detention of the patient in the hospital for a maximum of six hours so the patient can be assessed with a view to an application for detention under the Act being made.

3. SCOPE

The Health Board has in place appropriate governance arrangements to monitor and review the exercise of functions under the Act on its behalf. The Mental Health and Capacity Legislation Committee is specifically for this purpose.

This procedure is applicable to all qualified nurses' within all mental health inpatient settings.

4. DUTIES AND RESPONSIBILITIES OF NURSES' OF THE PRESCRIBED CLASS

A nurse of the prescribed class is defined in the Mental Health (Nurses') (Wales) Order 2008 as a nurse registered in sub-part 1 or 2 of the nurses' part of the Register of the Nursing and Midwifery Council, with a recordable qualification in mental health or learning disability nursing as follows:

A nurse registered in	**Sub-part 1** of the register, whose entry includes an entry to indicate the nurse's field of practice is mental health nursing

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Sub-part 2 of the register, whose entry includes an entry to indicate the nurse's field of practice is mental health nursing
Sub-part 1 of the register, whose entry includes an entry to indicate the nurse's field of practice is learning disabilities nursing
Sub-part 2 of the register, whose entry includes an entry to indicate the nurse's field of practice is learning disabilities nursing

5. ASSESSMENT PRIOR TO IMPLEMENTATION

Before using the power, nurses' should make as full as assessment an possible in the circumstances, but sometimes it may be necessary to invoke the power on the basis of only a brief assessment e.g. when events occur very quickly and the patient is determined to leave, the result of which could potentially have serious consequences if the patient was successful in leaving.

When making a full assessment they should assess:

- The likely arrival of the doctor or approved clinician
- The likely intention of the patient to leave, as it may be possible to persuade the patient to wait until a doctor or approved clinician arrives
- The harm that might occur to the patient or others if the patient were to leave the hospital before the doctor or approved clinician arrives. In this regard, the nurse should consider all aspect of the patient's communication and behaviour, including:
    - The patient's expressed intentions
    - The likelihood of the patient harming themselves or others, or behaving violently
    - Any evidence of disordered thinking
    - Any changes to their usual behaviour and any history of unpredictability or impulsiveness
    - Dates of special significance for the patient
    - Any recent disturbances on the ward
    - Any relevant involvement of other patients
    - Any formal risk assessments, which have been undertaken
    - Any other relevant information

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The use of the holding power permits the patient's detention for up to six hours or until a doctor or approved clinician with the power to use section 5(2) arrives at the place the person is being detained, whichever is the earlier. Detention under section 5(4) cannot be renewed although this does not prevent it from being used on more than one occasion if necessary.

The patient is detained from the moment the nurse makes the necessary record. The reasons for invoking the power and the time this was done should be entered on PARIS, the patients' electronic record. A Form HO13 is completed by the nurse. These

documents must then be faxed and posted to the Mental Health Act administration team.

A nurse using section 5(4) should use the least restricting intervention to prevent the patient leaving hospital.

The nurse must be fully aware of the diverse needs of the patient when considering detention and must take them in to account at all times. They must ensure the patient fully understands what is happening to them in a language and format which they are able to understand, this will include sensory and cognitive abilities and physical impairment. Where necessary, an interpreter should be obtained.

The nurse should ensure that the patient is made aware of their rights under the Act and this is documented in the patients' notes. Information and leaflets are available to download from the Cardiff and Vale, Mental Health Act intranet page.

Hospital managers should ensure suitably qualified, experienced and competent nurses' are available to all wards where there is a possibility of section 5(4) being invoked.

6. DOCTOR/APPROVED CLINICIAN RESPONSIBILITIES

The use of section 5(4) is an emergency measure, and the doctor or approved clinician with the power to use section 5(2) in respect of the patient should treat it as such and arrive as soon as possible. The doctor or approved clinician should not wait the maximum time of six hours before attending.

The power to detain lapses once the doctor or approved clinician arrives to assess the patient. The time at which the patient ceased to be detained under section 5(4) should be recorded in the patient's record, together with the reasons and outcome.

7. MENTAL HEALTH ACT ADMINISTRATOR RESPONSIBILITIES

The Mental Health Act administrator will ensure that all relevant documents are received within the Mental Health Act Administration department.

The Mental Health Act administrator will carry out the scrutiny of documents and ensure that forms comply with guidance and the persons completing the forms are authorised to do so.

The Mental Health Act administrator will ensure that the original detention papers are filed in the patients' statutory file within the Mental Health Act administration department.

8. SECTION 17 LEAVE

A patient detained on section 5(4) cannot receive section 17 leave. They are not detained by virtue of either an application under section 2 or section 3 and therefore do not have a Responsible Clinician to grant such leave.

9. COMMUNITY TREATMENT ORDER PATIENTS

Section 5(4) is not applicable to a patient subject to a Community Treatment Order (CTO). Patients can be recalled even during periods when they are in-patients. Therefore where it is considered necessary, the recall procedure must be used to detain the patient and within the 72 hours allowed a decision must be made whether to revoke the CTO.

Section 5(4) cannot be used to keep a patient in hospital after the end of the 72 hour recall period if the CTO has not been revoked.

10. SECTION 18 ABSENT WITHOUT LEAVE (AWOL)

A patient detained under section 5(4) who leaves the hospital is AWOL and can be retaken but only within the six hour period.

11. INAPPROPRIATE USE OF SECTION 5(4)

Section 5(4) cannot be used in the following circumstances:

- For an outpatient attending an accident and emergency department or any other out-patient facility.
- For a patient who is already liable to be detained in hospital or who is subject to a CTO.
- Is not to be used as a holding power simply for the purpose of persuading the patient to stay.

Patients should not be informally admitted with the sole intention of then using the holding power.

12. ENDING OF SECTION 5(4)

Section 5(4) holding powers last for a maximum of six hours and cannot be renewed.

Detention under section 5(4) will end if:-

- The result of the assessment is a decision not to make an application under section 2 or section 3.
- An application under section 2 or section 3 is made.
- The patient is discharged for clinical reasons before an assessment can be undertaken.

The patient should be informed once they are no longer held under section 5(4) and advised of the reasons why. If this is because section 2 or section 3 was not applied, the patient should be informed they are free to leave hospital.

13. MEDICAL TREATMENT OF PATIENTS

Patients subject to section 5(4) are not subject to consent to treatment provisions contained in Part 4 of the MHA. If the patient is mentally capable of making a decision about treatment, the common law enables them to refuse to be treated for either a physical or mental disorder. However, if the patient is assessed as being mentally incapable of making a decision about treatment, the treatment can be provided under the Mental Capacity Act 2005 if it is deemed to be in their best interests.

14. TRANSFER TO OTHER HOSPITALS

Patients detained under section 5(4) cannot be transferred to another hospital under section 19, because they are not detained by virtue of an application made under Part 2 of the Act. This includes transfer between hospitals managed by the same hospital managers.

A patient who is subject to section 5(4) of the Act but needs to go to another hospital urgently for treatment, security or other exceptional reasons, can only be taken there if they consent to the transfer. If the patient lacks capacity to consent to the transfer, any transfer must be carried out in accordance with the MCA.

If, following transfer, the patient tries to leave the receiving hospital, a new situation will have arisen. In this circumstance, the receiving hospital may need to use section 5(4) to provide authority to detain the patient in that hospital.

In all cases, if the conditions are met, an emergency application for detention under section 4 of the Act could be made by the sending hospital. The patient could then be transferred to the receiving hospital under section 19. Alternatively, an emergency application under section 4 could be submitted to the managers of the receiving hospital.

15. APPEALS

A patient detained under section 5(4) cannot make an application to the Mental Health Review Tribunal for Wales or appeal to the hospital managers.

16. MONITORING

Hospital managers should monitor the use of section 5(4), including:

- How quickly patients are assessed for detention and discharged from the holding power
- The proportion of cases in which applications for detention are, in fact, made following use of section 5(4).
- Ensure the patients are made aware of their rights under section 132 of the Mental Health Act.

17. TRAINING

The health board will provide ongoing training for staff who have a delegated duty under the scheme of delegation. Details of training courses available can be found by contacting the Mental Health Act administration team.

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18. IMPLEMENTATION

This document will be widely disseminated to staff in Cardiff And Vale University Health Board. It will be published on the organisations intranet sites and referred to during training relevant to the Act.

19. RESPONSIBILITIES

19.1 Chief Executive

The Chief Executive Officer has overarching responsibility for ensuring that Cardiff and Vale University Health Board is compliant with the law in relation to the Mental Health Act.

19.2 Chief Operating Officer

The Chief Operating Officer is the Executive Lead for Mental Health. He has overarching responsibility for ensuring compliance with the contents of this procedure.

19.3 Designated Individuals

All qualified nursing staff caring for patients on mental health inpatient wards should be familiar with the procedures detailed in the document and other related policies/procedures.

20 REFERENCES

All staff will work within the Mental Health Act 1983 and in accordance with the Code of Practice for Wales 2007, Mental Capacity Act 2005, and Human Rights Act 1998.

Mental Health Act 1983 - www.legislation.gov.uk/ukpga/1983/20/contents
Mental Capacity Act 2005 - www.legislation.gov.uk/ukpga/2005/9/schedule/7
Mental Health Review Tribunal for Wales www.justice.gov.uk/tribunals/mental-health
Human Rights Act 1998 - www.legislation.gov.uk/ukpga/1998/42/contents
http://www.legislation.gov.uk/wsi/2008/2441/article/2/made

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MINUTES OF THE MEETING OF THE MENTAL HEALTH ACT HOSPITAL MANAGERS POWER OF DISCHARGE SUB COMMITTEE HELD AT 10AM ON 24 APRIL 2018 IN TRAINING ROOM TWO AT HAFAN Y COED.

Present:

Mr Jeff Champney-Smith	Chair, PoD Group
Mrs Elizabeth Singer	Vice Chair, Pod Group
Mr Rashpal Singh	PoD member
Mr John Owen	PoD member
Mr Huw Roberts	PoD member
Mrs Teresa Goss	PoD member
Mrs Mary Williams	PoD member
Mrs Elaine Gorvett	PoD member
Mrs Mair Rawle	PoD member
Mrs Patricia Hallett	PoD member
Mr Alan Parker	PoD member
Mr Simon Williams	PoD member

In attendance:

Mr Owen Baglow	Clinical Lead for Quality, Safety and Governance
Mrs Bianca Simpson-Lepore	Mental Health Act Admin Manager
Mr Simon McDonald	Mental Health Act Coordinator

Apologies:

Ms Sunni Webb	MHA Manager
Mrs Wendy Hewitt-Sayer	PoD member
Mrs Sharon Dixon	PoD member
Dr John Copley	PoD member
Mr Peter Kelly	PoD member
Mrs Sarah Vetter	PoD member
Mr Tony Summers	PoD member

1 Welcome and Introductions

The Chair of the group introduced everyone to the meeting and explained that the MHA manager would not be present at the meeting today as normal.

2 Apologies

All apologies were received and noted

3 Minutes of Meeting held on 09 January 2018

Mrs Mary Williams is to be added to the list of attendees at the meeting on 09th January 2018.

The minutes were otherwise accepted as a true and accurate record of the previous meeting.

4 Matters Arising

The safety of the PoD members at hearings was again raised as an issue. The general view of those present was that alarm fobs for each PoD member is unnecessary despite some PoD members appearing to already have one. It was noted that clients are risk assessed prior to attending hearings and that if necessary hearings are held on the ward. The Chair of the PoD group will be looking into online breakaway training to see how beneficial this would be to the group. It is possible that this training will become part of the mandatory training PoD members have to do each year.

At the last PoD group meeting there was a query relating to the lines on the Control Charts submitted to PoD members mean. The MHA Coordinator has put together an information pack to explain in detail what the lines meant. It was briefly discussed that the lines are averages and that if the figures on the charts were to go above or below the limits then this would give rise to a possible investigation.

The group were informed about the upcoming changes in the law regarding data protection and that the General Data Protection Regulation will be coming into place on 25th May 2018. One POD member reminded the group to be vigilant when opening emails as there is potential for spam emails to be rife when opting into services as a result of the GDPR. The group were informed that the change in regulation is unlikely to affect their role as the Health Service has what will be known as a 'legitimate concern' and that it will be assumed people want the NHS to have their data to enable successful treatment.

PoD members have also previously queried how they can safely dispose of their computers/ tablets after having had patient confidential information on them. It was explained that it is the responsibility of the individual to dispose of their items correctly but that if PoD members brought their computers/ tablets to the MHA Dept then we will be able to destroy them securely on their behalf. It was briefly discussed that in the private sector patient reports are not sent out to PoD members and that panel members have to attend an hour or so prior to hearings to read reports.

5 Members points for Open Discussion

One member of the group was in particular concerned about the increase in back to back hearings that he has experienced. Those present discussed this and it appears to just be certain members of the group that have experienced an increase. The rest have not seen any change. A couple of PoD members complained about being taken off hearings if they could not sit on both panels but it was reiterated that PoD members are paid per session (two hearings if necessary) rather than per hearing and that this is a more prudent way of using NHS finances. The ongoing issue of chairing two hearings in a row was again raised but it was explained that if any PoD member felt unable to do this then they should let the MHA department know. There appears to have been an increase in the number of adjourned hearings lately, the group noted the cost impact of this. PoD members have asked that MHA administrators let them know when they are being booked on an adjourned hearing. It was confirmed that administrators do endeavour to put the same panel together for adjourned hearings but this is not always possible.

The newer PoD members have expressed a desire for a mentoring scheme to be put together for them. The more experienced PoD members would also potentially benefit from this. The chair of the PoD group has agreed to begin a mentoring programme and will be looking into this further in the near future. It is expected that a mentoring protocol will be in place by the next PoD group.

***Action - MHA staff to inform PoD members when arranging adjourned hearings*.**

6 MHA Activity Monitoring report January- March 2018

PoD Activity

PoD members were pleased to note there was one PoD group discharge during the last quarter. This is the first, in approximately, three years. The details of the case were discussed. It was agreed that this was a positive action by the PoD members. It was noted that PoD members are not entitled to follow up information subsequent to a patients discharge. The higher number of postponements was also noted, this was partially as a result of adverse weather.

MHRT Activity
PoD members were informed that unfortunately they will not be entitled to observe Mental Health Review Tribunals.

The process of a Welsh minister's referral was explained.

7 Recommendations from Power of Discharge Group hearings Jan- Mar 2018

The chair of the panel felt that compliments to professionals could be raised more often- those present agreed.

One recommendation in particular was discussed at length due to the contentious nature of the case. The clinical lead for quality, safety and governance agreed to escalate this to the responsible clinician. The Chair of the PoD group reiterated that all the recommendations are passed through to the legislation committee. PoD members were pleased with this as there is some concern regarding this one case.

The Chair of the PoD group read out a compliment given to the PoD group from an advocate following a recent hearing. PoD members were complimented on allowing the advocate to speak openly and understanding the purpose of the advocate role.

One complaint was also discussed whereby a panel member had not introduced her role clearly and the social worker had therefore misunderstood that the hearing was a managers hearing rather than a Mental Health Review Tribunal. All PoD members were asked to introduce themselves at hearings but it is thought that the social worker has also received further training.

Action- Clinical Lead for Quality, Safety and Governance to escalate recommendation

8 Training

A workshop will be arranged to look at decision making/writing. Managers hearing and MHRT outcomes will be compared to see how and whether manager's hearings reasons can be improved. PoD members had a similar kind of group some years ago which they found beneficial.

The all Wales training day was also discussed. It was explained that there is no confirmed date as yet but that it will be going ahead. PoD members will be informed as soon as more definite arrangements have been made.

9 Any other business

The Chair of the panel thanked all the other members for their cooperation during the review process. He commented that he was pleased to note the various views of the PoD members in regard to a range of different matters. All members have been appointed for another year and it was confirmed that Mr Peter Kelly would be commencing sitting on hearings again as of July 2018.

The Chair of the PoD group explained that his review was conducted by the Mental Health Clinical Board director of operations and that he is happy for the Chair of the panel to carry on conducting the reviews in future. Any issues that the PoD members feel they are unable to raise with the chair of the group can be discussed with the Mental Health Clinical Board Director of Operations. It was also agreed that, in future, as part of the review process some hearings will be observed by the Mental Health Act Manager, the Lead for Quality, Safety and Governance and the Mental Health Clinical Board Director of Operations.

PoD members queried whether or not they will need further DBS checks. One PoD members thinks this is not necessary but it was agreed that this will be looked into so that PoD members can be given a definitive answer.

Action - MHA Manager/ Coordinator- to investigate DBS checks

The group were informed that two temporary members of staff have been brought into the MHA office to hopefully alleviate some of the pressure on the office at present.

The Mental Health Act Admin Manager will be on maternity leave by the time of the next PoD group.

All those who are currently using the CJSM system agreed that it is working well and is a successful introduction to the group. The last remaining members not using the system will be trained fairly soon.

The E-expenses system also seems to be working well and PoD members don't have any concerns regarding its usage.

One PoD member would like a breakdown of the wards specialities so that when wards are referenced in reports it is clearer why patients are being placed where they are.

Some PoD members noted that reports are occasionally being sent out at short notice. They were aware of the pressure the MHA Office is currently under and took note of this.

Action – MHA Coordinator to produce list of ward/specialities for the group

10 Date of future meetings to be held at 10.00hrs in the Seminar Room, First Floor, HYC, and UHL:

24 July 2018
30 October 2018

Bwrdd Iechyd Prifysgol Caerdydd a'r Fro
Cardiff and Vale University Health Board

Hospital Managers' Power of Discharge Handbook

Reference No:	Mental Health Document only	**Version No:**	2	**LHB Ref No:**	

Documents to read alongside this Policy , Procedure etc (delete as necessary)	• The Mental Health Act 1983 (as amended by the Mental Health Act 2007) • Mental Health (hospital, guardianship, community treatment and consent to treatment)(Wales) regulations 2008 • The Mental Capacity Act 2005 (including the Deprivation of Liberty Safeguards delegated to this Act under the Mental Health Act 2007) • The respective Codes of Practice of the above Acts of Parliament • The Human Rights Act 1998 (and the European Convention on Human Rights) • Domestic Violence, Crime and Victims Act, 2004 All Cardiff and Vale UHB policies on the Mental Health Act 1983 as appropriate including: Hospital Managers' Scheme of Delegation Policy Receipt of applications for detention under the Mental Health Act Mental Health Review Tribunal Procedure and Guidance Section 5(4) Nurses' Holding Power Policy Section 5(4) Nurses' Holding Power Procedure Section 5(2) Doctors' Holding Power Policy Section 5(2) Doctors' Holding Power Procedure Community Treatment Order Policy Community Treatment Order Procedure

Classification of document: *Mental Health Act 1983*

Area for Circulation: *Mental Health Clinical Board*

Author/Reviewee: *Mental Health Act Manager*

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Executive Lead:	*Executive Director, Public Health*
Group Consulted Via/ Committee:	*Mental Health and Capacity Legislation Committee*
Approved by:	*Patient Quality and Safety*
Date of Approval:	*11 April 2018*
Date of Review:	*Date document due for review*
Date Published:	

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OUT OF DATE POLICY DOCUMENTS MUST NOT BE RELIED ON

Version Number	Date of Review Approved	Date Published	Summary of Amendments
Mental Health Document only			Amendments made to reflect the changes made to the Mental Health Act Code of Practice, (Revised 2016). Supervised Community Treatment has been replaced with Community Treatment Order. Includes further information on types of mental disorder. Guidance included on what to do if the panel cannot reach a unanimous decision. Amendments made to reflect changes made to the Police and Crime Act 2017, in relation to section 135 and 136.

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Hospital Managers' Power of Discharge Handbook

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1. INTRODUCTION

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

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

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

2. EQUALITY STATEMENT

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

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

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

3. CONFIDENTIALITY

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

4. THE MENTAL HEALTH ACT 1983(2007) "THE ACT"

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

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

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

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

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

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

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

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

4.1 Protection from liability

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

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

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4.2 Rights

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

4.3 Limitations

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

4.4 Age range of the Act

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

4.5 Where does the Act apply?

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

5. KEY PARTS OF THE ACT

5.1 Definition of mental disorder

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

5.2 Powers to admit and treat people in hospital

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

5.3 Criminal and Court related powers

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

5.4 Community powers

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

5.5 Treatment

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

5.6 Mental Health Review Tribunal for Wales (The Tribunal)

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

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

The Tribunal's principal powers are to:

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

There are separate Tribunals in England and Scotland.

5.7 Hospital Managers

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

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

5.8 Independent Mental Health Advocacy

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

5.9 Healthcare Inspectorate Wales

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

5.10 Nearest Relative

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

5.11 Conflicts of interest

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

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

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

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

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

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

N.B:

This is a statutory code concerning the practical use of the Act. It represents current thinking on best practice when using the legislation.
The Act does not impose a legal duty to comply with the Code, but due regard must be paid to it by those involved in the application of the Act and reasons for any departure from it should be recorded. Departures from the Code could give rise to legal challenge. In reviewing any such departure, a court will scrutinise the reasons for doing so to ensure that there is sufficiently convincing justification under the circumstances.

7.1 The Guiding Principles

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

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

8. HUMAN RIGHTS ACT 1998

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

8.1 Article 2 – The Right to Life

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

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

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

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8.3 Article 5 - Right to Liberty and Security

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

8.4 Article 8 – Right to a Private Life

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

8.5 Article 14 – Prohibition of Discrimination

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

9. THE HOSPITAL MANAGERS – WHO ARE THEY?

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

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

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

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

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

9.1 Duties of Hospital Managers:

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

9.2 Powers of Hospital Managers:

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

9.3 Hospital Managers' Power of Discharge

The Hospital Managers do not conduct reviews of informal patients.

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

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

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

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9.4 The Mental Health and Capacity Legislation Committee

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

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

10. MENTAL DISORDER

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

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

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

10.1 Dependence on alcohol or drugs

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

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

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

2 2.6 MHA CoP for Wales, (Revised 2016)

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organic mental disorders associated with prolonged abuse of drugs or alcohol remain mental disorders for the purposes of the Act. [3]

10.2 Learning disabilities

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

10.3 Autistic spectrum disorders

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

10.4 Personality disorders

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

11. ASSESSMENT FOR POSSIBLE ADMISSION UNDER THE ACT

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

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

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

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3 2.7 MHA CoP for Wales, Revised 2016(Revised 2016)

4 2.9 MHA CoP for Wales, Revised 2016(Revised 2016)

5 2.12 MHA CoP for Wales, Revised 2016(Revised 2016)

6 2.13 MHA CoP for Wales, Revised 2016(Revised 2016)

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

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

Admission may either be informal or formal.

12.1 Informal Admission

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

12.2 Formal Admission

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

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

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

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

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

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

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

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

12.4 Who decides in an emergency?

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

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

12.5 Appropriate medical treatment test

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

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

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

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

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12.6 What happens when the patient arrives at the hospital?

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

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

12.7 What is the role of the nearest relative?

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

12.8 Identifying the nearest relative

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

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

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

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

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

- **Carers**

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

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

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

12.9 Exclusions

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

The following people are excluded from being a nearest relative:

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

12.10 Nearest Relatives of detained patients who are not UK residents

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

12.11 Unrelated Nearest Relatives

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

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12.12 Information for patients and nearest relatives

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

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

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

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

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

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

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

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

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

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

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

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

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

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

  - The patient's diagnosis and the need for medical treatment.
  - The freedom of the individual.
  - The protection of the public and
  - The best interests of the patient.

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

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

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

  Tribunals have the power to:

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

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- Reconvene if their recommendations are not complied with – however, the hospital is not obliged to follow up recommendations of a Tribunal.

- **Hospital Managers' Review (Hearings) -** Section 23 gives the Hospital Managers the power to discharge an unrestricted detained patient from detention or CTO.

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

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

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

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

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

12.15 Section 2 – Admission for Assessment

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

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

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

12.16 Section 3 – Admission for Treatment

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

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

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

12.17 Section 37 – Hospital Order

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

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

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

12.18 Section 4 – Emergency Admission for Assessment

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

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

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

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

12.20 Section 5(4) – Nurse's Holding Power

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

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

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

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

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

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

12.23 Section 136 – Police power of arrest

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

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12.24 Section 17A – Community Treatment Order (CTO)

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

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

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

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

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

12.25 Section 7 – Guardianship

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

12.26 Part 4 – Treatment

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

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

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

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

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

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

- They have an attorney or deputy who can give authority for the treatment; or if the Court of Protection is asked to give authority, through an order of the court;

or

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

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

12.28 Section 17 – Leave of absence

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

12.29 Section 18 – Absent without leave (AWOL)

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

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

12.30 Section 20 – Renewal of authority to detain

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

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

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12.31 Section 20A – Extending a Community Treatment Order

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

12.32 Section 23 – Discharge from detention

Sections can end in a number of ways including:

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

12.33 Section 117 – Aftercare

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

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

13. ARRANGEMENTS FOR HOSPITAL MANAGERS’ POWER OF DISCHARGE HEARINGS

13.1 When to hold a review

Hospital Managers:

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

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

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

13.2 Chairing a panel

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

13.3 Agreeing key questions

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

13.4 Location

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

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

13.5 Uncontested Hearings

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

13.6 Contested Hearings

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

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

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13.7 Potentially Complex Hearings

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

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

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

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

13.8 Mental Health Act Office Responsibilities

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

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

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

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

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

13.9 Conduct of proceedings

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

15.1

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

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

Any questions should be asked of all parties in a manner that is thorough, fair and courteous.
Care should be taken not to undermine the patient's relationship with the patient's care team or his/her family.

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

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

13.10 Questioning the clinical team

Some essential questions which must be asked:

13.11 Medical Staff:

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

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

Section 2 patients:

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

Other detained patients:

15.1

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

CTO patients:

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

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

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

Section 25 barring order

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

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

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

15.1

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

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

13.12 Nursing staff:

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

13.13 Social Worker/Care Coordinator:

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

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

13.14 The Patient

Panel members must ascertain if the patient would:

- Whether the patient would stay in hospital as an informal patient if the Section was lifted; would they continue to comply with treatment as an outpatient (the credibility of the answers would have to be assessed in the light of past evidence).

- The patient's right to a **Mental Health Review Tribunal** should be clarified, and the patient's understanding of his or her rights should be ascertained.

13.15 The nearest relative

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

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

13.16 Appraising Professional views and reports

15.1

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

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

13.17 Reaching a decision

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

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

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

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

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

13.18 Recording hearings and decisions

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

15.1

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

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

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

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

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

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

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

13.19 Adjourning/ postponing a hearing

The Code states that:

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

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

Additional information may be required if there are:

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

15.1

Other reasons for adjourning may include:

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

13.20 Unable to reach a unanimous decision

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

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

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

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

13.21 Informing the patient of the Hospital Managers' decision

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

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

15.1

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

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

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

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

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

It also includes the following:

- **Reasons for doubting a person's capacity**
  There needs to be a reason for doubting a person's ability to take their own decisions. The Mental Capacity Act Code of Practice explains this further.
- **A statutory test for capacity**
  The Act provides the test to be used to decide if someone can take a particular decision for themselves.
- **Identifies who has the authority to make decisions for the person**

The source of authority for a decision will vary from one context to another. The Act sets out who has the authority in differing circumstances.

- **The IMCA (Independent Mental Capacity Advocate) safeguard**
  The Act sets out when a person is entitled to the support of a statutory advocate.

- **The best interests process**
  Any decision that is made on behalf of a person who lacks capacity must follow the process set out in the Act.

15.1

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

14.1 Deprivation of Liberty Safeguards (DoLS)

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

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

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

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

15.1

Appendix 1

Key words and phrases

A

Absent without leave (AWOL)
When a patient absconds from legal custody in the following circumstances:

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

The Act
Unless otherwise stated, the Mental Health Act 1983.

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

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

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

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

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

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

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

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

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

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

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

Apathy
Lack of feelings, emotions, interests or concerns.

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

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

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

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

Approved Mental Health Professional (AMHP)
A professional with training in the use of the Act, approved by a local authority to carry out a number of functions under the Act.

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

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

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

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

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

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

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

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

C

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

Care and treatment Plan –see Mental Health (Wales) Measure 2010
A statutory plan prepared for the purpose of achieving the outcomes which the provisions of mental health services for a relevant mental health patient are designed to achieve.

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

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

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

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

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

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

Children Act 1989
A law relating to children and young people and those with parental responsibility for them which also describes the roles, duties and responsibilities of statutory agencies, such as local authority social services.

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

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

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

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

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

Compulsion
A recurring irresistible impulse to perform an act.

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

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

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

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

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

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

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

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

15.1

Convey (and conveyance)

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

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

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

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

D

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

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

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

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

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

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

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

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

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

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

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

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

Doctor
A registered medical practitioner.

Doctor approved under section 12
A doctor who has been approved under the Act by the Welsh Ministers in Wales or the Secretary of State in England as having special experience in the diagnosis or treatment of mental disorder. The practice in Wales is that Local Health Boards take these decisions on behalf of the Welsh Ministers.

15.1

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

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

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

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

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

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

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

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

Dysphasia
A disturbance of either the comprehension or expression of speech.

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

E

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

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

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

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

F

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

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

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

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

G

GP
A patient's general practitioner (or "family doctor").

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

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

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

H

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

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

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

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

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

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

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

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

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

Human Rights Act 1998
A law largely incorporating into UK law the substantive rights set out in the European Convention on Human Rights.

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

I

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

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

Illusions
False perceptions or false responses to a sensory stimulus.

Independent Hospital
A hospital which is not managed by the NHS.

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

Independent Mental Health Advocate (IMHA)
An advocate available to offer help to patients under arrangements which are specifically required to be made under the Act.

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

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

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

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

J
K
L

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

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

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

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

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

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

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

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

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

M

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

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

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

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

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

Mental Capacity Act 2005
The Mental Capacity Act provides the legal framework to assess a person's mental capacity to make decisions about themselves in relation to finance, health and social care. It provides additional powers to make decisions on behalf of a person who lacks capacity to make such decisions for themselves.

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

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

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

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

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

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

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

N

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

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

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

O
P

Part 2
The part of the Act which deals mainly with the detention, guardianship and supervised community treatment of civil i.e. non-offender patients.

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

Part 2 patient
A civil patient who became subject to compulsory measures under the Act as a result of an application for detention or guardianship by a nearest relative or an approved mental health professional.

Part 3
The part of the Act that deals with mentally disordered offenders and defendants in criminal proceedings. It allows courts to detain people in hospital for treatment instead of punishing them where particular criteria are met. It also allows the Secretary of State for Justice to transfer certain individuals from prison to detention in hospital for treatment.

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

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

Part 4A
The part of the Act which deals with the medical treatment for mental disorder of CTO patients when they have not been recalled to hospital.

Part 4A certificate
A certificate issued by a SOAD or Approved Clinician certificate approving particular forms of medical treatment for mental disorder for a CTO patient.

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

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

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

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

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

15.1

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

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

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

Q

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

R

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

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

Rehabilitation
See habilitation.

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

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

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

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

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

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

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

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

Relapse
Return of symptoms.

S

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

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

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

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

Community patient
A patient who is supervised on a community treatment order.

Section 12 Doctor
A doctor with special experience in the diagnosis and treatment of mental disorder.

Second Opinion Appointed Doctor (SOAD)
An independent doctor appointed in Wales by Healthcare Inspectorate Wales who gives a second opinion on whether certain types of medical treatment for mental disorder should be given without the patient's consent.

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

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

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

Section 117
See aftercare.

Section 135(1)
The power to forcibly enter a property to look for and remove a person to a place of safety (usually hospital) for assessment for a period of up to 24 hours.

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

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

Symptoms of schizophrenia

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

T

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

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

Thought broadcasting
A person believes that everyone can hear their thoughts.

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

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

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

15.1

U

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

V

Voluntary Patient.
See Informal patient.

W

Welsh Ministers
Ministers of the Welsh Government.

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