

Mental Health Legislation & Mental Capacity Act Committee

Tue 25 October 2022, 10:00 - 12:10

Agenda

10:00 - 10:01 **1.**
1 min
Welcome & Introductions

Ceri Phillips

10:01 - 10:02 **2.**
1 min
Apologies for Absence

Ceri Phillips

10:02 - 10:03 **3.**
1 min
Declarations of Interest

Ceri Phillips

10:03 - 10:05 **4.**
2 min
Minutes of the Meeting held on 26 July 2022

Ceri Phillips

 04 Mental Health Committee Mins 26.07.22MD.pdf (14 pages)

10:05 - 10:07 **5.**
2 min
Action Log from the meeting held on 26 July 2022

Ceri Phillips

 05 Action LogMD.pdf (2 pages)

10:07 - 10:09 **6.**
2 min
Chair's Action taken since last meeting

Ceri Phillips

10:09 - 10:10 **7.**
1 min
Any Other Urgent Business Agreed with the Chair

Ceri Phillips

Mohamed Sarah
17/10/2022 16:12:46

10:10 - 10:40
30 min

8. Mental Capacity Act

15 minutes

8.1. Mental Capacity Act Monitoring Report and DoLS monitoring

Jason Roberts

15 minutes

📄 8.1 MCA and DoLS report for MHLMCA 25.10.22.pdf (6 pages)

8.2. Liberty Protection Safeguards Monitoring Report

Jason Roberts

📄 8.2 Liberty Protection Safeguards Report for MHLMCA 25.10.22.pdf (2 pages)

10:40 - 11:20
40 min

9. Mental Health Act

9.1. Mental Health Act Monitoring Exception Report

Paul Bostock / Daniel Crossland

10 minutes

BREAK at 11am for 10 minutes

📄 9.1 Mental Health Act Monitoring Exception Report October 2022.pdf (7 pages)

📄 9.1a Mental Health Act Monitoring Report July - September 2022.pdf (50 pages)

9.2. HIW MHA Inspection Reports - Verbal Update

Paul Bostock

10 minutes

9.3. Section 49 Activity Update

Daniel Crossland

10 minutes

📄 9.3 S49 MHMCLC Cover Report AF.pdf (4 pages)

11:20 - 11:30
10 min

10. Mental Health Measure

10.1. Mental Health Measure Monitoring Reporting including Care and Treatment Plans Update Report

Mohamed Sarraf
17/10/2022 16:32:46

10 minutes

📄 10.1 Mental Health Measure Oct 2022 AMS and CAMHS Final.pdf (11 pages)

11:30 - 12:00
30 min

11. Items to bring to the attention of the Committee for Noting / Information

11.1.

Draft Mental Health Bill

Daniel Crossland / David Seward

15 minutes

A copy of the draft Mental Health Bill and the Explanatory Notes are published under the Supporting Documents section of the website and AdminControl

📄 11.1 MHLMCAC Report - Draft Mental Health Bill.pdf (16 pages)

11.2.

Corporate Risk Register

Nicola Foreman

10 minutes

📄 11.2 MHCLC Corporate Risk Register Report - July 2022.pdf (3 pages)

📄 11.2a Detailed Corporate Risk Register MHCLC entries September 2022.pdf (1 pages)

11.3.

Sub-Committee Meeting Minutes:

5 minutes

Jeff Champney-Smith / Robert Kidd

i) Hospital Managers Power of Discharge Sub Committee Minutes – 4 October 2022

ii) Mental Health Legislation and Governance Group Minutes & Action Log – 6 October 2022

📄 11.3.1 PoD Minutes October 2022.pdf (3 pages)

📄 11.3.2 MHLGG Minutes October 2022.pdf (7 pages)

📄 11.3.2b MHLGG Action Log (4).pdf (3 pages)

12:00 - 12:10
10 min

12. Items for Approval Ratification

12.1.

Policies

Paul Bostock / David Seward

📄 12.1 Policy Approval Cover Report.pdf (3 pages)

12.1.1.

Review of Detention and Community Treatment Order Policy & Procedure

📄 12.1.1a Review of Detention and Community Treatment Policy Final(2).pdf (42 pages)

📄 12.1.1b Review of Detention and CTO Procedure.pdf (14 pages)

12.1.2.

Patients' rights, information to detained/community patients' policy & procedure

- 📄 12.1.2a Patient Rights Information Policy Final.pdf (42 pages)
- 📄 12.1.2b Patient Rights Information Procedure Final.pdf (18 pages)

12.1.3.

Application for admissions under Part 2 Mental Health Act (MHA) policy & procedure

- 📄 12.1.3a Application for admission under Part II of the MHA Policy.pdf (40 pages)
- 📄 12.1.3b Application for admission under Part II of the MHA Procedure.pdf (19 pages)

12.2.

Mental Health Legislation and Governance Group Terms of Reference

Daniel Crossland / David Seward

- 📄 12.2 MHLMCAC - MHLGG ToR 2022 Covering Report.pdf (2 pages)
- 📄 12.2a MHLGG ToR June 2022.pdf (3 pages)

12:10 - 12:10
0 min

13. Any Other Business

Ceri Phillips

12:10 - 12:10
0 min

14. Review of the Meeting

Ceri Phillips

12:10 - 12:10
0 min

15. To note the date, time and venue of the next meeting:

January 31 2023 at 10am

Mohamed Sarah
17/10/2022 16:32:46

**Minutes of the Mental Health Legislation and Mental Capacity Act Committee
Held on 26th July 2022 – 10am
Via MS Teams**

Chair:		
Ceri Phillips	CP	UHB Vice Chair and Committee Chair
Present		
Akmal Hanuk	AH	Independent Member - Community
Sara Moseley	SM	Independent Member – Third Sector
In Attendance:		
Rebecca Aylward	RA	Interim Deputy Executive Nurse Director
Jeff Champney-Smith	JCS	Chair, Powers of Discharge sub-Committee
Daniel Crossland	DC	Deputy Director of Operations - Mental Health
Timothy Davies	TD	Head of Corporate Business
Marcia Donovan	MD	Head of Corporate Governance
Hannah Evans	HE	Managing Director Operations – Non-Acute
Charles Janczewski	CJ	UHB Chair
Robert Kidd	RK	Interim Clinical Director Psychology & Psychological Therapies
Suzanne Rankin	SR	Chief Executive Officer
Jason Roberts	JR	Executive Nurse Director
David Seward	DS	Interim Mental Health Act Manager
Rose Whittle	RW	Directorate Manager – Child Health
Observers:		
Emily Howell	EH	Audit Wales
Secretariat		
Nathan Saunders	NS	Senior Corporate Governance Officer
Apologies:		
Nicola Foreman	NF	Director of Corporate Governance
Sara Moseley	SM	Independent Member – Third Sector (from 11am)
Catherine Wood	CW	Director of Operations – Children & Women's

Item No	Agenda Item	Action
MHLMCA 22/07/001	Welcome & Introductions The Committee Chair (CC) welcomed everybody to the meeting.	
MHLMCA 22/07/002	Apologies for Absence Apologies for Absence were noted	
MHLMCA 22/07/003	Declarations of Interest No declarations of Interest were noted.	
MHLMCA 22/07/004	Minutes of the Meeting held on 26 April 2022 The Minutes of the Meeting held on 26 April 2022 were received. The Committee Resolved that:	

Mohammed Sarah
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	a) The minutes of the meeting held on 26 April 2022 were agreed as a true and accurate record.	
MHLMCA 22/07/005	<p>Action Log from the meeting held on 26 April 2022</p> <p>The Action Log was received and discussed.</p> <p>The Committee Resolved that:</p> <p>a) The Action Log was noted.</p>	
MHLMCA 22/07/006	<p>Chair's Action taken since last meeting</p> <p>The Committee Resolved that:</p> <p>a) No Chair's Actions were taken since the last meeting.</p>	
MHLMCA 22/07/007	<p>Any Other Urgent Business Agreed with the Chair</p> <p>The Committee Resolved that:</p> <p>a) No other urgent business was agreed with the Chair.</p>	
MHLMCA 22/07/008	<p>Mental Capacity Act Monitoring Report</p> <p>The Mental Capacity Act Monitoring Report was received.</p> <p>The Executive Nurse Director (END) advised the Committee that after appropriate concerns raised from the Committee regarding the level of detail within the report, the report had been revised to outline 3 broad areas:</p> <ul style="list-style-type: none"> • Mental Capacity Act and the detail on referrals received • Mental Capacity training and compliance • Deprivation of Liberty Safeguards (DoLS) applications received. <p>The END advised the Committee that the first area highlighted the number of Independent Mental Capacity Advocate (IMCA) referrals and noted that out of the 97 total referrals received, 60 of those were for Relevant Person's Representative (RPR).</p> <p>He added that it was appropriate because most referrals required an RPR to be appointed to support the patient.</p> <p>It was noted that the second part of the report highlighted the overall Compliance by Staff group in relation to Mental Capacity training. It was identified that overall 59% of the relevant staff had undertaken the training.</p> <p>The END advised the Committee that the third part of the report highlighted the DoLS actions.</p>	

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It was noted that there had been a considerable improvement, compared to 18 months ago, with the Health Board's ability to process the referrals as they came in.

The END advised the Committee of the May 2022 DoLs data and noted that out of the 76 applications received, 53 were urgent, 19 were standard and 4 were reviewed.

He added that out of the 76 applications, 26 had breached. That had meant 70% of the referrals had been completed and 30% had breached.

The Independent Member – Third Sector (IMTS) commented that whilst the breaches had come down they were still high. She noted that training compliance appeared to be getting worse.

The END responded that it was complex because the Health Board had struggled to achieve good levels of MCA training.

He added that the last 2 years of the pandemic had not helped the situation with regards to statutory training in general.

It was noted that the Mental Capacity element of the training had now been linked to the Safeguarding training in order to improve the MCA training compliance rates and so it was hoped an improvement trajectory would be seen.

It was noted that a Liberty Protection Safeguards project lead had been appointed and that new appointee would be providing MCA training.

The Independent Member – Community (IMC) asked if newly recruited people into the Mental Health area were pre-trained in Mental Health law or did they receive that training after appointment.

The END responded that Mental Health law was a very unique area of knowledge and the ability to recruit relevant staff was very difficult due to the fact a lot of other Organisations were also looking for those staff.

He added that in the upcoming paper being presented to the Committee it would be identified that Welsh Government (WG) had provided resource to employ 2 “best interest” assessors which would help reduce breaches.

The Committee resolved that:

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	<p>a) The contents of the report and the current compliance and actions with Mental Capacity Act and Deprivation of Liberty indicators were noted.</p>	
<p>MHLMCA 22/07/009</p>	<p>Liberty Protection Safeguards</p> <p>The Liberty Protection Safeguards (LPS) information was received.</p> <p>The END advised the Committee that the Consultation in connection with the Welsh Government LPS draft Regulations, was launched on 17th March 2022.</p> <p>He added that the Consultation deadline for responses had been extended to 15th July 2022 and that the draft Regulations for Wales were aligned with the UK Government's Consultation on draft Regulations for England and new Code of Practice for the Mental Capacity Act and the LPS for England and Wales.</p> <p>It was noted that the Consultation was closed and the Health Board was waiting for feedback.</p> <p>The END advised the Committee that the main issue to raise was that the Health Board had been given the funding from WG and had advertised , at risk, permanent appointments within the Organisation.</p> <p>It was noted that further funding had been received from WG to undertake a training needs analysis in connection with Health Board staff.</p> <p>The END added that further risk to the Organisation was that WG had advised against undertaking any LPS training because until the outcome of the Consultation was known, a training package could not be provided until early 2023.</p> <p>It was noted that the risk would be minimised by the fact that the Health Board would be running DoLS alongside LPS for the first year so that the safety of patients would be captured in two frameworks which should mitigate the risk of staff not being trained as this time.</p> <p>The UHB Chair noted that the funding identified was £466,000 and asked if that was all for the Health Board and if it was sufficient.</p> <p>The END responded that it was all for the Health Board and that a further piece of work would be undertaken to identify if the funding was the appropriate amount. He added that it was in line with other Health Boards.</p> <p>The UHB Chair noted that it would be important to make that assessment as early as possible.</p>	

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	<p>The Committee resolved that:</p> <p>a) The contents of the report and the current progress to the implementation of Liberty Protection Safeguards were noted.</p>	
<p>MHLMCA 22/07/010</p>	<p>DOLs Audit update on recommendations</p> <p>The update regarding the progress made with regards to Internal Audit's recommendations from the DOLs Audit was received.</p> <p>The END advised the Committee that the paper outlined 4 key recommendations and that they were all completed.</p> <ul style="list-style-type: none"> • Recommendations 1&3: Improvement of timescales for undertaking DoLS urgent authorisations (high priority) and standard authorisations. <p>Action taken - it was noted that WG funding for Mental Capacity Act 2005 / Deprivation of Liberty Safeguards (DoLS) for financial year 2022/23 would enable the recruitment of two full time Best Interest assessor posts which would clear the backlog of DoLS standard (7 day) and urgent (21-day) authorisations. The recruitment to those two permanent posts was approved at Management Executive on 13th June 2022.</p> <ul style="list-style-type: none"> • Recommendation 2: Deprivation of Liberty training <p>Action taken - it was noted that the DoLS awareness training was now provided within the mandatory Safeguarding training and that individual areas within the Health Board had received targeted training.</p> <p>It was noted that the focus of future training was Mental Capacity assessments in preparation for transition to LPS</p> <ul style="list-style-type: none"> • Recommendation 4: Produce Implementation plan for implementation of LPS. <p>Action taken - it was noted that the LPS Draft Code of Practice and Regulations consultation had commenced on 17th March 2022 and had closed on 14th July 2022.</p> <p>The Health Board would be unable to produce a detailed implementation plan until the outcome of the Consultation was known and the new Code of Practice was finalised. Accordingly, the Committee noted that this action should remain "amber". The Health Board had received Welsh Government Phase 1 & 2 funding to support the preparation for LPS.</p>	

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	<p>The Committee resolved that:</p> <p>a) the contents of the report and the assurance provided to the completion of the recommendations and transition as part of the implementation of the Liberty Protection Safeguards were noted.</p>	
<p>MHLMCA 22/07/011</p>	<p>Mental Health Act Monitoring Exception Report</p> <p>The Mental Health Act Monitoring Exception Report was received.</p> <p>The Mental Health Act Manager (MHAM) advised the Committee that there had been one defective application during the last quarter. That related to a patient who had been detained at UHW under Section 2.</p> <p>It was noted that a conversation had been held with the Local Authority regarding the defective application and the MHAM would attend the quarterly AMHP meetings so that he could advise on what was expected and the outcomes.</p> <p>The MHAM also advised the Committee that during the first quarter there had been one lapsed Section 5(2) detention.</p> <p>The IMTS asked what the situation was generally in terms of the availability of AMHPs.</p> <p>The MHAM responded that he was unsure because they were employed by Local Authorities but after speaking with the lead AMHP for Cardiff it was identified that the LA had been struggling with annual leave, sickness and Covid-19.</p> <p>The Interim Clinical Director Psychology & Psychological Therapies (ICDPPT) added that LA colleagues had identified the struggles and the shortage of AMHPs. However in the last Mental Health Legislation and Governance Group (MHLAGG) it was noted that there were no incidents where the shortage of AMHPs had an impact on the Health Board’s ability to carry out relevant functions under the Act.</p> <p>The Managing Director Operations – Non-Acute (MDONA) asked if the exceptions being raised were normal numbers and if the position the Health Board was in was good or bad.</p> <p>The MHAM responded that whilst there had been one fundamental defective application this quarter, it was a “one off”. The last one occurred in September 2021 and then prior to that there was one in September 2020.</p>	

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He added that the improper use of Section 5(2) was a training issue which would be addressed and that an online module for the Mental Health Act was being developed.

The Chief Executive Officer (CEO) noted that the level of MCA compliance with doctors was the worst amongst the staff groups and asked if the MHAM could attend a “grand round” for training and also provide a presentation to the Clinical Senate Group which should help with training compliance levels.

The MHAM responded that it was something he would be happy to discuss offline.

The IMTS added that the training should be more incidental and accessible and should provide people with the information about what legislation and guidance applied under what circumstances.

The MHAM advised the Committee that Section 136 numbers had stayed roughly the same and there had not been a large increase or decrease at the moment for adults.

He added that for Child and Adolescent Mental Health Services (CAMHS) there had been 19 assessments this quarter compared to 6 in the last quarter. That was a large increase.

It was noted that of those 19 assessments, 9 had related to the same person, 4 related to one patient, and 3 for another patient. Whilst a number of repeat presentations were identified, it was noted that each counted as a separate assessment.

It was noted that a management plan was in place for repeat presenters and conversations had been held with the Police to ensure that they know what processes were in place and how to follow those.

The IMTS noted that the increase in CAMHS referrals was hard to read and asked the Directorate Manager – Child Health (DMCH) if assurance could be provided around those.

The DMCH responded that the system was dealing with very complex young people at the moment with significant issues interlinked with Social Care and Social Services and the support that Social Services were able to actually provide to those young people.

She added that the Health Board had been working hard to improve relationships with Social Services and noted that there would be a

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	<p>development of a joint team that would support some of the young people.</p> <p>The DMCH concluded that the difficulties being seen across teams could not be underestimated. She added that the complex and difficult situations were not entirely in the gift of the Health Board to address because a multi-agency response was required.</p> <p>The CEO added that she was in regular dialogue with the Chief Executives from the Local Authorities on the risks described in relation to children and young people who required Mental Health services. She acknowledged that some Young People in our care have needs which would be better met elsewhere.</p> <p>The IMC asked if more training for the Police was required because sometimes it appeared that the use of section 136 was misused/overused at times.</p> <p>The Deputy Director of Operations - Mental Health (DDOMH) responded that the Mental Health Team held regular meetings with the Police and were also involved in the joint planning from the Regional Crisis Care Concordat and that the issues identified were discussed regularly and any joint training opportunities are also discussed.</p> <p>The MHAM concluded that the Operations Manager at the Tribunal had left and that he was waiting to hear of his replacement.</p> <p>It was noted that there had been no official update from the Tribunal regarding the rollout of Teams or all Hearings. However, the majority of new hearings were being listed via Teams rather than teleconference.</p> <p>It was noted that nothing has been communicated to the Health Board that this would be standard practice going forward, but the MHAM advised the Committee that he had raised the issue again with the Business Manager and was awaiting an official decision which would be shared with the Committee at the next meeting.</p> <p>The Committee Resolved that:</p> <p>a) The approach taken by the Mental Health Clinical Board to ensure compliance with the appropriate Mental Health legislation, as set out in the report was noted.</p>	DC/DS
<p>MHLMCA 22/07/012</p>	<p>HIW Mental Health Act Annual Report – Verbal Update</p>	

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	<p>The HIW Mental Health Act Annual Report – Verbal Update was received.</p> <p>The DDOMH advised the Committee that the formal report had not yet been received from HIW. Minimal issues had been identified for escalation. HIW had advised the Mental Health Team that there was very little to note and that they were happy with the provision provided from the Mental Health Act office.</p> <p>The Committee Resolved that:</p> <p>a) The HIW Mental Health Act Annual Report verbal update was noted.</p>	
<p>MHLMCA 22/07/013</p>	<p>Mental Health Measure Monitoring Reporting including Care and Treatment Plans Update Report.</p> <p>The Mental Health Measure Monitoring Reporting including Care and Treatment Plans Update Report was received.</p> <p>The DDOMH reminded the Committee that the Mental Health measure was a piece of legislation divided into 4 parts.</p> <p>Part 1 related to the primary Mental Health Support Services and was a tier one target of referral to assessment within 28 days.</p> <p>It was noted that the Health Board had achieved 95% compliance, that the WG target was 80% and so performance was good with a background of increasing activity.</p> <p>It was noted that in 2020/21 referrals had been up by 30% and that in the first quarter of 2021/22 referrals were up 8% by comparison.</p> <p>The DMCH advised the Committee that overall, in part due to the Adult compliance rate, the CAMHS compliance rate was ok but had dropped off from March 2022.</p> <p>She added that CAMHS had been struggling with a combination of vacancies, short term and long-term sickness and a significant decrease in the capacity within the team.</p> <p>It was noted that the average weight for an appointment was around 29 days, although that was a very volatile target.</p> <p>The Committee was advised that there was a plan in place for CAMHS recovery. Agency staff had started that week and 2 core members of staff had completed their induction and would start that week.</p>	

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The DDOMH advised the Committee that in relation to Part 1b (ie the 28-day assessment to intervention compliance target of 80% for the Adult service), compliance was currently at 100%.

The DMCH advised the Committee that CAMHS were not at the same level as the Adult service for Part 1b compliance and that compliance against Part 1b target had not been achieved since December 2021 as a result of focus on the external waiting list for assessment and reduced capacity over school holiday periods.

It was noted that as part of the move towards a Joint Assessment Team model, a brief intervention pathway would be created to ensure that young people were seen within 28 days of the commencement of their treatment, following assessment.

The DMCH also added that the Health Board was reorganising the “front door” and that should have an impact upon the Part 1a and Part 1b assessments.

The DDOMH advised the Committee that 90% of individuals under **Part 2** of secondary Mental Health services had a valid care and treatment plan.

He added that there had been a steep climb in April 2022 although it was suspected that there had been reporting anomalies within the PARIS system from the beginning of the financial year.

It was noted that the Mental Health team had written to the Digital team to ask them to look at that and to query the accuracy of the reporting.

The DMCH added that it was recognised that CAMHS needed to make improvements within Part 2 and it was hoped that the services rearrangement would help to define areas.

The DDOMH commented that with regards to **Part 3** of the legislation (right to request an assessment by self referral) the target was that service users should receive a confirmation letter regarding the outcome of their assessment within 10 days.

He added that since changes in the data captured in August 2021 had indicated some inaccuracies in reporting performance, the performance was improving, whilst Part 3 referrals were rising.

It was noted that performance had improved since the issue was identified and that in May 2022 there was one breach (confirmation letter was sent at 11 days).

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	<p>The DDOMH advised the Committee that Part 4 of the legislation related to advocacy and the standard was to have access to an IMHA within 5 working days.</p> <p>He added that advocacy remained 100% compliant.</p> <p>The CC noted that given the demands of the service the work undertaken by the DDOMH, DMCH and their teams was highly commendable and thanked everybody for their hard work.</p> <p>The Committee Resolved that:</p> <p>a) The contents of the report were noted.</p>	
<p>MHLMCA 22/07/014</p>	<p>Care and Treatment Planning Audit</p> <p>The Care and Treatment Planning Audit was received.</p> <p>The DDOMH advised the Committee that the audit sat behind the data of the Care and Treatment Plans (CTP) and noted that the team had developed a quarterly audit using Microsoft Forms and Teams.</p> <p>He added that the Local Authorities were invited to contribute and that every quarter the Mental Health Team looked at a random selection of CTPs that were reviewed by managers and themes were identified.</p> <p>It was noted that themes had developed from the CTP audit that reflected the same issues from previous Delivery Unit audits which included:</p> <ul style="list-style-type: none"> • CTPs could be more strength based as they tended to focus on medical / diagnostic issues • Incorporation of service users' views on outcomes, strategies for risk / safety management could be more developed. • Outcome focused care with a view towards discharge is something that was not reflected in most CTPs audited. • Inclusion and engagement of carers / relatives / significant others in CTP planning was limited in the audit. <p>The DDOMH advised the Committee that the challenges identified were around goals focused and strengths focused outcomes of the CTPs which included:</p>	

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	<ul style="list-style-type: none"> • Timescales, • SMART goals, • Strengths, • Focus, • User involvement. <p>It was noted that there was good compliance with the scale and scope of the different areas in connection with crisis planning and safety planning around risk assessment.</p> <p>The Committee was advised of the actions being taken to provide assurance which included:</p> <ul style="list-style-type: none"> • Continuation of the quarterly audit • Local data would be shared with managers for action • A new Data Subgroup was being set up within the Cardiff and Vale Crisis Care Concordat Group where the data report would be collated and any issues escalated to the National Crisis Care Concordat. • A range of service areas in Mental Health Clinical Board and Local Authority had undergone Care Aims training, Suicide Mitigation training, and Collaborative Conversations training all of which supported outcome focused, collaborative care and safety planning. <p>It was noted that further work was needed to engage service users in Care and Treatment Planning to develop more co-produced and outcome focused CTPs that reflected the needs of the service user and their carers more effectively.</p> <p>The Chair of the Powers of Discharge sub-Committee (CPDSC) advised the Committee that the Hospital Managers felt that there was an improvement overall in the CPTs in both completion and the quality of them.</p> <p>The Committee Resolved that:</p> <p>a) The content of the audit was noted.</p>	
<p>MHLMCA 22/07/015</p>	<p>Sub-Committee Meeting Minutes:</p> <p>The Committee received copies of the Sub-Committees' meeting minutes:</p> <ul style="list-style-type: none"> • Mental Health Act Hospital Managers Power of Discharge Sub Committee • Mental Health Legislation and Governance Group (MHLGG) 	

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	<p>The Committee Resolved that:</p> <p>a) The Sub-Committee Meeting Minute were noted.</p>	
<p>MHLMCA 22/07/016</p>	<p>Corporate Risk Register</p> <p>The Corporate Risk Register (CRR) was received.</p> <p>The Head of Corporate Business reminded the Committee of the change to the CRR and how it only recorded risks scored 20 or above unless the risk was deemed to have potential impact on strategic objectives.</p> <p>He added that there was one Mental Health related risk on the CRR which related to the health and well-being of minor inpatients who were being, by necessity, admitted to Adult Mental Health services locations.</p> <p>The MDONA advised the Committee that there were ongoing actions around the risk which could be added to the CRR to provide the Committee with assurance and noted that she would speak to the HCB offline around those actions.</p> <p>The Committee Resolved that:</p> <p>a) The Corporate Risk Register risk entry linked to the Mental Health Legislation and Mental Capacity Act Committee and the Risk Management development work which was now progressing with Clinical Board, was noted.</p>	<p>HE/TD</p>
<p>MHLMCA 22/07/017</p>	<p>Committee Effectiveness Survey Results 2021-2022</p> <p>The Committee Effectiveness Survey Results 2021-2022 were received.</p> <p>The HCB advised the Committee that routine monitoring of the effectiveness of the Board and its Committees was a vital part of ensuring strong and effective governance within the Health's Board's governance structure.</p> <p>He added that there had been discussion at other Committees of the Board around the effectiveness of the tool being used to perform the assessments and noted there was a plan to move towards a more nuanced and more qualitative method.</p> <p>The Committee Resolved that:</p>	

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	<p>a) The results of the Annual Board Effectiveness Survey 2021-2022, relating to the Mental Health Legislation and Mental Capacity Act Committee were noted.</p>	
<p>MHLMCA 22/07/018</p>	<p>Policies</p> <p>The Committee received 1 policy:</p> <ul style="list-style-type: none"> • Community Treatment Order Policy & Procedure <p>The Committee resolved that:</p> <p>a) The Committee approved the policy</p>	
<p>MHLMCA 22/07/019</p>	<p>Any Other Business</p> <p>The MHAM advised the Committee that the draft Mental Health Act Bill was published at the end of June 2022 and that had outlined a number of changes.</p> <p>He added that a full report would be received by the Committee at the next meeting in October.</p> <p>The DDOMH advised the Committee that the Mental Health Clinical Board had noticed increasing Mental Capacity Act Section 49 activity and the number of requests being received.</p> <p>He added that he had worked with the ICDPPT and legal teams to develop an SBAR which would be brought to the next Committee meeting.</p> <p>The CC asked the DDOMH to update the Committee on the Deputy Ministerial visit to the Mental Health Clinical Board.</p> <p>The DDOMH advised the Committee that the Deputy Minister had visited Hafan Y Coed to have discussions with peer workers who were people with “lived experience” and who had used their experience therapeutically to the benefit of other service users.</p> <p>He added that it was a very positive visit and that the Minister had met with a number of peer workers who had commented upon the Recovery College. Positive feedback had been received.</p> <p>The Committee resolved that:</p> <p>a) All other business was noted.</p>	<p>DS</p> <p>DC</p>
	<p>To note the date, time and venue of the next meeting:</p> <p>October 25 2022 at 10am Via MS Teams</p>	

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ACTION LOG
MENTAL HEALTH LEGISLATION AND MENTAL CAPACITY ACT COMMITTEE – 26th JULY 2022
(UPDATED FOR 25th OCTOBER MEETING)

MINUTE REF	SUBJECT	AGREED ACTION	DATE	LEAD	STATUS/COMMENT
Actions Completed					
MHCLC 09/04/008	Mental Capacity Act Monitoring Report – DoLs Monitoring Report – MCA Training Update	A future update on progress being made within MCA Training would be useful for the Committee.	25.10.22	Rebecca Aylward	COMPLETED 25.10.22 Agenda item: 8.1
MHLMCA 22/07/011	Mental Health Act Monitoring Exception Report - Mental Health Review Tribunal	An update on whether the Tribunal has made an official decision roll out TEAMS, as standard, for all hearings would be shared with the Committee at the next meeting	25.10.22	Daniel Crossland / David Seward	COMPLETED 25.10.22 Agenda item: 9.1
MHLMCA 22/07/016	Corporate Risk Register	Ongoing actions around the risk to be discussed with Head of Corporate Business.	25.10.22	Hannah Evans / Tim Davies	COMPLETED 25.10.22 Agenda item 11.2
MHLMCA 22/07/019	Draft Mental Health Act Bill	Full report to be provided to Committee	25.10.22	Daniel Crossland / David Seward	COMPLETED 25.10.22 Agenda item 11.1
MHLMCA 22/07/019	Section 49 activity update	An SBAR would be brought to the next Committee meeting	25.10.22	Daniel Crossland	COMPLETED 25.10.22 Agenda item 9.3
Actions in Progress					
Actions referred to committees of the Board / Other					
MHC 20/02/005	Mental Capacity Act Monitoring Report	The issue regarding poor compliance on Medical Training be reviewed by the Strategy and Delivery Committee.	27.09.22 (S&D meeting)	Meriel Jenney	COMPLETED 25.10.22

MINUTE REF	SUBJECT	AGREED ACTION	DATE	LEAD	STATUS/COMMENT
					This action was reported to the S&D Committee on 27 September 2022 (agenda item 2.8).

Mohamed Sarah
17/10/2022 16:32:46

Report Title:	Mental Capacity Act (MCA) and DoLS monitoring		Agenda Item no.	8.1	
Meeting:	Mental Health Legislation and Mental Capacity Act Committee	Public	x	Meeting Date:	25.10.2022
		Private			
Status <i>(please tick one only):</i>	Assurance	x	Approval	Information	
Lead Executive:	Executive Nurse Director				
Report Author (Title):	Interim Deputy Executive Nurse Director				
Main Report					
Background and current situation:					

The purpose of this report is to provide a general update on current issues relating to the Mental Capacity Act (MCA) and Deprivation of Liberty.

The MCA indicators provide a level of detail on number and type of IMCA referrals. In preparation for the implementation of Liberty Protection Safeguards (LPS) the current advocacy arrangements and contracts remain under review. Procurement have begun the process of market engagement for renewal of our IMCA contract (current contract expires March 2024), with a view to making this an All Wales agreement; as this approach has reportedly proved successful for the provision of IMHA's.

The MCA indicators provide Mental Capacity training compliance by staff group. There is additional information contained within this report relating to the additional training being provided with the use of Welsh Government funding for the implementation of the LPS.

The DoLS indicators detail the number of DoLS applications received, processed and withdrawn. It is noted that there has been a significant increase in applications since the end of August following a piece of work carried out in Medicine Clinical Board.

Executive Director Opinion and Key Issues to bring to the attention of the Board/Committee:

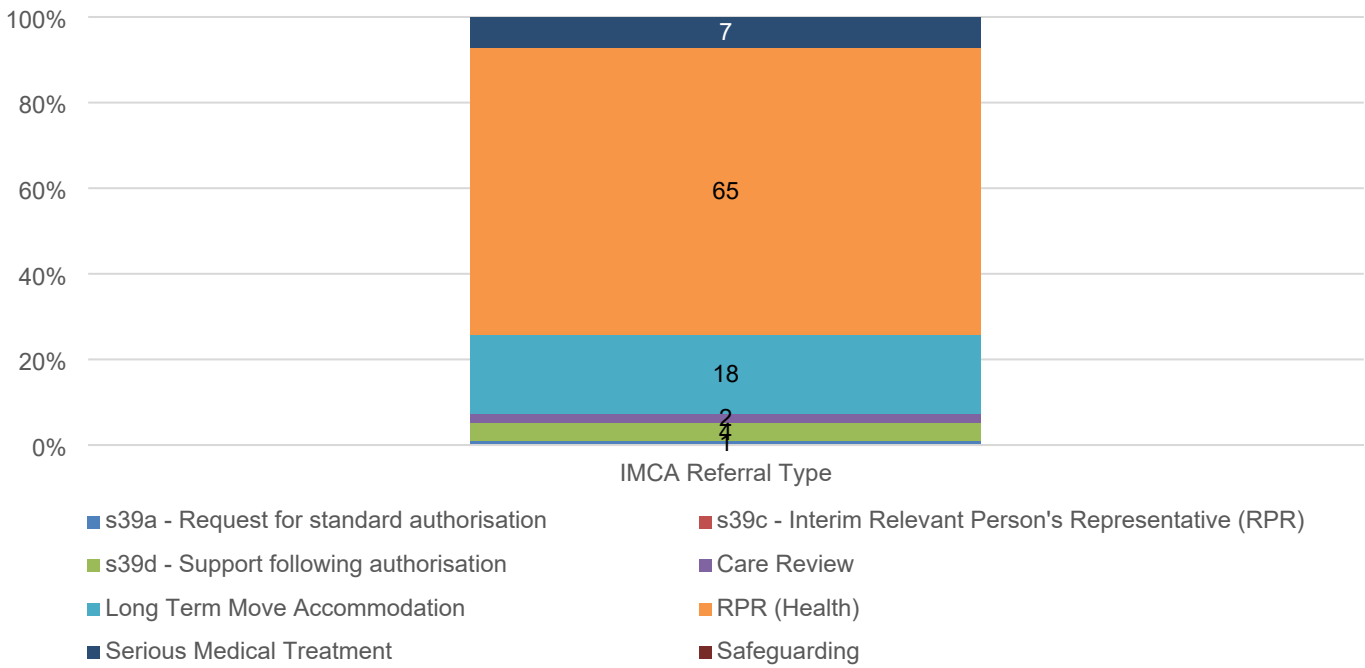
Mental Capacity Act Monitoring actions:

- **Mental Capacity IMCA Referral type**

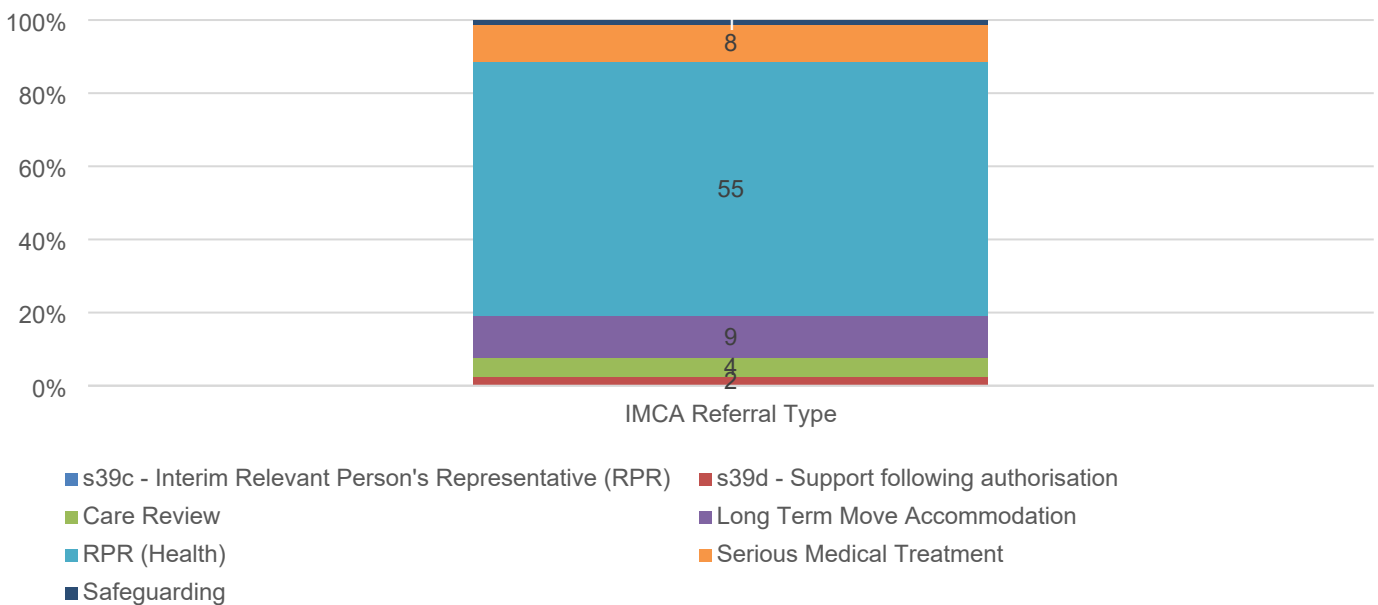
The MCA Indicators demonstrate the following breakdown of IMCA referrals. Data is included for the quarter from April to June 2022, as this was not available in time for the last meeting, and the most recent quarter from July to September 2022.

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April - June 2022 Total Referrals - 100



July-September 2022 Total Referrals - 79



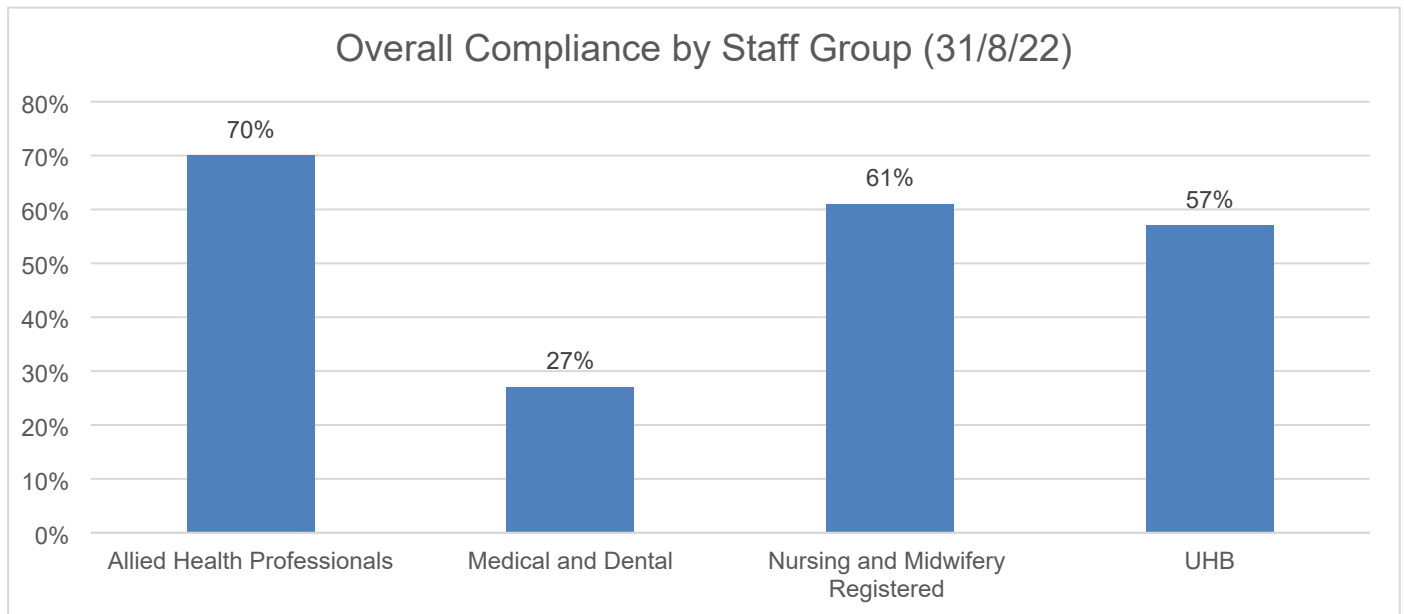
▪ **Mental Capacity Training**

The following graph demonstrates overall Compliance by Staff group.

It is identified that work will need to be carried out to improve compliance of mandatory training in readiness for implementation of the LPS.

MCA Level 2 mandatory training is available as a module on ESR and taught sessions are offered on a monthly basis; rotating between UHW, UHL and Teams. Attendance at training has been low which is thought to be due to the continued pressures on staffing.

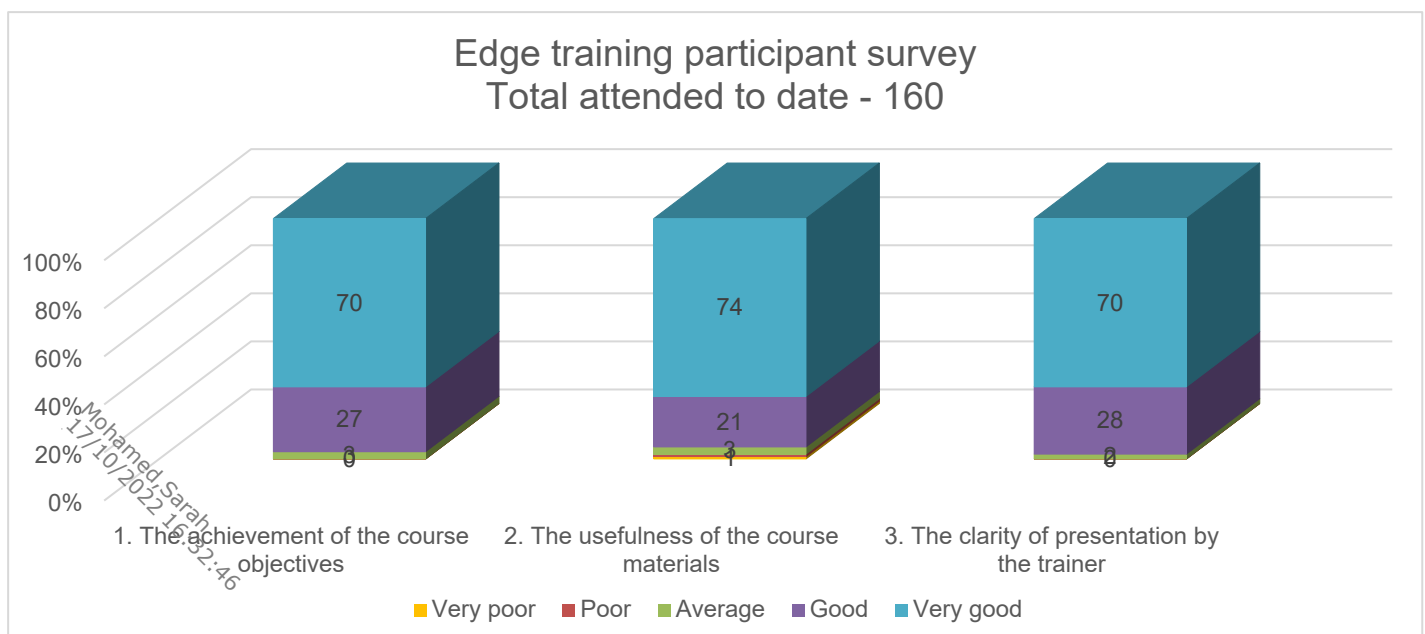
The LPS Project Lead has continued to provide this training whilst the MCA and Consent Lead post has been vacant and has recently met with the Education, Culture and Organisational Development team to look at ways to try and make training more accessible to staff. We have recently appointed a new MCA and Consent Lead and hope to have the successful candidate in post in November 2022.



▪ **Additional Mental Capacity Act training**

As discussed at the April Committee, the UHB has utilised Welsh Government LPS funding to provide training from an external provider (Edge Training) to educate staff on assessing mental capacity and best interest decision making. Seven sessions have been provided to date and this appears to have been well received by staff. The table below provides data relating to feedback on its perceived quality and usefulness. To try and circumnavigate the risk of poor attendance rates due to staffing pressures, all sessions are overbooked which appears to have helped ensure adequate numbers; though the plan is to increase this further to allow for winter pressures.

Due to the training's apparent success, provision has been made to add 4 additional sessions in the new year.



Five UHB staff have recently begun the Level 7 MSc module provided by Swansea University, entitled 'Assessing Decision Making Capacity', with representation from Mental Health (2), PCIC (1), Medicine (1) and Children and Women (1) Clinical Boards. A further five staff are due to undertake the module in the January 2023 term.

- **Deprivation of Liberty Safeguards Monitoring actions:**

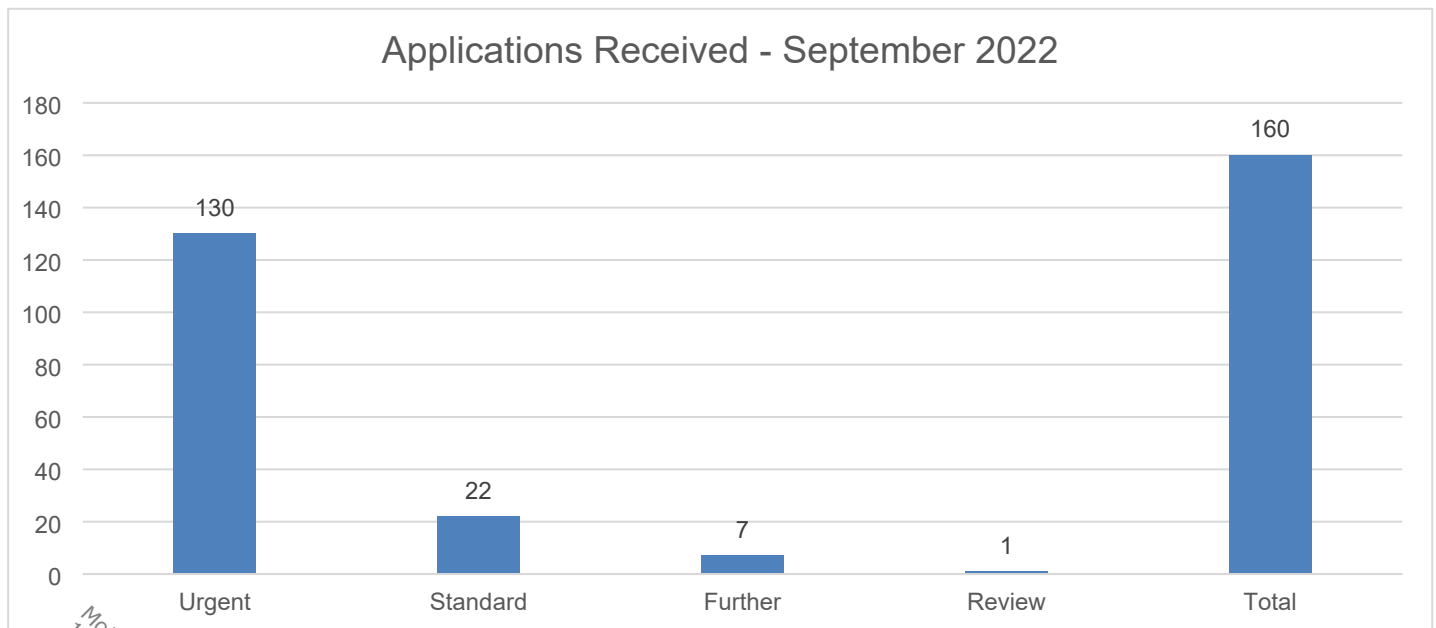
Following an internal review within the Medicine Clinical Board in late August 2022. It was identified that there was considerable variability in the practices surrounding DoLS applications and ongoing management. In order to address these concerns, the Clinical Board have worked hard to raise staff awareness and ensure compliance with the Safeguards going forward. This has contributed to a significant increase in the number of DoLS applications this quarter which is reflected in the figures below.

Due to delays in recruitment processing the UHB has been unable to recruit two Best Interest Assessors as initially planned. The job descriptions for these posts have recently been finalised however, we await further discussion with the local authority in relation to arrangements for specially trained assessors under the LPS (in the new role of Approved Mental Capacity Professionals, AMCP) which may alter the UHB's position on this going forward.

The UHB has sought the approval of the Welsh Government to utilise LPS funding to assist in addressing the recent backlog of assessments as a result of the Medicine CB review and arrangements for this are in place by the Supervisory Body.

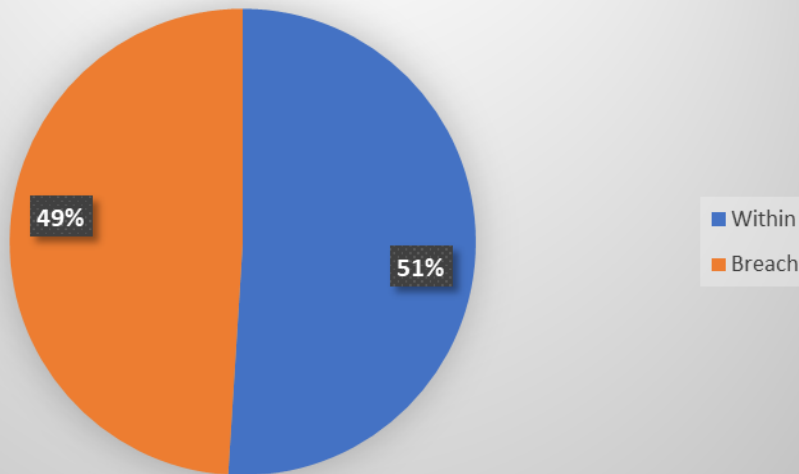
September 2022 – indicators

September indicators as below, demonstrate 160 DoLS applications were received; 130 Urgent (7 days), 22 standard (21 days), 1 review. This is a significant increase from the figured provided in May 2022 which totaled 76 DoLS applications.



The below table demonstrates 51% applications were within time and 49% breached. This was expected due to the significant increase in applications as a result of the work in Medicine Clinical Board and measures are in place to double assessment capacity to reduce the current backlog. NB. The average breach % for the year to date is 30%.

Percentage of Breaches Processed and Withdrawn included



Recommendation:

The Mental Health Legislation and Mental Capacity Act Committee is requested to:-

a) **NOTE** the contents of the report and the current compliance and actions with Mental Capacity Act and Deprivation of Liberty indicators.

Link to Strategic Objectives of Shaping our Future Wellbeing:

Please tick as relevant

1. Reduce health inequalities	✓	6. Have a planned care system where demand and capacity are in balance	
2. Deliver outcomes that matter to people		7. Be a great place to work and learn	
3. All take responsibility for improving our health and wellbeing		8. Work better together with partners to deliver care and support across care sectors, making best use of our people and technology	✓
4. Offer services that deliver the population health our citizens are entitled to expect	✓	9. Reduce harm, waste and variation sustainably making best use of the resources available to us	
5. Have an unplanned (emergency) care system that provides the right care, in the right place, first time		10. Excel at teaching, research, innovation and improvement and provide an environment where innovation thrives	

Five Ways of Working (Sustainable Development Principles) considered

Please tick as relevant

Prevention		Long term		Integration	✓	Collaboration		✓ Involvement	
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Impact Assessment:

Please state yes or no for each category. If yes please provide further details.

Risk: Yes

Risk of Non-compliance to the Mental Capacity Amendment Act 2019

Safety: No

Financial: No	
Workforce: Yes	
Risk of inability to recruit to posts	
Legal: Yes	
Risk of Non-compliance to the Mental Capacity Amendment Act 2019	
Reputational: Yes	
Risk of Non-compliance to the Mental Capacity Amendment Act 2019	
Socio Economic: No	
Equality and Health: No	
Decarbonisation: No	
Approval/Scrutiny Route:	
Committee/Group/Exec	Date:

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Report Title:	Liberty Protection Safeguards progress to implementation		Agenda Item no.	8.2	
Meeting:	Mental Health Legislation and Mental Capacity Act Committee	Public	<input checked="" type="checkbox"/>	Meeting Date:	25.10.2022
		Private	<input type="checkbox"/>		
Status <i>(please tick one only):</i>	Assurance	<input checked="" type="checkbox"/>	Approval	<input type="checkbox"/>	Information
Lead Executive:	Executive Nurse Director				
Report Author (Title):	Interim Deputy Executive Nurse Director				
Main Report					
Background and current situation:					

Background and current situation:

Consultations for the Welsh Regulations for the LPS and the revised Mental Capacity Act Code of Practice ended on 14th July 2022 and we are awaiting a response from the Welsh and UK Governments respectively. Welsh Government (WG) have advised that feedback on the consultation of the Welsh Regulations is expected to be released in Autumn 2022. As yet, there is no confirmed date for implementation of the LPS.

Welsh Government have advised that work is underway to develop training for the LPS, in conjunction with Social Care Wales. It is anticipated that training materials will be available from late 2022.

Whilst we await further details of implementation, the focus for the UHB remains on providing training for staff to improve knowledge and confidence in applying the Mental Capacity Act, which will be essential for ensuring the effective implementation of the new safeguards by UHB staff.

An LPS Implementation Board has been set up, with its purpose being to strategically oversee the changes introduced as part of the LPS and provide representation from across the UHB. Plans are in place to begin awareness raising sessions in key areas in the new year before the dissemination of training in relation to the new Safeguards.

The UHB LPS project plan is on target and progress is in line with Welsh Health Boards

Executive Director Opinion and Key Issues to bring to the attention of the Board/Committee:

- A Digital solution for recording and monitoring purposes is in the scoping phase and may require the recruitment of a data analyst (fixed term post) to progress this work which will be funded by WG phase 2 funding
- A new role is required to support LPS implementation a Mental Capacity Specialist Practitioner, this role will provide guidance to staff for all aspects of the MCA including consent, mental capacity. The role will be funded by WG phase 2 funding, for the implementation phase of LPS. Evaluation of the role will be required to secure permanent funding whether this is WG or UHB funded
- Due to delays in consultation and feedback leading to uncertainty over what is required for the implementation of LPS across Wales. WG has asked Health Boards and Local authorities to report and return underspend. Currently the UHB has a projected underspend of £16,229, of our total allocation of £266,000 this financial year. WG will request a further review of this in January 2023.

Recommendation:

The Mental Health Legislation and Mental Capacity Act Committee is requested to:-

a) **NOTE** the contents of the report and the current progress to implementation of Liberty Protection Safeguards.

Link to Strategic Objectives of Shaping our Future Wellbeing:

Please tick as relevant

1. Reduce health inequalities		6. Have a planned care system where demand and capacity are in balance	✓
2. Deliver outcomes that matter to people		7. Be a great place to work and learn	
3. All take responsibility for improving our health and wellbeing		8. Work better together with partners to deliver care and support across care sectors, making best use of our people and technology	✓
4. Offer services that deliver the population health our citizens are entitled to expect	✓	9. Reduce harm, waste and variation sustainably making best use of the resources available to us	
5. Have an unplanned (emergency) care system that provides the right care, in the right place, first time		10. Excel at teaching, research, innovation and improvement and provide an environment where innovation thrives	

Five Ways of Working (Sustainable Development Principles) considered

Please tick as relevant

Prevention		Long term		Integration	✓	Collaboration	✓	Involvement	
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Impact Assessment:

Please state yes or no for each category. If yes please provide further details.

Risk: Yes

Risk of Non-compliance to the Mental Capacity Amendment Act 2019

Safety: No

Financial: Yes

Risk of Welsh Government Funding of posts is non-recurrent post implementation.

Workforce: Yes

Risk of inability to recruit to posts

Legal: Yes

Risk of Non-compliance to the Mental Capacity Amendment Act 2019

Reputational: Yes

Risk of Non-compliance to the Mental Capacity Amendment Act 2019

Socio Economic: No

Equality and Health: No

Decarbonisation: No

Approval/Scrutiny Route:

Committee/Group/Exec Date:

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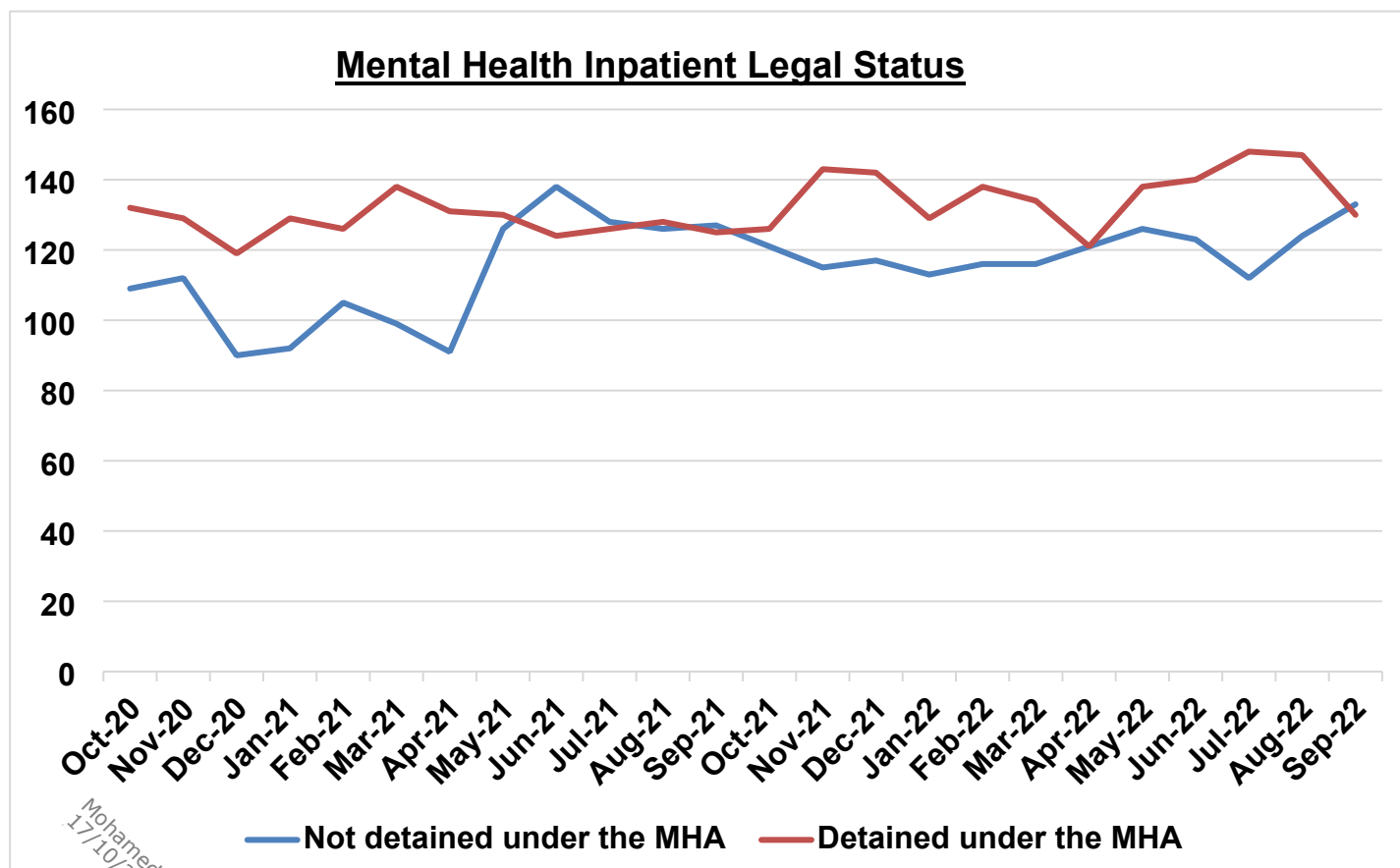
Report Title:	Mental Health Act Monitoring Exception Report	Agenda Item no.	9.1
Meeting:	Mental Health Legislation and Mental Capacity Act Committee	Public	X
		Private	
Meeting Date:			25 October 2022
Status (please tick one only):	Assurance X	Approval	Information
Lead Executive:	Chief Operating Officer		
Report Author (Title):	Mental Health Clinical Board Director of Opertations		

Main Report
Background and current situation:

This report provides the Committee with further information relating to wider issues of the Mental Health Act (MHA). Any exceptions highlighted in the MHA 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 MHA allows.

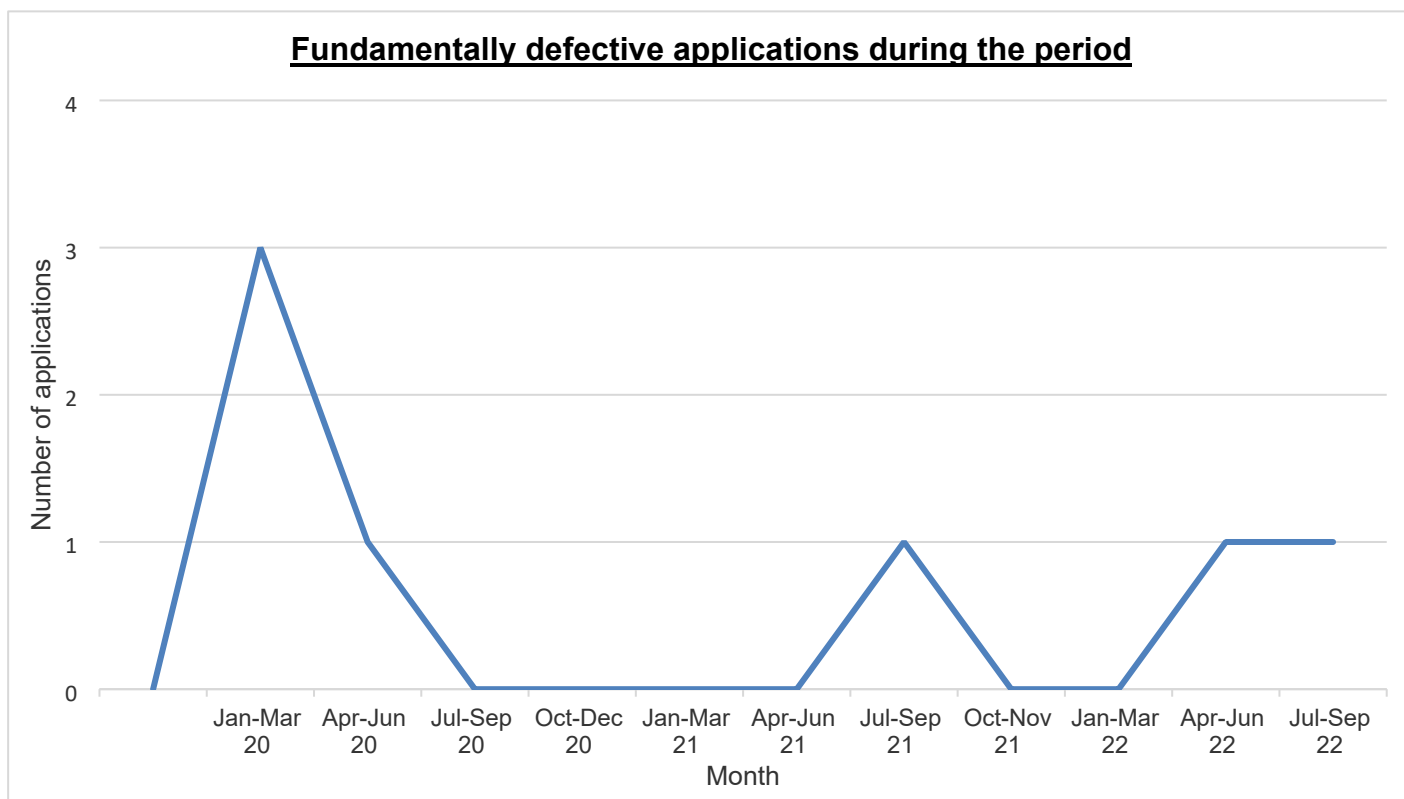
Executive Director Opinion and Key Issues to bring to the attention of the Board/Committee:

Use of the MHA



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Fundamentally defective applications



During the quarter there was 1 fundamentally defective section 2 application.

P was assessed in London on 12/07/2022 by an AMHP working for the Emergency Duty Team and an application was completed for detention under section 2 to Hafan Y Coed with P being transferred straight here. The Mental Health (Hospital, Guardianship, Community Treatment and Consent to Treatment) (Wales) Regulations 2008 state that if a patient is being admitted to a hospital in Wales, a Welsh AMHP application (HO2) must be used. The AMHP from London completed an English application which we were unable to accept. England have moved onto signing MHA documentation with electronic signatures however, Wales still requires a 'wet' signature and unfortunately the AMHP had signed the application electronically which we were also unable to accept. We tried to get hold of the AMHP to see if they had completed a Welsh application but we weren't able to locate them.

The ward were advised we couldn't accept the s2 paperwork and P would have to be told that he wasn't detained. If P wanted to leave, the ward staff would need to assess whether section 5(4) or 5(2) would be appropriate to hold P until a new MHA assessment could be arranged. The following day a section 5(2) was completed and P was subsequently detained under section 2.

Fundamentally defective report

During the quarter there was 1 fundamentally defective section 5(2) report.

On 02/08/2022 P was on ward C7 in University Hospital of Wales where a doctor completed a report under section 5(2). This was sent to our generic e-mail account but unfortunately, we couldn't accept it as the doctor had typed their name in the signature box and in Wales we still require a 'wet' signature. The doctor was unable to be contacted to physically sign the form therefore, we advised the ward that P wasn't being held on a section 5(2) and they would need to be re-assessed and another section 5(2) form completed if appropriate.

Section 136 A&E

There could be instances when treatment under a 136 is related to the mental disorder but the patient is not fit for a mental health act assessment within the 24/36-hour period causing the 136 to lapse, for example,

Patient has taken an overdose which is related to their mental disorder. Needs to go to A&E for physical treatment, therefore the clock starts ticking when they arrive in A&E. Patient receiving physical treatment beyond the 24/36-hour period. 136 has lapsed with no mental health act assessment.

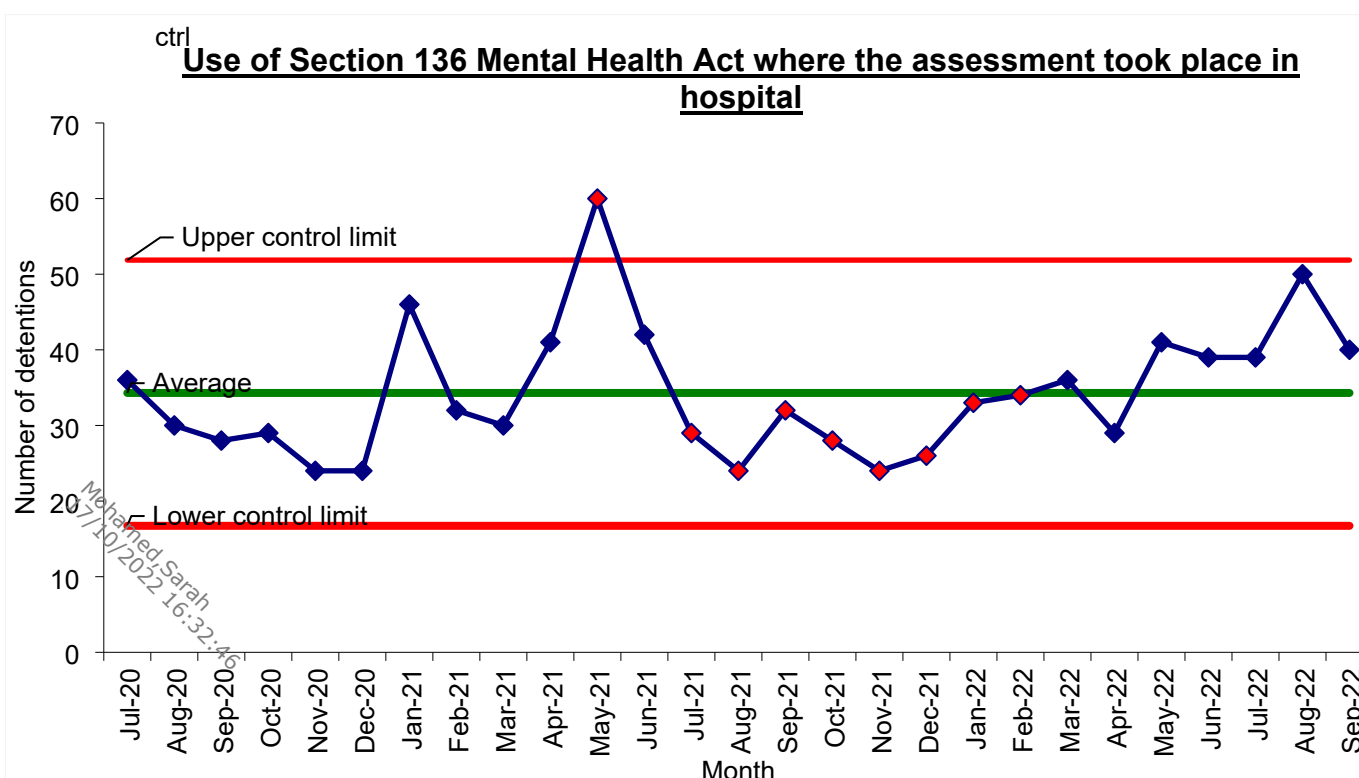
In all instances where the 136 has lapsed due to the patient not being fit for a mental health act assessment, a DATIX will be completed.

Section 136

During the period, the use of section 136 has increased.

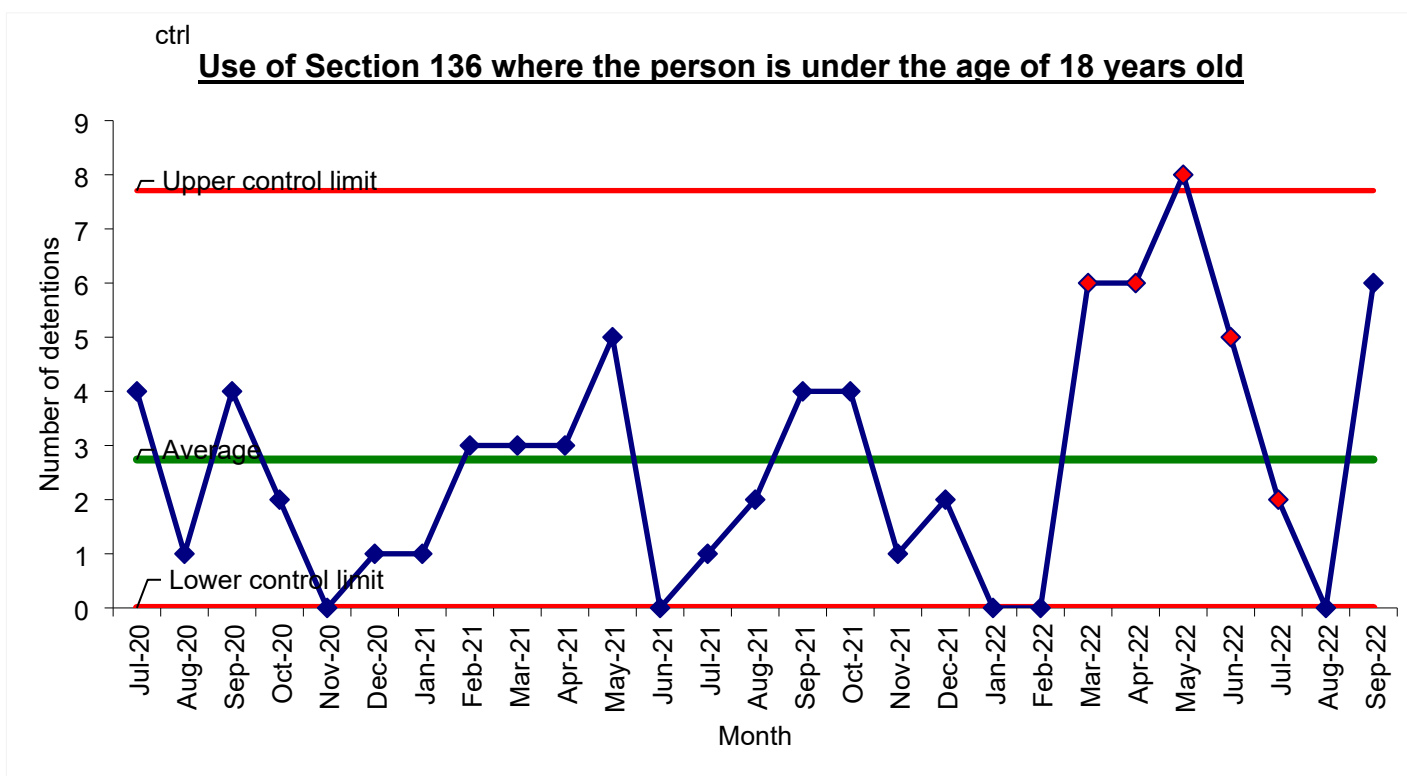
It was noted that 69.0% of individuals assessed were not admitted to hospital, with 48.1% being discharged to community services and 20.9% were discharged with no follow up. Overall during the period 30.2% of patients were admitted to hospital following a 136 assessment which is higher than the previous quarter at 28.5%. During the period 1 patient didn't have an assessment because the 24-hour time had lapsed and no extension had been requested.

Period	% not admitted to hospital
July – September 2022	69.0%
April – June 2022	71.5%
January – March 2022	63.4%
October – December 2021	68.0%
July – September 2021	74.1%
April – June 2021	73.5%
January – March 2021	81.5%
October – December 2020	67.5%
July – September 2020	73.7%

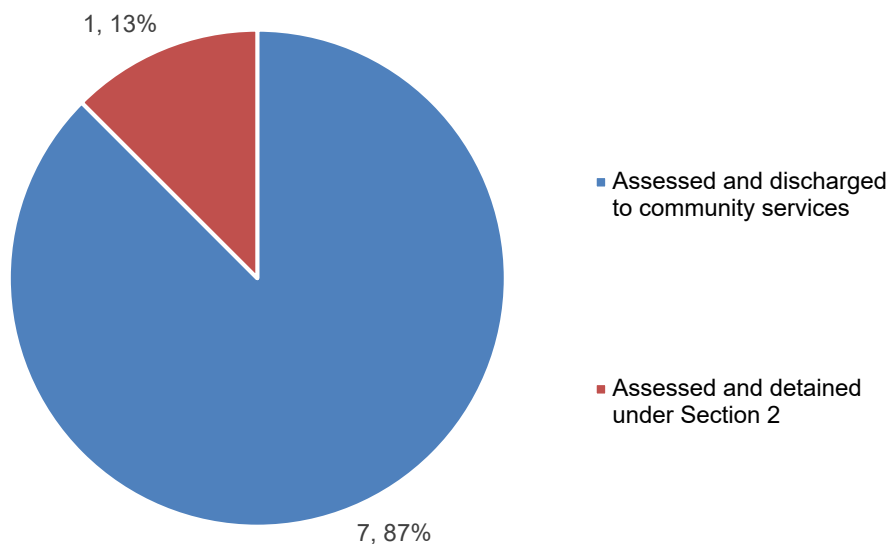


Section 136 - CAMHS

The number of those under 18 assessed under section 136 has decreased from 19 in the previous quarter to 8 in this quarter. There were 5 repeat presentations for one patient.



Outcome of CAMHS Section 136 assessments



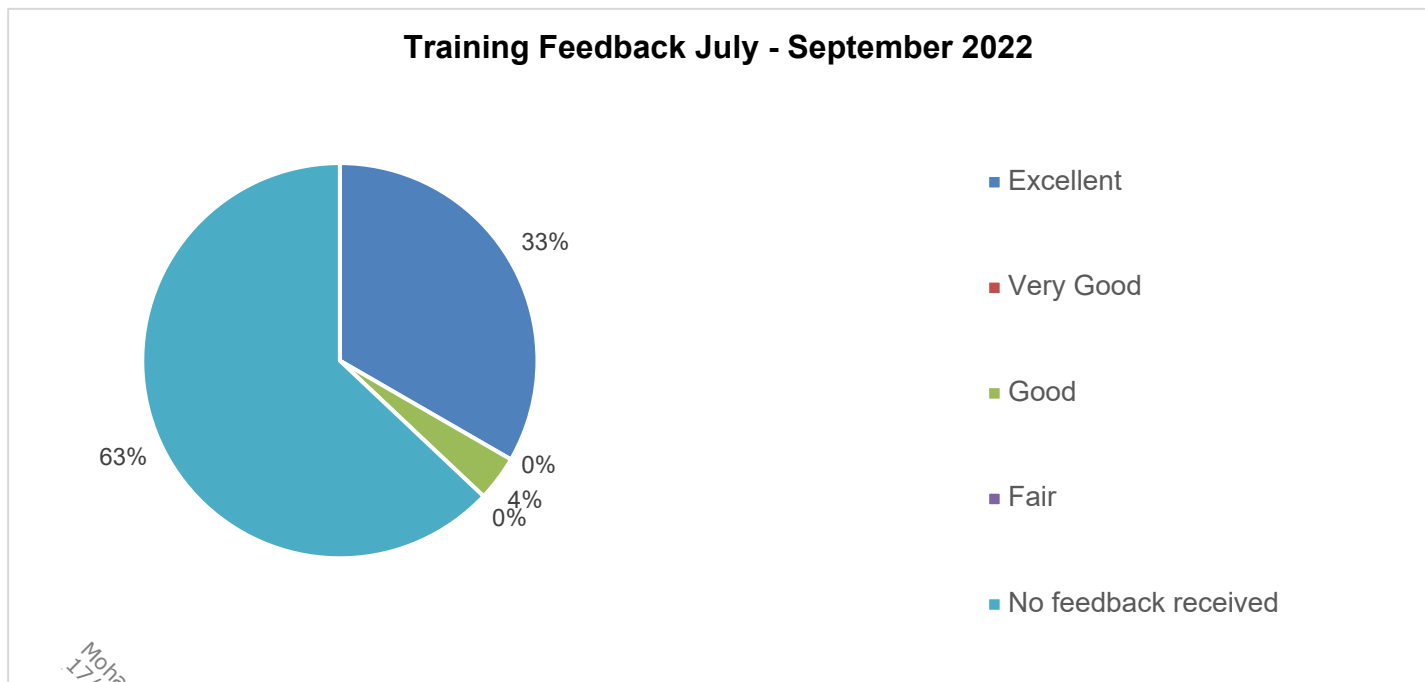
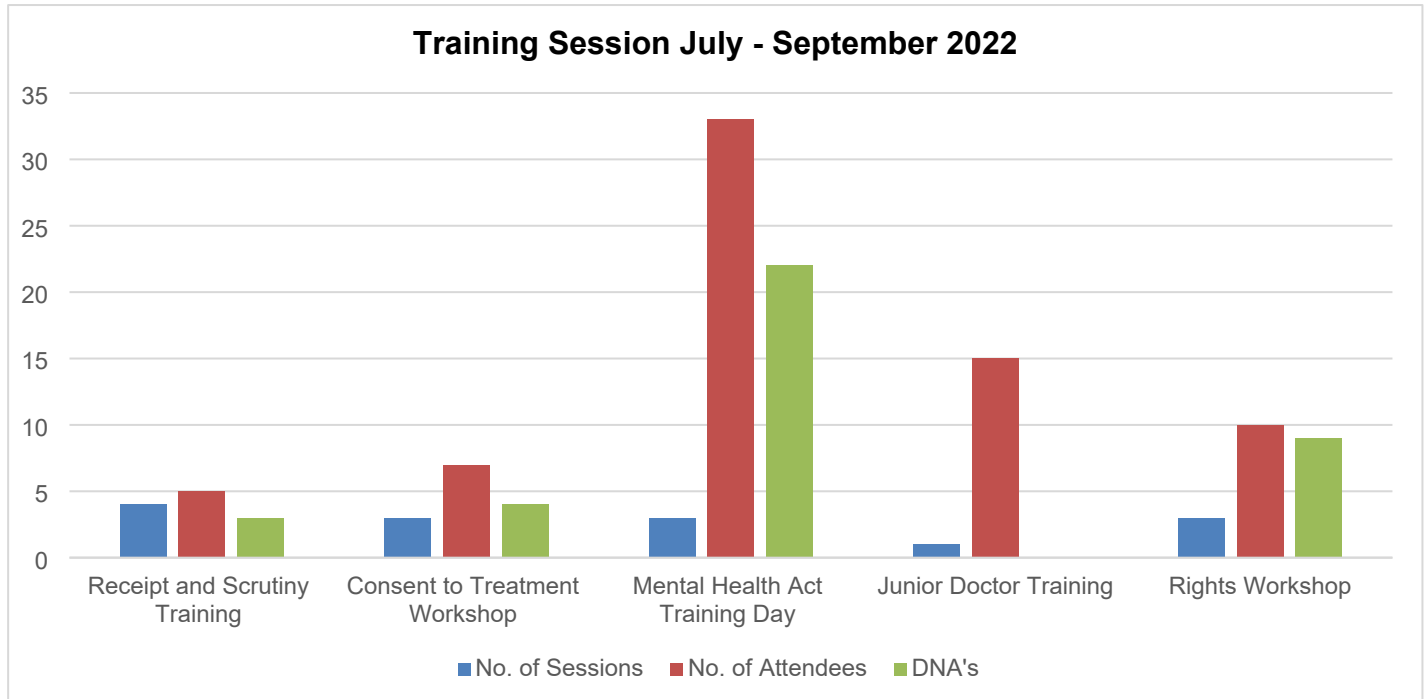
Mental Health Review Tribunal for Wales (MHRT)

I have met with the new Senior Operations Manager at the Tribunal and have discussed how the Tribunal is moving forward. It was confirmed that Teams hearings will be provided as default for all hearings being listed. We briefly discussed observers being allowed to attend hearings but I haven't been made aware of any requests being made by staff, with that request being approved or denied, so unable to take this forward without any data.

We have agreed to meet every other month to share any issues or trends that we may be seeing on either side which can be discussed further and rectified, however, any urgent matters will be addressed before these meetings.

Development Sessions

The MHA office continues to run MHA awareness sessions including a monthly MHA training day, which is available to all staff within the Health Board, Receipt and Scrutiny, Consent to Treatment and a Rights workshop. Also, we continue to support the Nurse Foundation Programme and Junior Doctor’s Inductions with MHA training.



Audits

The MHA office has recently started attending the wards again to conduct audits, as this stopped due to Covid. This is to ensure compliance with the MHA and best practices are maintained. We will hopefully be attending CMHT’s by the end of the year. If any issues are found during the audit we will follow up with an e-mail confirming what is needed to rectify the issue and re-audit within 4-6

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weeks. Audit data will be provided next quarter once the majority of wards/CMHTs have been audited.

The Mental Health Clinical Board continues to take the following approach:

Fundamentally defective applications

Continue to ensure effective communication between the Local Authority and the UHB and promote MHA training across the UHB.

Fundamentally defective reports

Continue to ensure effective communication across the UHB and promote MHA training.

Section 136

Continue to monitor with colleagues in South Wales Police and ensure any incidents related to an assessment not being completed within the 24/36-hour period due to physical health issues are reported accordingly.

Section 136 – CAMHS

Continue to monitor and report accordingly ensuring that at least one of the people involved in the child's formal assessment (i.e. one of the two registered medical practitioners or the approved mental health professional) is an experienced specialist CAMHS practitioner wherever possible.

Mental Health Review Tribunal

Continue to work with the MHRT for Wales to find a suitable resolution, to ensure that action is taken to protect the patients' right to a fair hearing and ensure any incidents are reported accordingly.

Development sessions

Continue to develop a robust training rota to ensure that development sessions in relation to all areas of the MHA are available and easily accessible. This will be provided by creating an MHA e-learning module.

Audits

Continue to audit wards and CMHT's, while providing support and guidance on maintaining compliance with the MHA and best practices.

Recommendation:

The Committee is requested to:

- a) NOTE the approach taken by the Mental Health Clinical Board to ensure compliance with the appropriate Mental Health legislation, as set out in the report.

Link to Strategic Objectives of Shaping our Future Wellbeing:

Please tick as relevant

1. Reduce health inequalities	X	6. Have a planned care system where demand and capacity are in balance	X
2. Deliver outcomes that matter to people	X	7. Be a great place to work and learn	X
3. All take responsibility for improving our health and wellbeing	X	8. Work better together with partners to deliver care and support across care sectors, making best use of our people and technology	X
4. Offer services that deliver the population health our citizens are entitled to expect	X	9. Reduce harm, waste and variation sustainably making best use of the resources available to us	X

5. Have an unplanned (emergency) care system that provides the right care, in the right place, first time	X	10. Excel at teaching, research, innovation and improvement and provide an environment where innovation thrives	X
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Five Ways of Working (Sustainable Development Principles) considered

Please tick as relevant

Prevention	X	Long term	X	Integration	X	Collaboration	X	Involvement	X
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Impact Assessment:

Please state yes or no for each category. If yes please provide further details.

Risk: Yes/No

No

Safety: Yes/No

Yes – there is a potential risk that if a 136 lapses with no assessment being completed the patient will be allowed to leave and could harm themselves or others.

Financial: Yes/No

No

Workforce: Yes/No

No

Legal: Yes/No

Yes – communication between the UHB, Local Authority and South Wales Police needs to continue to be monitored to ensure all risks regarding detaining someone without authority are mitigated.

Reputational: Yes/No

No

Socio Economic: Yes/No

No

Equality and Health: Yes/No

No

Decarbonisation: Yes/No

No

Approval/Scrutiny Route:

Committee/Group/Exec

Date:

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NHS
WALES
GIG
CYMRU

Bwrdd Iechyd Prifysgol
Caerdydd a'r Fro
Cardiff and Vale
University Health Board

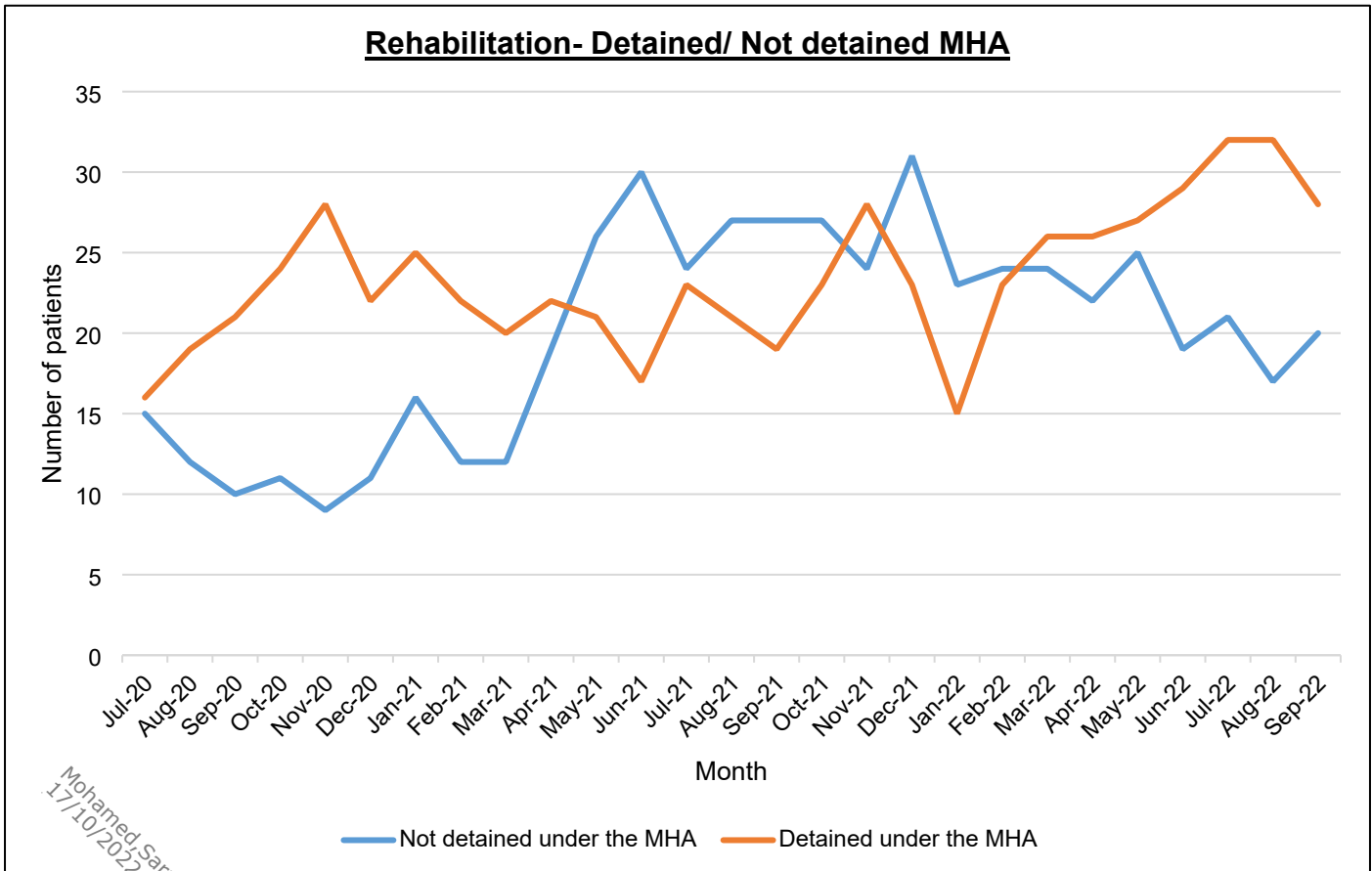
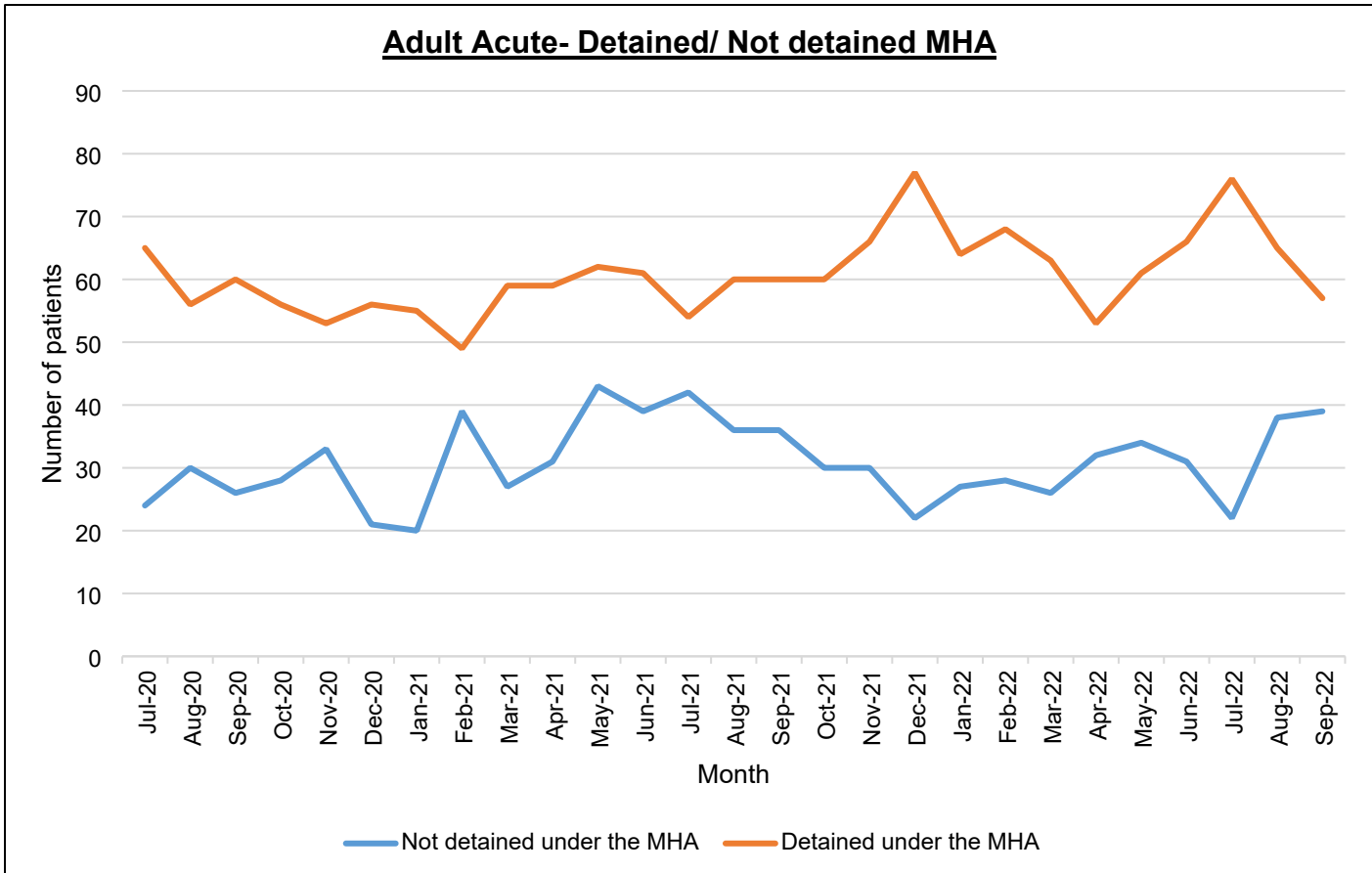
**Report to the
Mental Health Legislation and Mental Capacity Act Committee
on the use of The Mental Health Act, 1983**

July - September 2022

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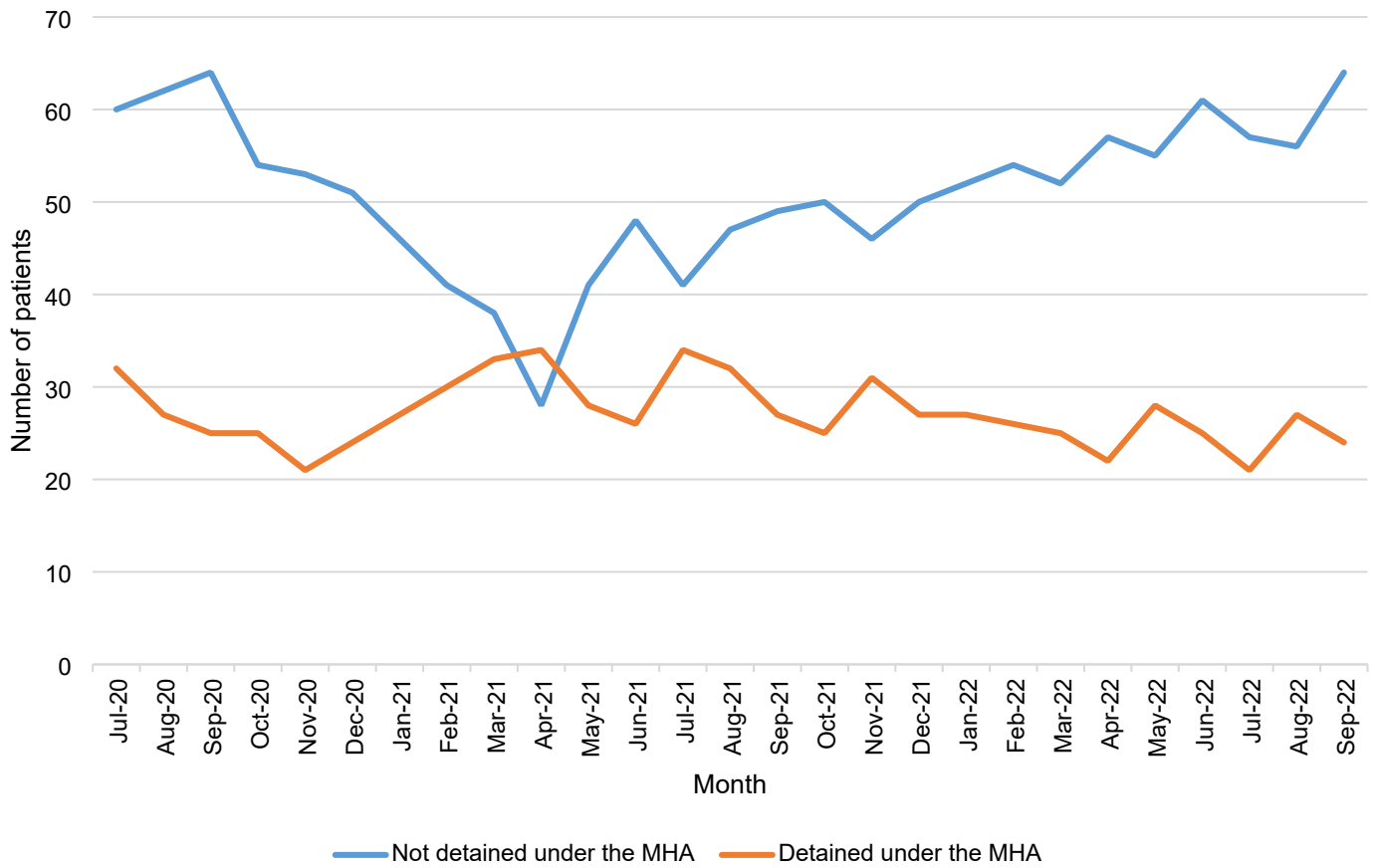
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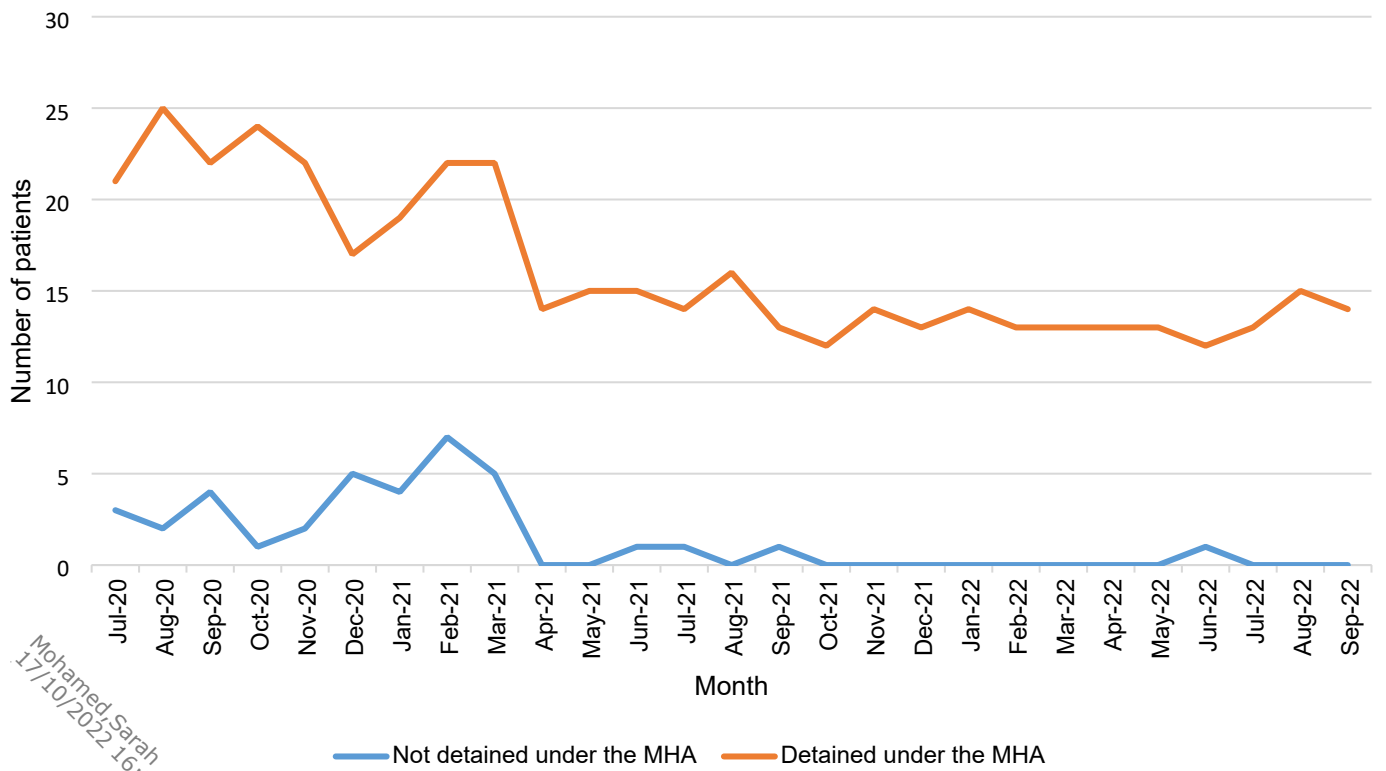


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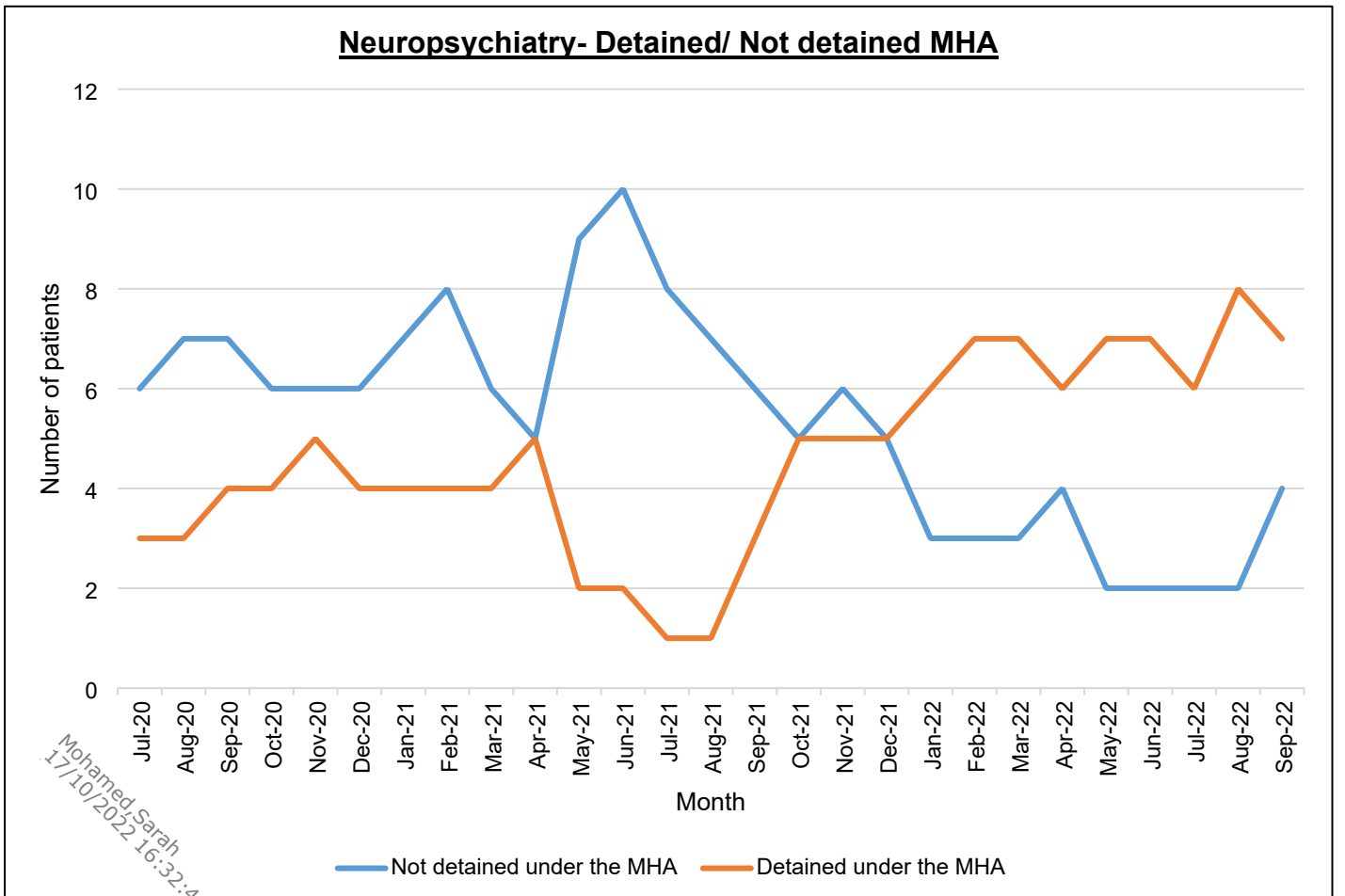
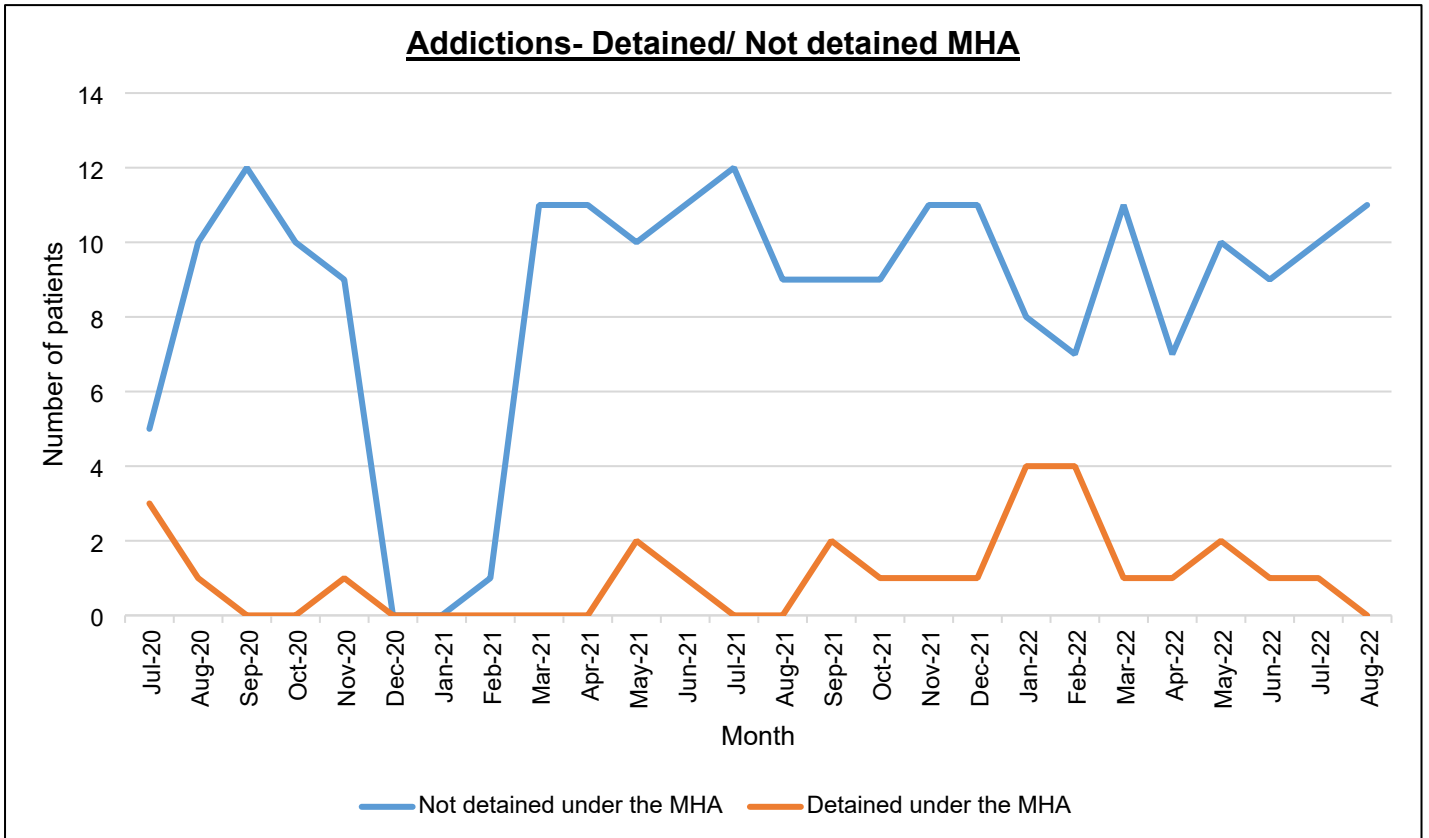
Mental health services for older people- Detained/ Not detained



Low Secure- Detained/ Not detained MHA



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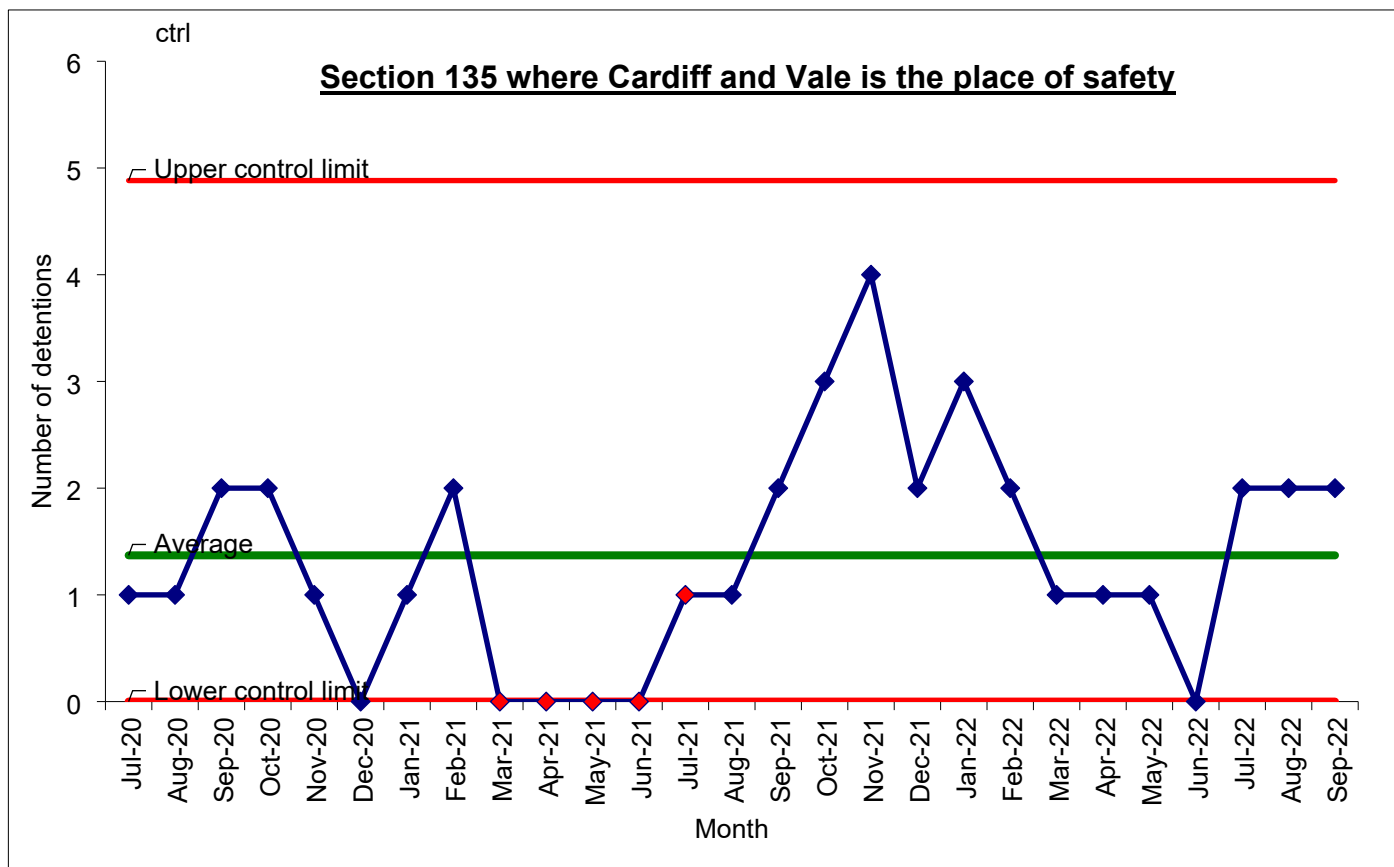


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Section 135 – Warrant to search for and remove a mentally disordered person/patient from private premises to a place of safety

During the period Section 135 (1) powers were used four times. All four uses resulted in a Section 2.

During the period Section 135(2) powers were used twice. Both patients were brought back into hospital under Section 2.



Mohamed Sarah
17/10/2022 16:32:46

Voluntary Assessment

During Summer 2020, the electronic All Wales Monitoring Form (AWMF) was put into use. This is an electronic form that should be completed by Police Officers for every occasion that they bring a patient to Hospital for a Mental Health Assessment. The reasons for this can be;-

- Use of s135
- Use of s136
- Voluntary Assessment
- Mental Capacity Act

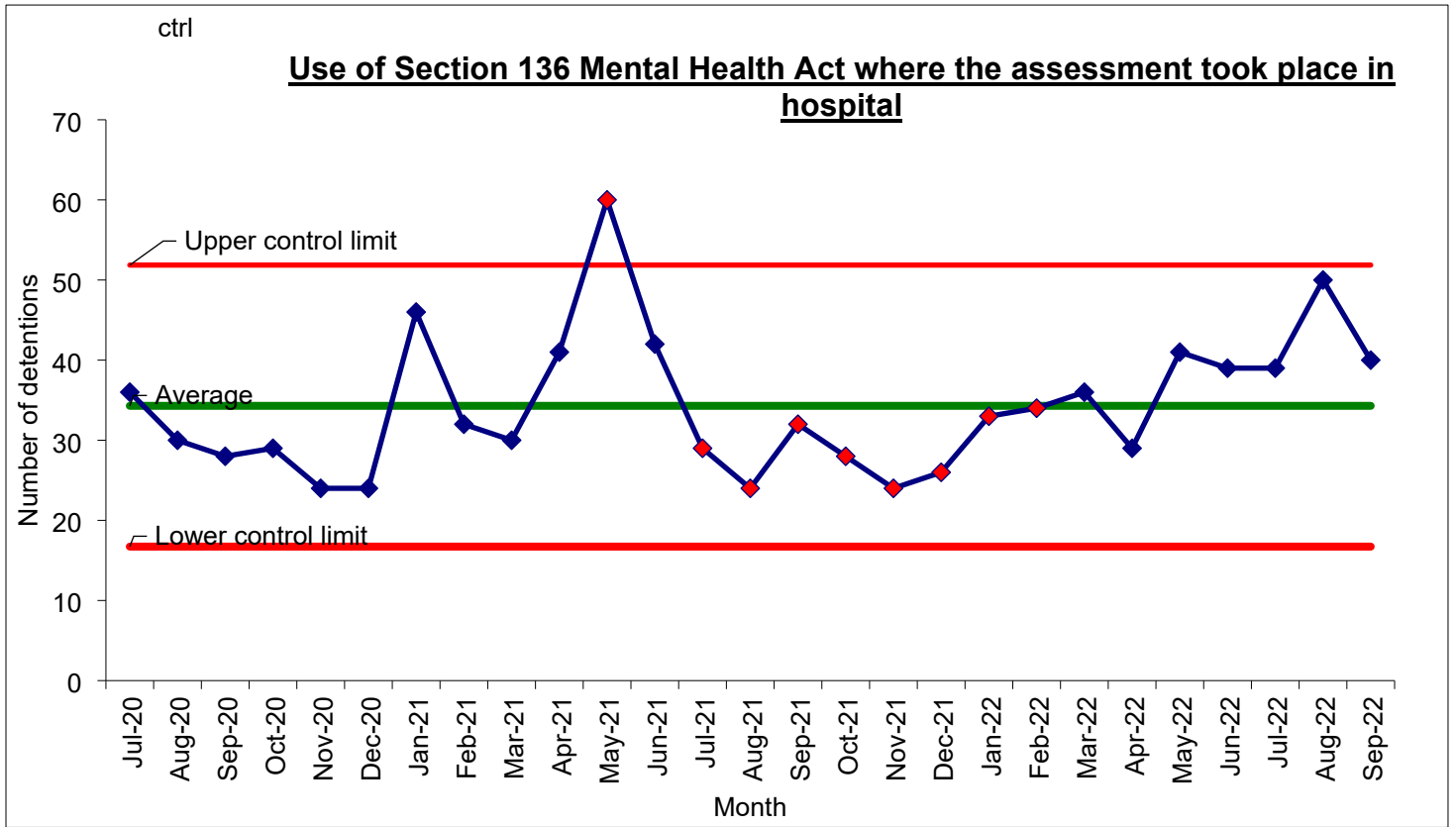
We continue to work with South Wales police to ensure the AWMF is completed each time a person is brought to hospital for an assessment and hope to see an improvement in the use of the electronic form going forward.

For this period we have seen eight people for a Voluntary Assessment and one was brought into hospital under the Mental Capacity Act.

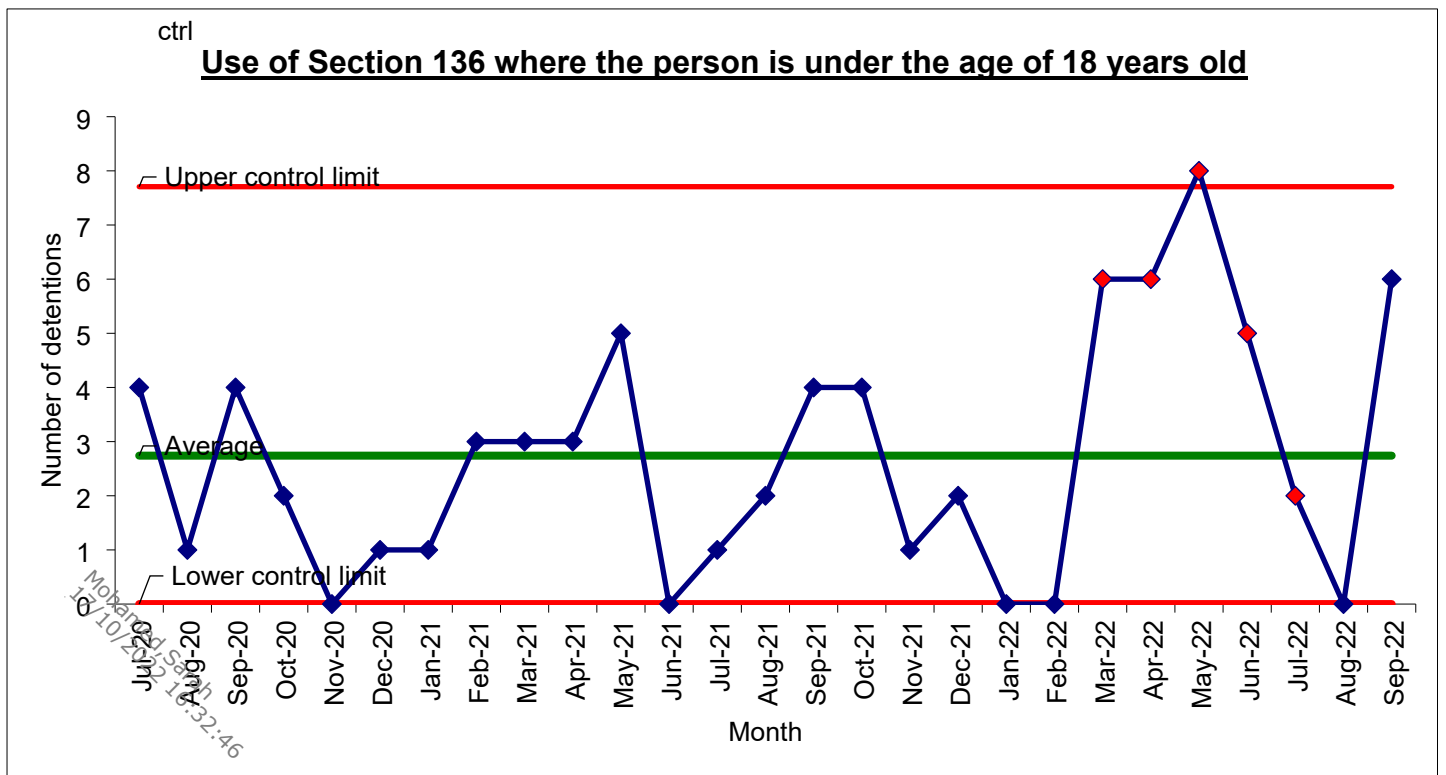
Mohamed Sarah
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Section 136- Mentally disordered persons found in public places Mental Health Act assessments undertaken within Cardiff and Vale UHB

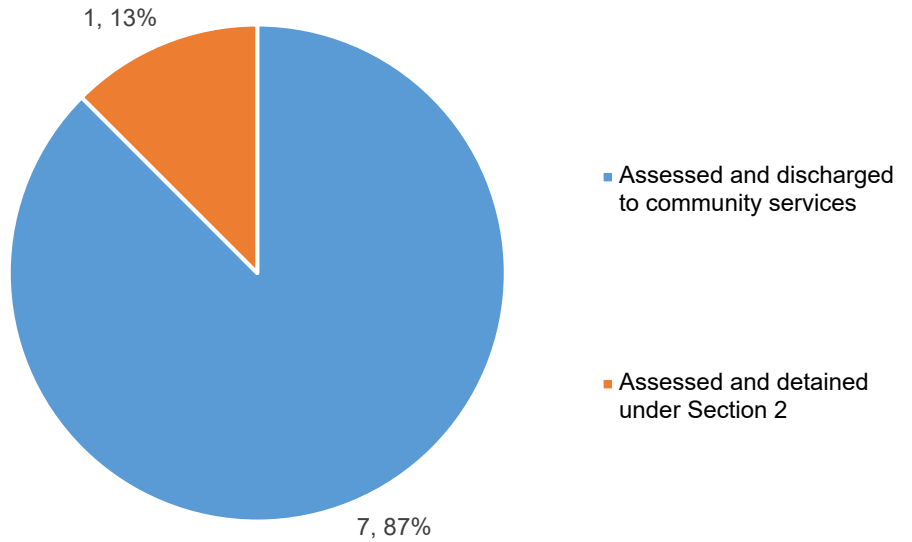
During the period a total of 129 assessments were initiated by Section 136 where the MHA assessment took place in a hospital as the place of safety.



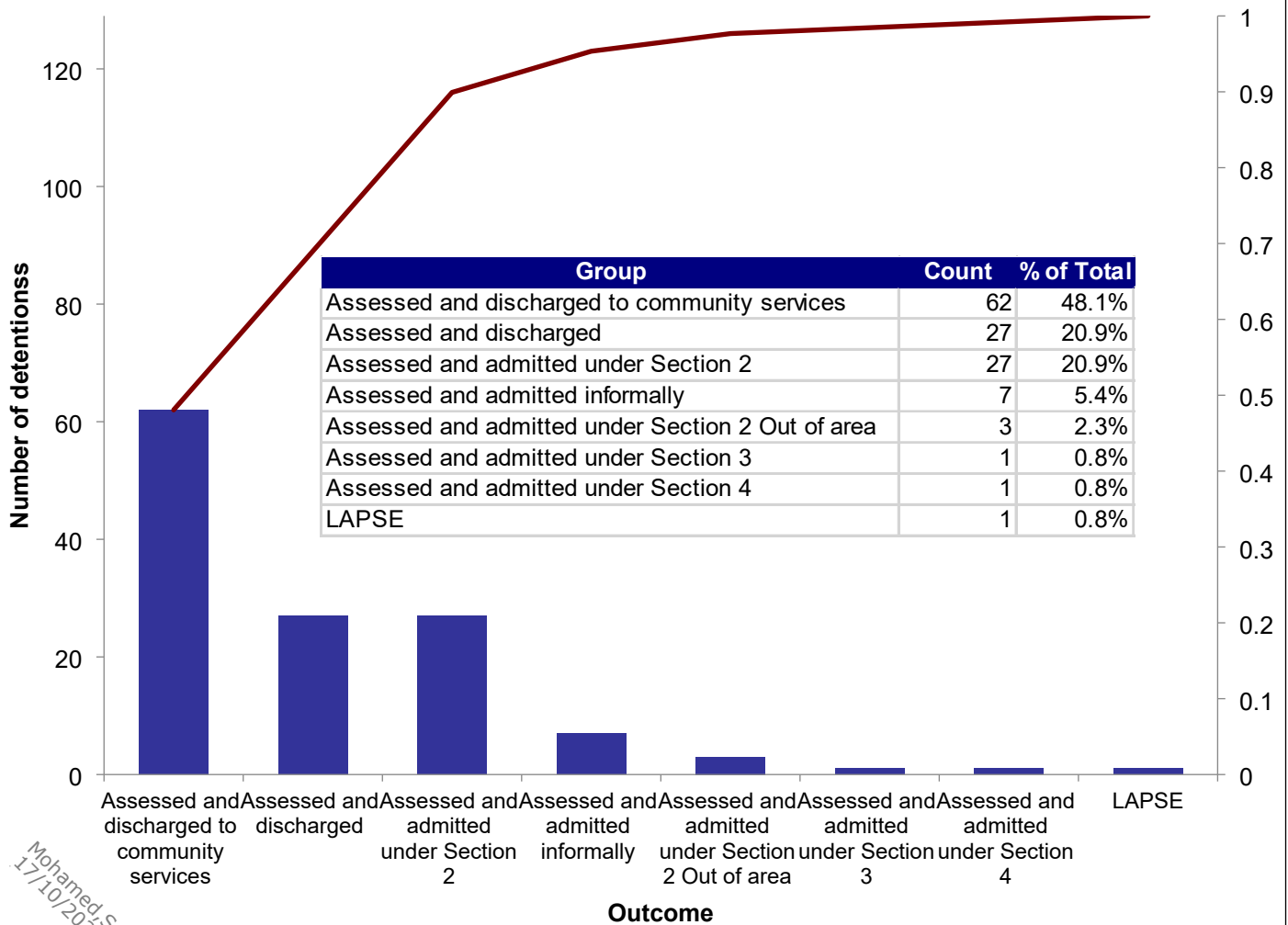
Eight of those assessments were carried out on patients under the age of 18. Included in the above data are those under 18 years of age. This is extracted below;-



Outcome of CAMHs Section 136 assessments



Outcome of Section 136 assessments which took place in hospital during the period July- September 2022



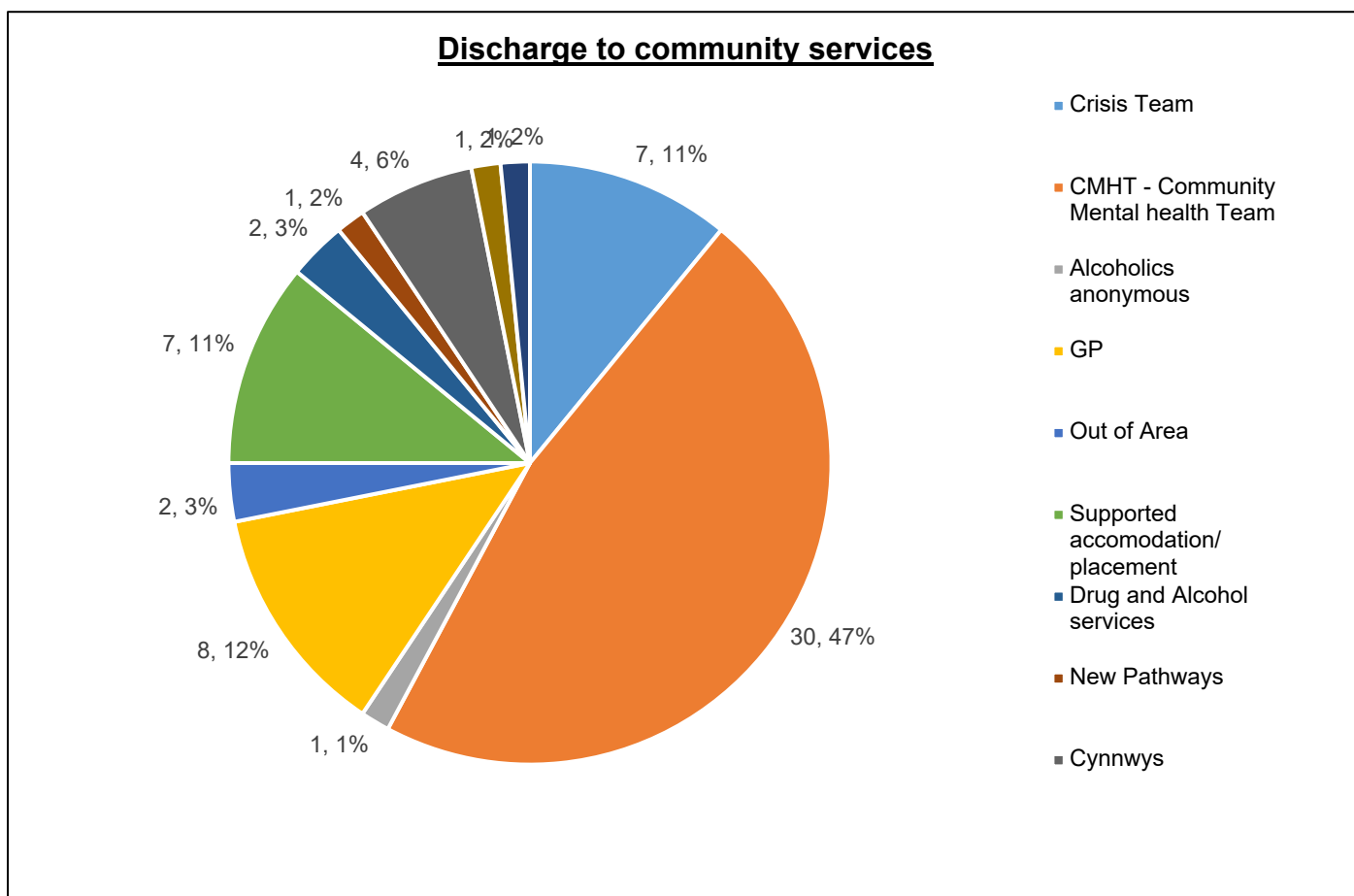
Mohamed Sarah
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The pareto chart highlights that 69% of individuals assessed in hospital under Section 136 were not admitted to hospital. Those individuals who are not admitted or discharged to another service are provided with information on Mental Health support services for possible self-referral.

Included in the above data are the outcomes for those under 18 years of age.

- One detention LAPSED as the patient was not assessed within the 24 hour period.
- Five of the CAMHs assessments were on the same patient.
- One patient was detained under Section 4 due to safety risks.

The below chart is a breakdown of the referrals to Community Services as a result of a s136 assessment. Please note that patients can be referred to multiple Community Services, so it is possible that the numbers below are higher than the total number of s136 used.

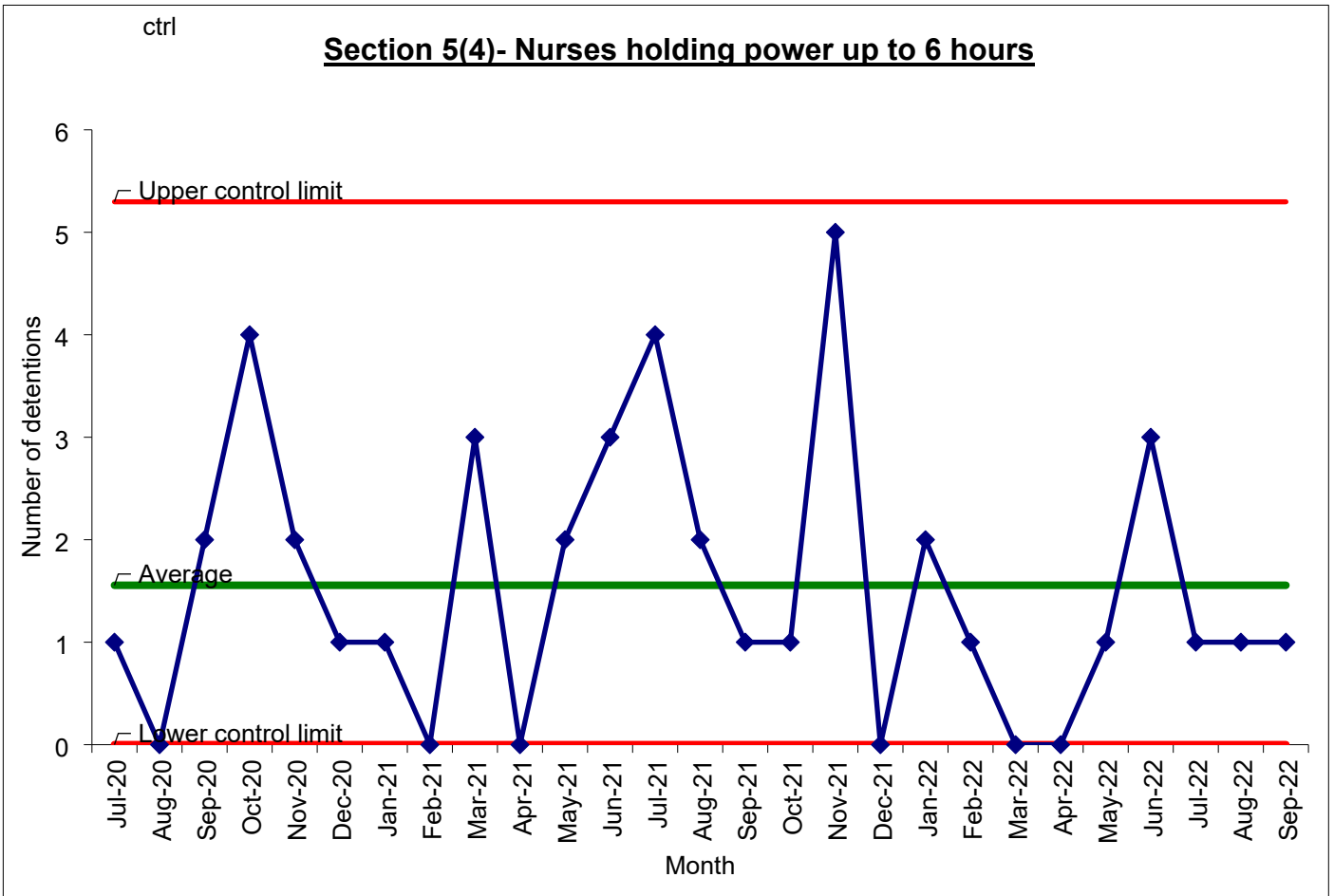


Section 136- Mentally disordered persons found in public places Mental Health Act assessments undertaken within a Police Station

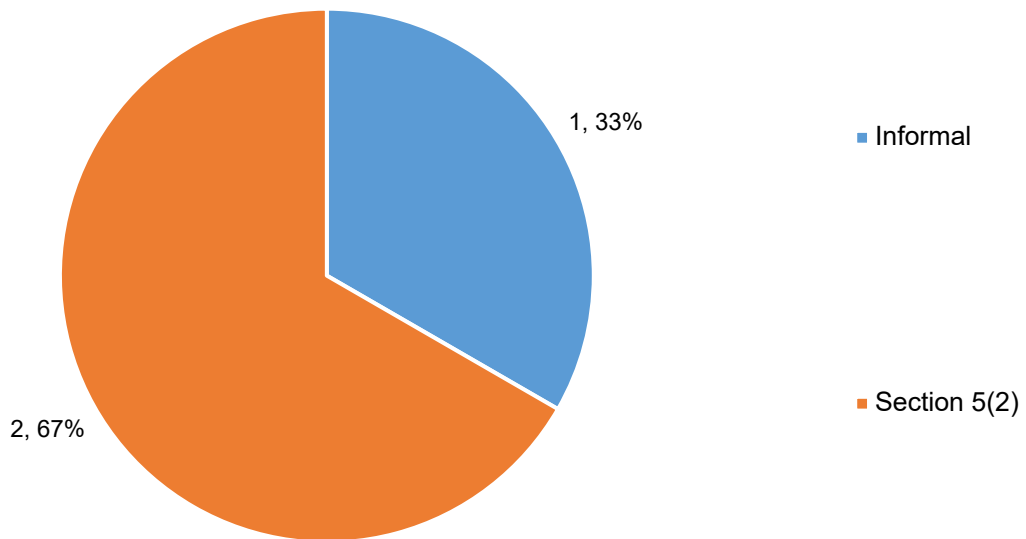
During the period there were no assessments initiated by Section 136 powers where the MHA Assessment took place in Cardiff Bay Custody Suite.

Ms Sarah
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Section 5(4) - Nurses Holding Power

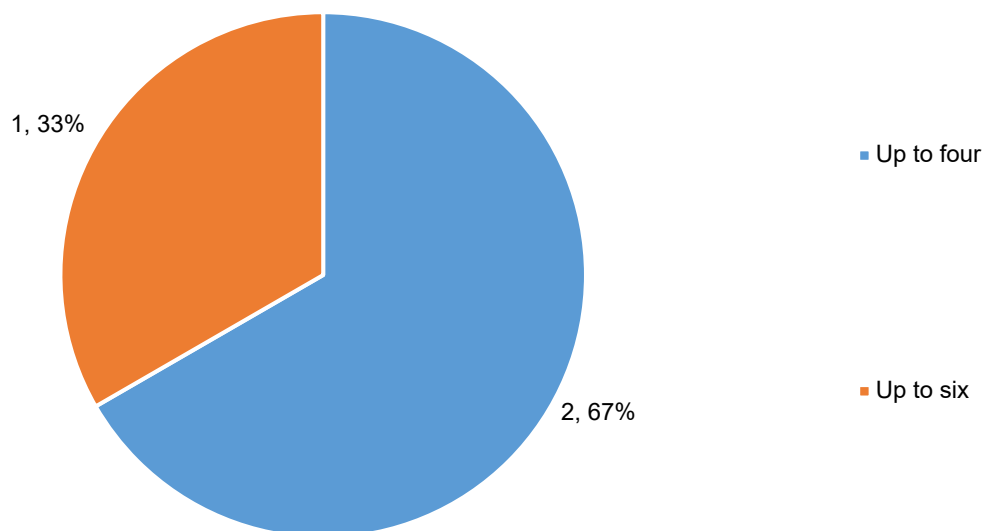


Outcome of Section 5(4) during the period July- September 2022



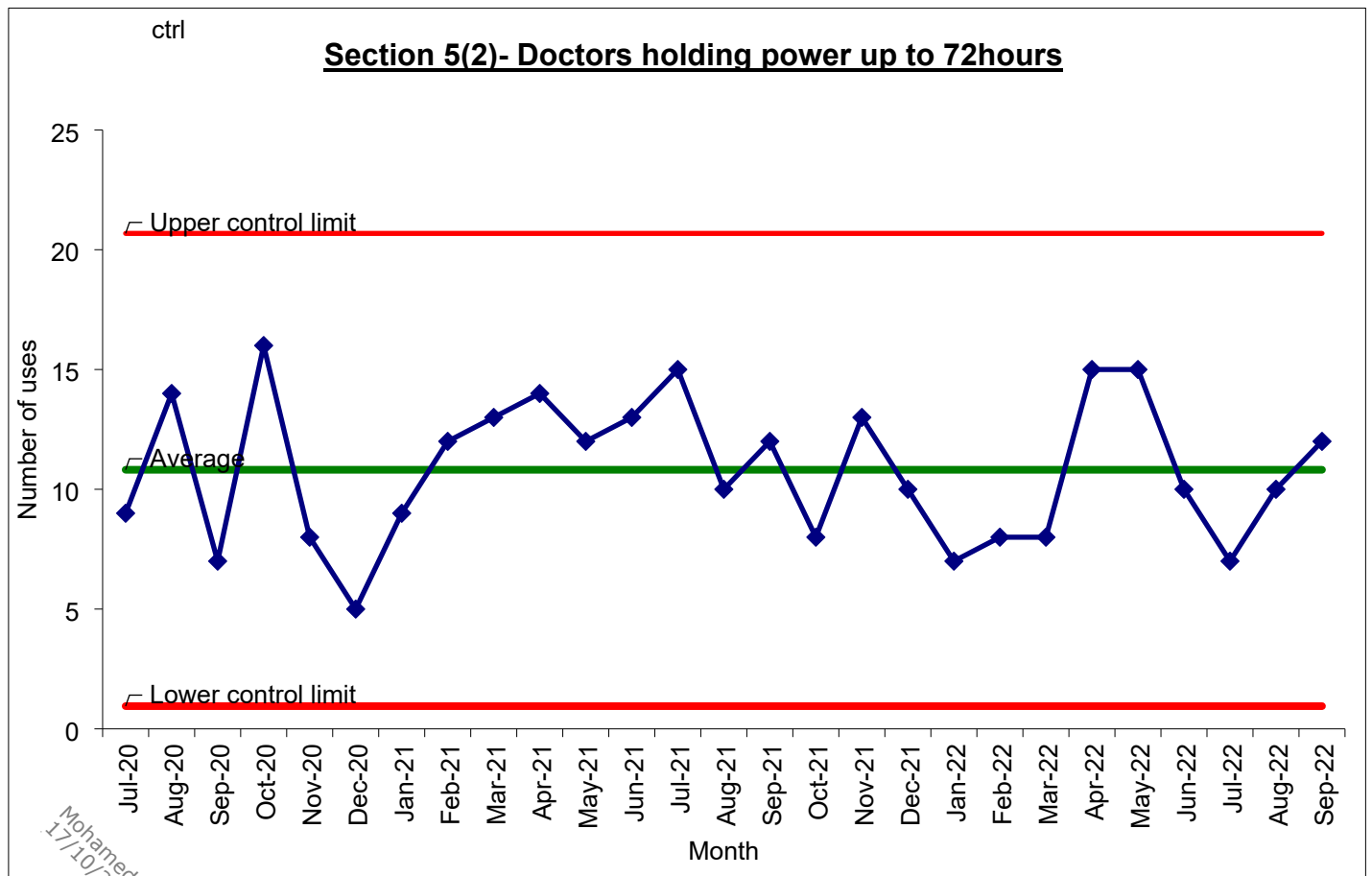
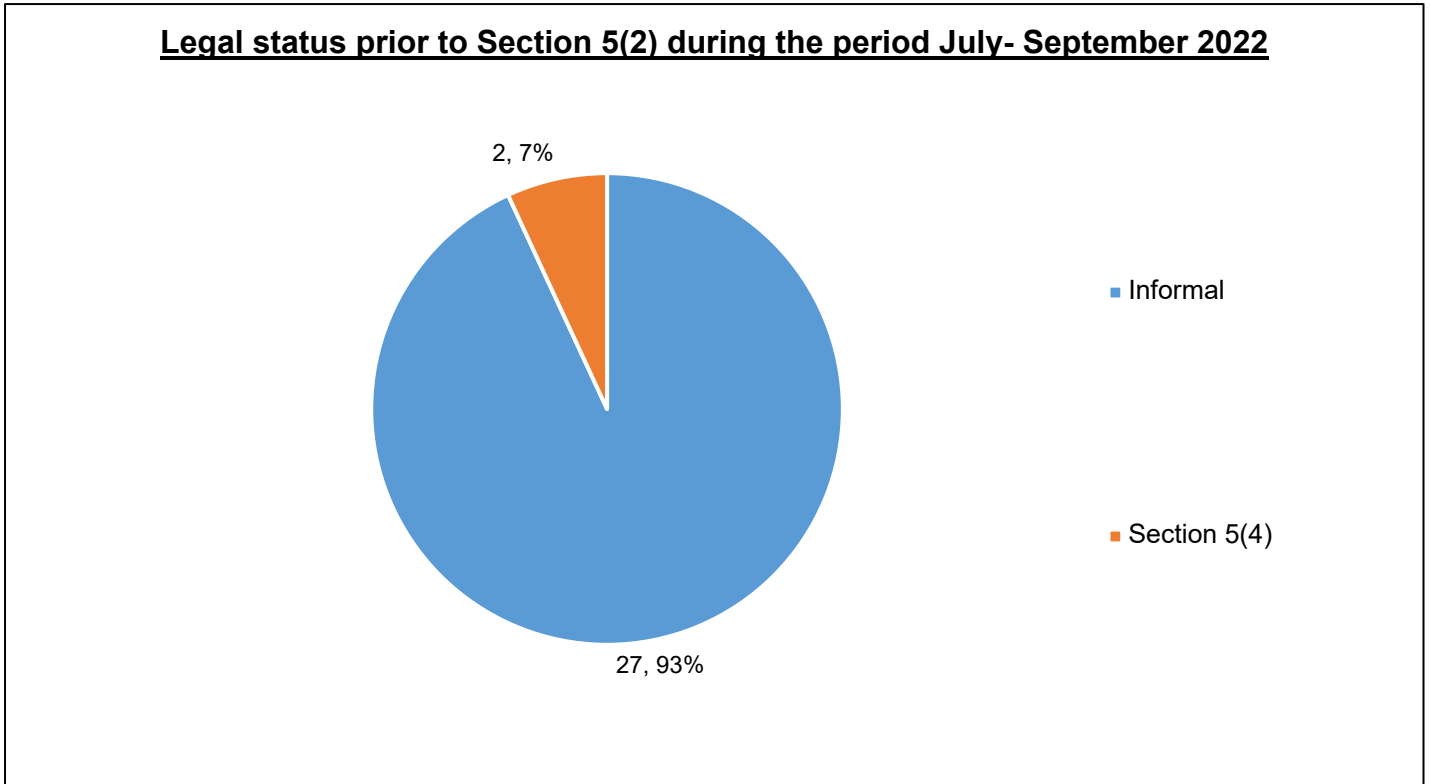
Mohamed Sarah
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Number of hours patients were detained under Section 5(4) during the period July- September 2022

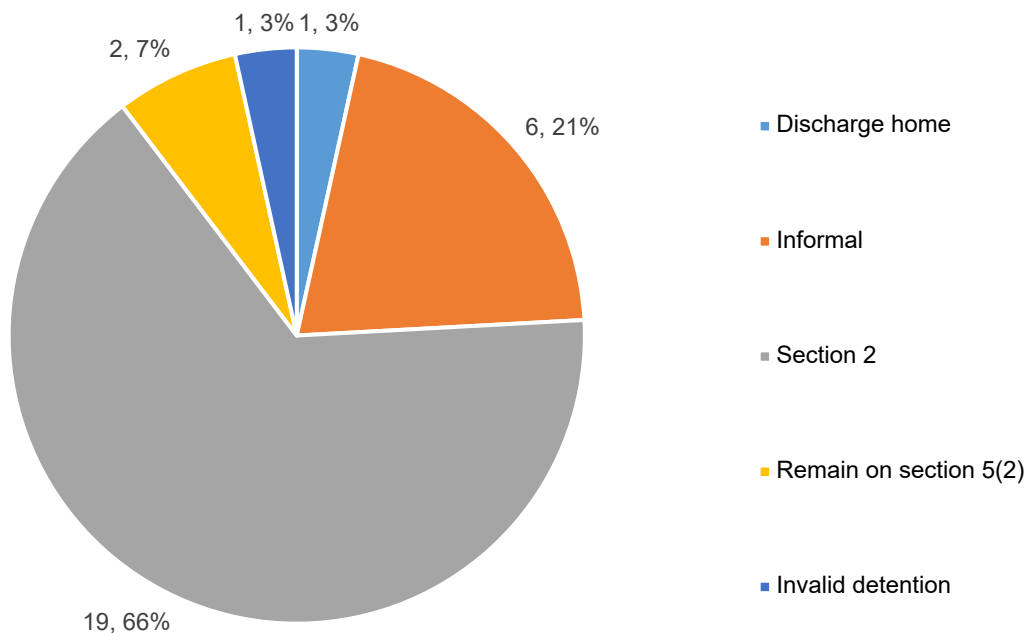


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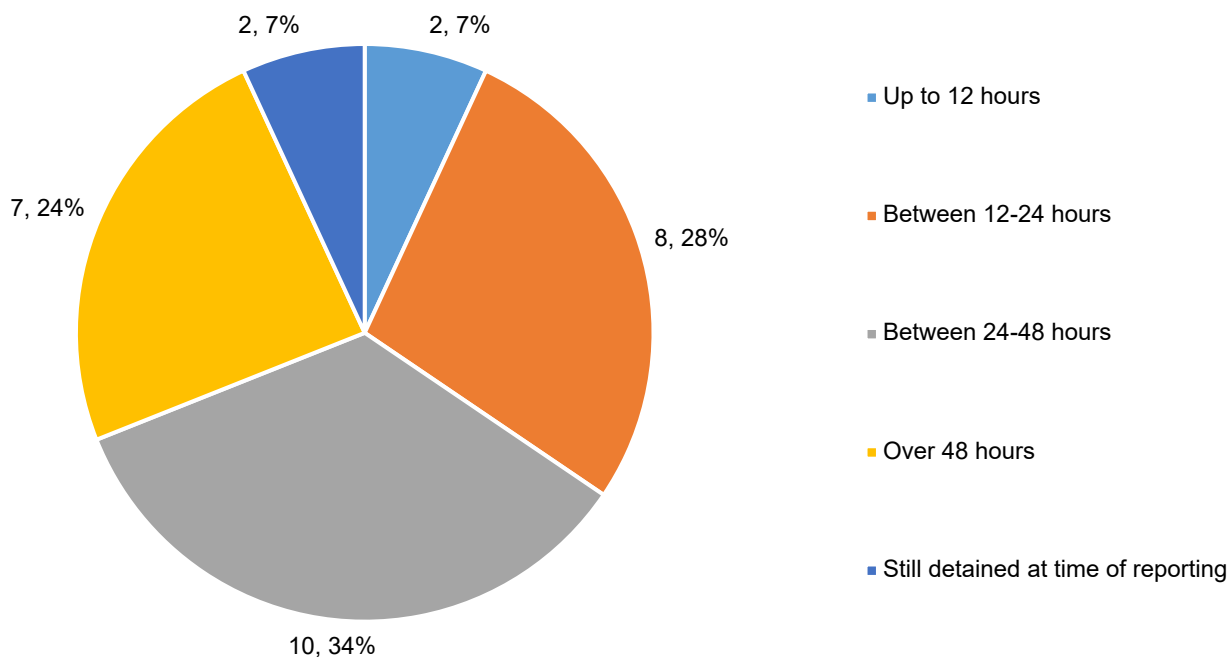
Section 5(2) - Doctors holding power



Outcome of Section 5(2) during the period July- September 2022



Number of hours patients were detained under Section 5(2) during the period July- September 2022

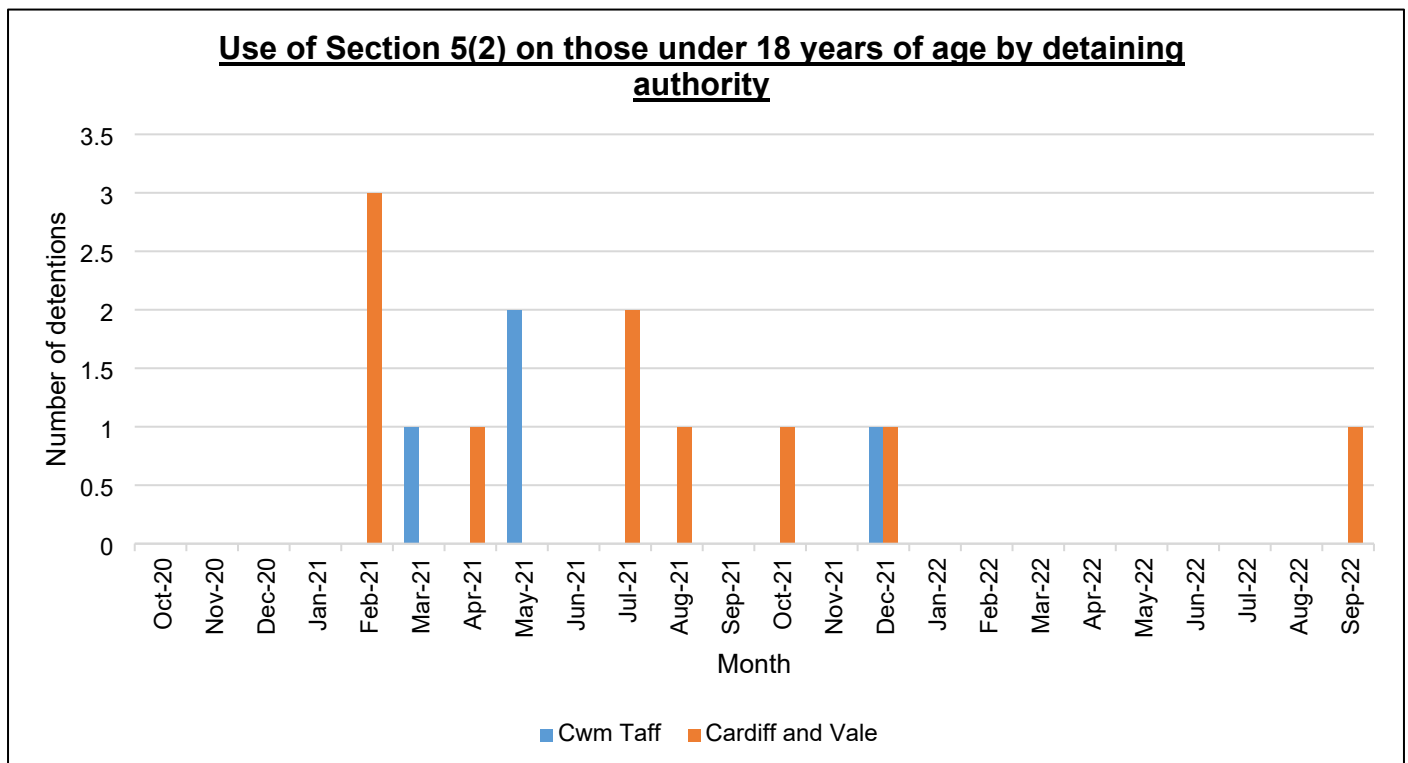


DURING THE PERIOD THERE WAS ONE INSTANCE OF A FUNDAMENTALLY DEFECTIVE SECTION 5(2).

CAMHS Commissioned Inpatient Data

Cwm Taf Morgannwg UHB are commissioned to perform the role of Inpatient CAMHS for Cardiff and Vale UHB area patients.

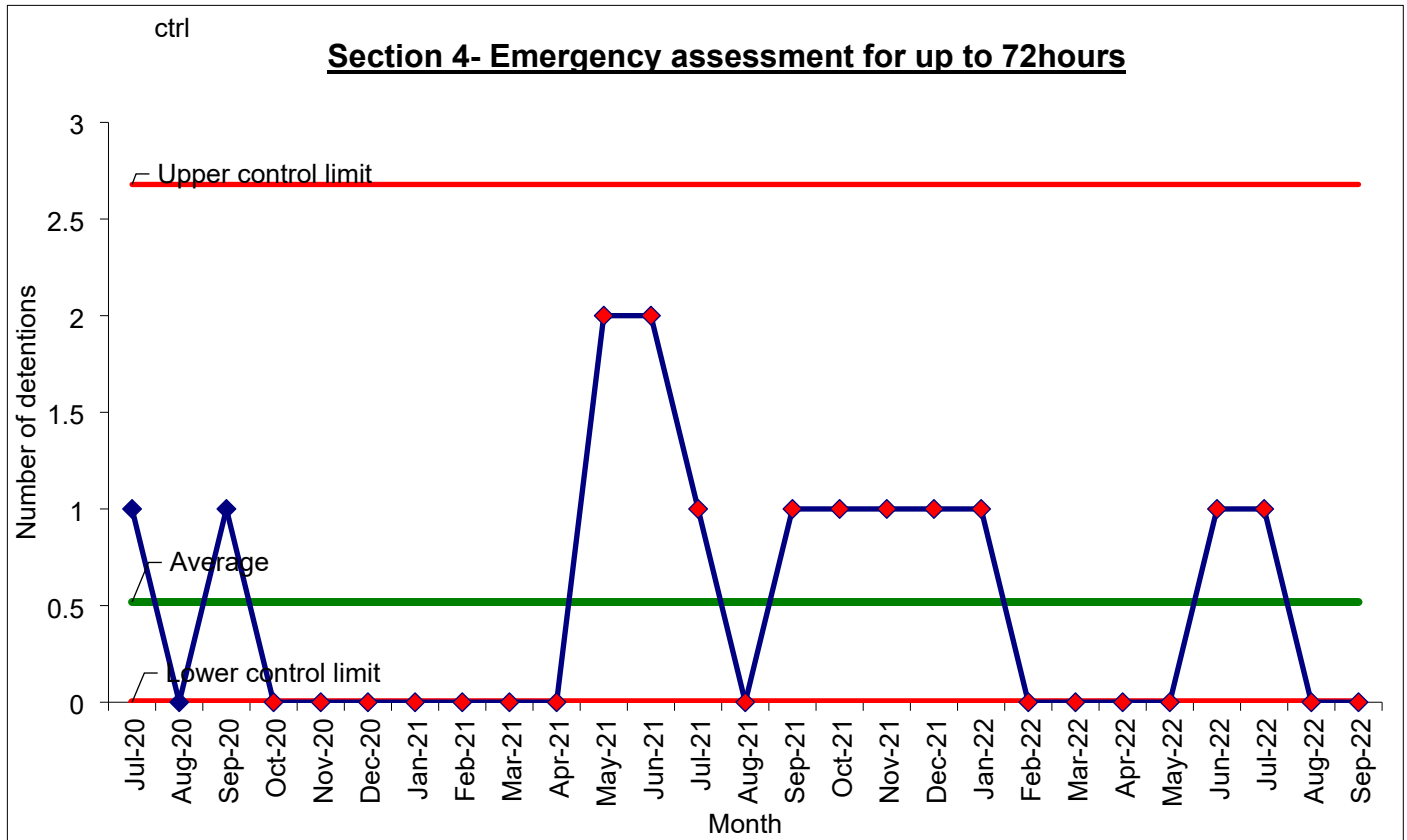
During the period there was one use of Section 5(2) or Section 5(4) holding powers on patients under the age of 18 in either Cardiff and Vale UHB or Cwm Taf Morgannwg UHB. The patient was subsequently detained under Section 2.



Mohamed, Sarah
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Section 4 - Admission for Assessment in Cases of Emergency

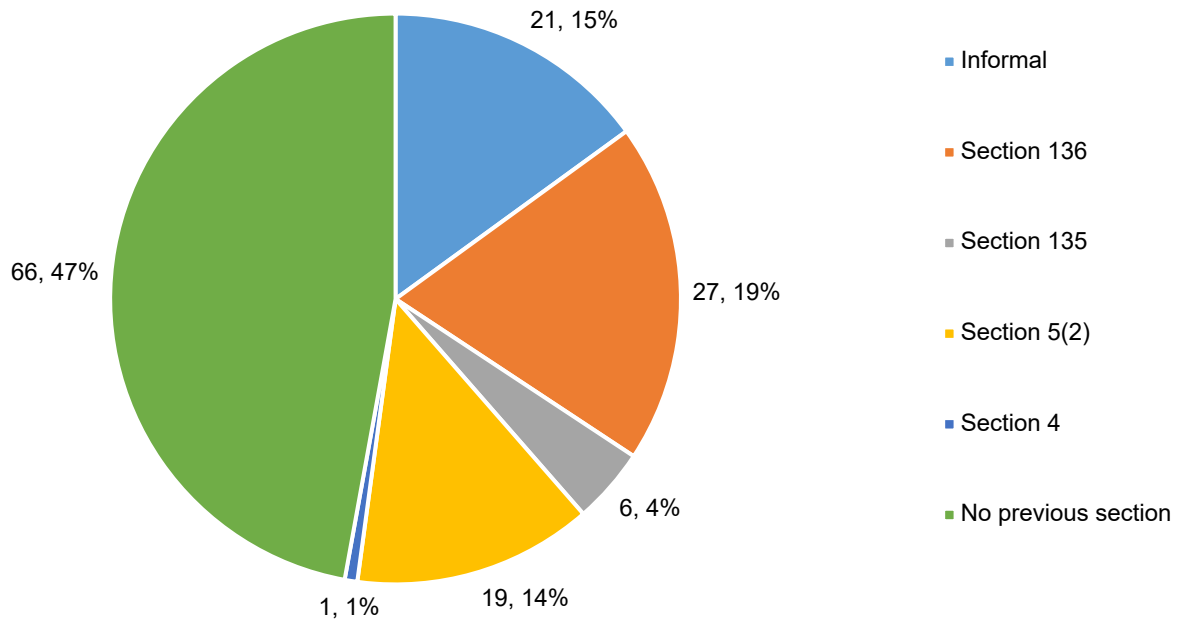
Section 4 was used on one occasion during the period due to an immediate and significant risk of mental or physical harm to the patient or others. The patient was detained under Section 2.



Mohamed Sarah
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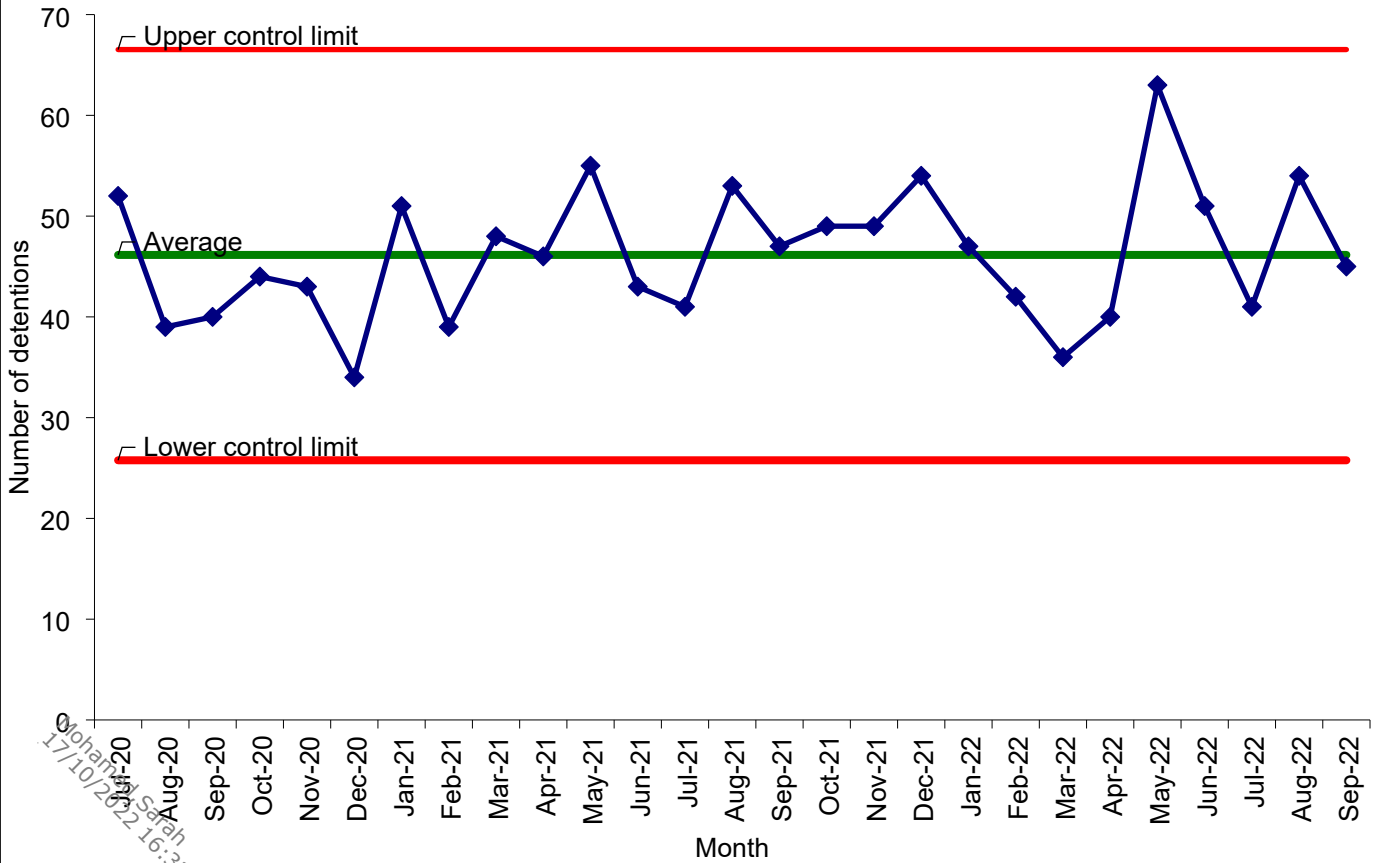
Section 2 – Admission for Assessment

Legal status prior to Section 2 during the period July- September 2022

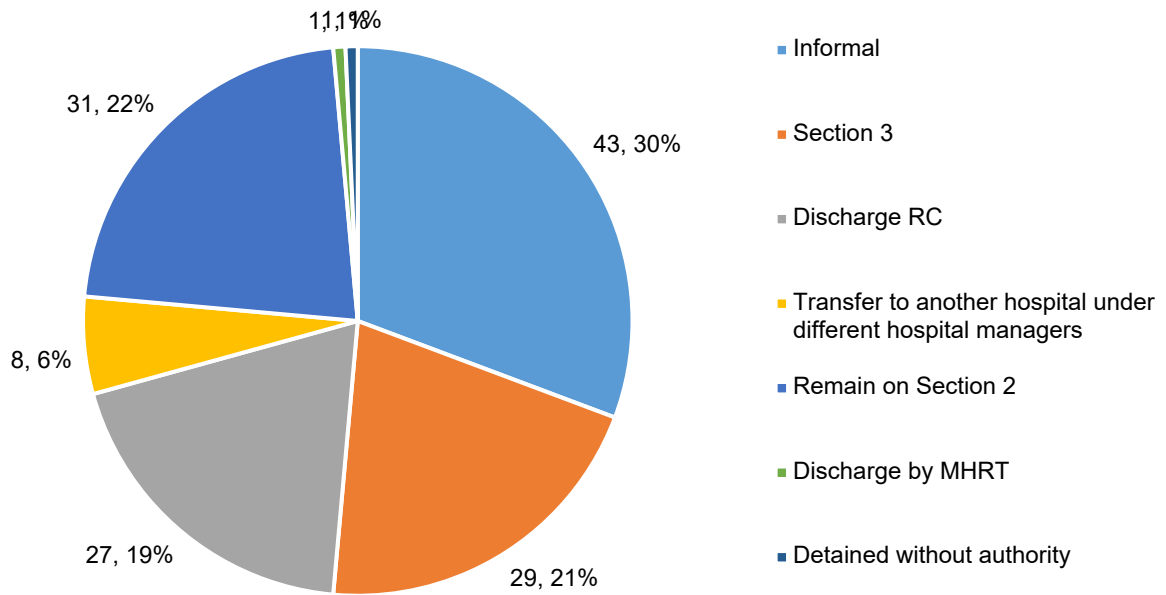


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Section 2- Admission for assessment up to 28 days



Outcome following Section 2 detention during the period July-September



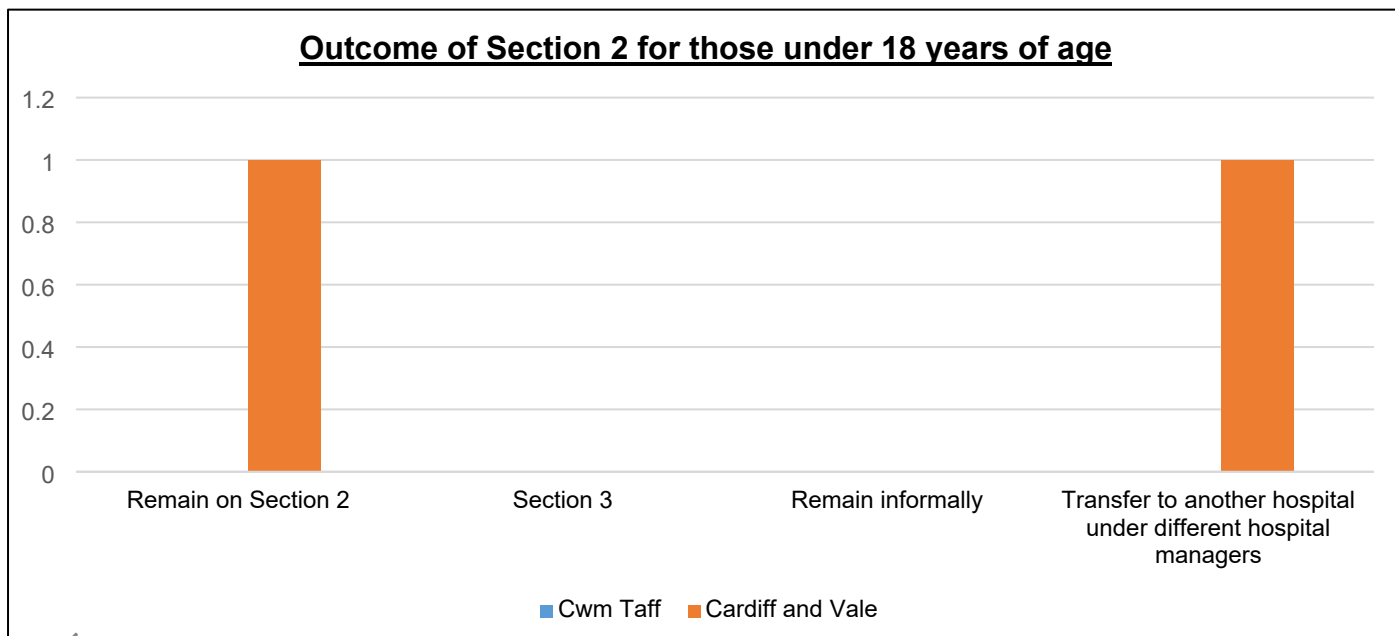
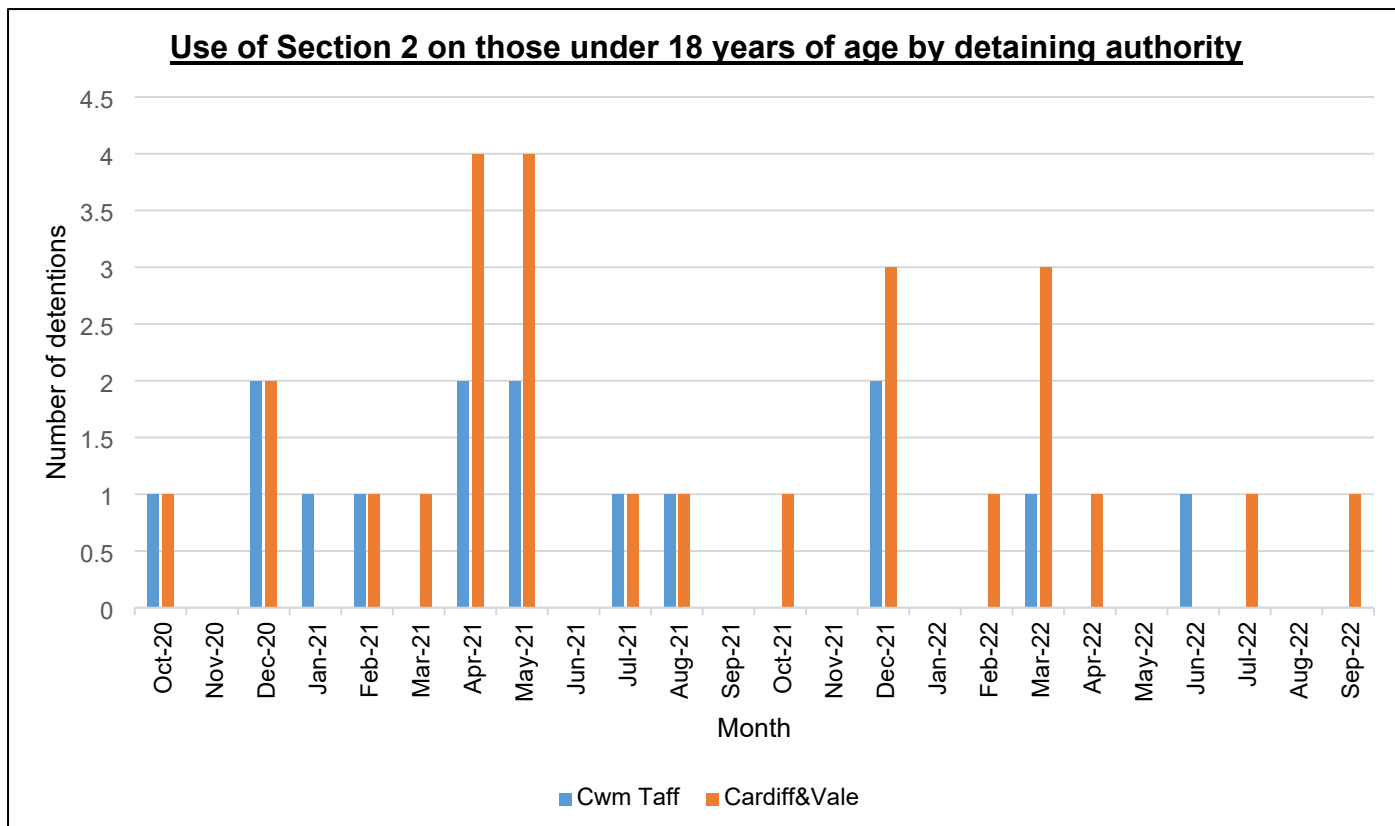
DURING THE PERIOD THERE WAS ONE INSTANCE OF A FUNDAMENTALLY DEFECTIVE APPLICATION RESULTING IN A PATIENT BEING DETAINED UNDER SECTION 2 WITHOUT AUTHORITY DUE TO THE DETENTION PAPERS NOT HAVING BEEN COMPLETED IN LINE WITH WELSH REGULATIONS.

Mohamed Sarah
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CAMHS Commissioned Inpatient Data

Cwm Taf Morgannwg UHB are commissioned to perform the role of Inpatient CAMHS for Cardiff and Vale UHB area patients.

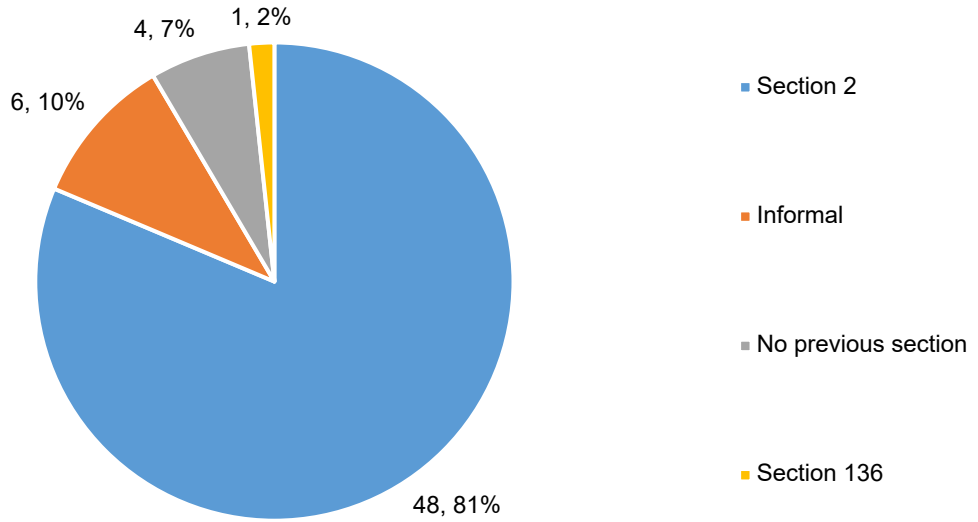
Included in the above data are those under 18 years of age. This is extracted below;-



Mohamed Sarah
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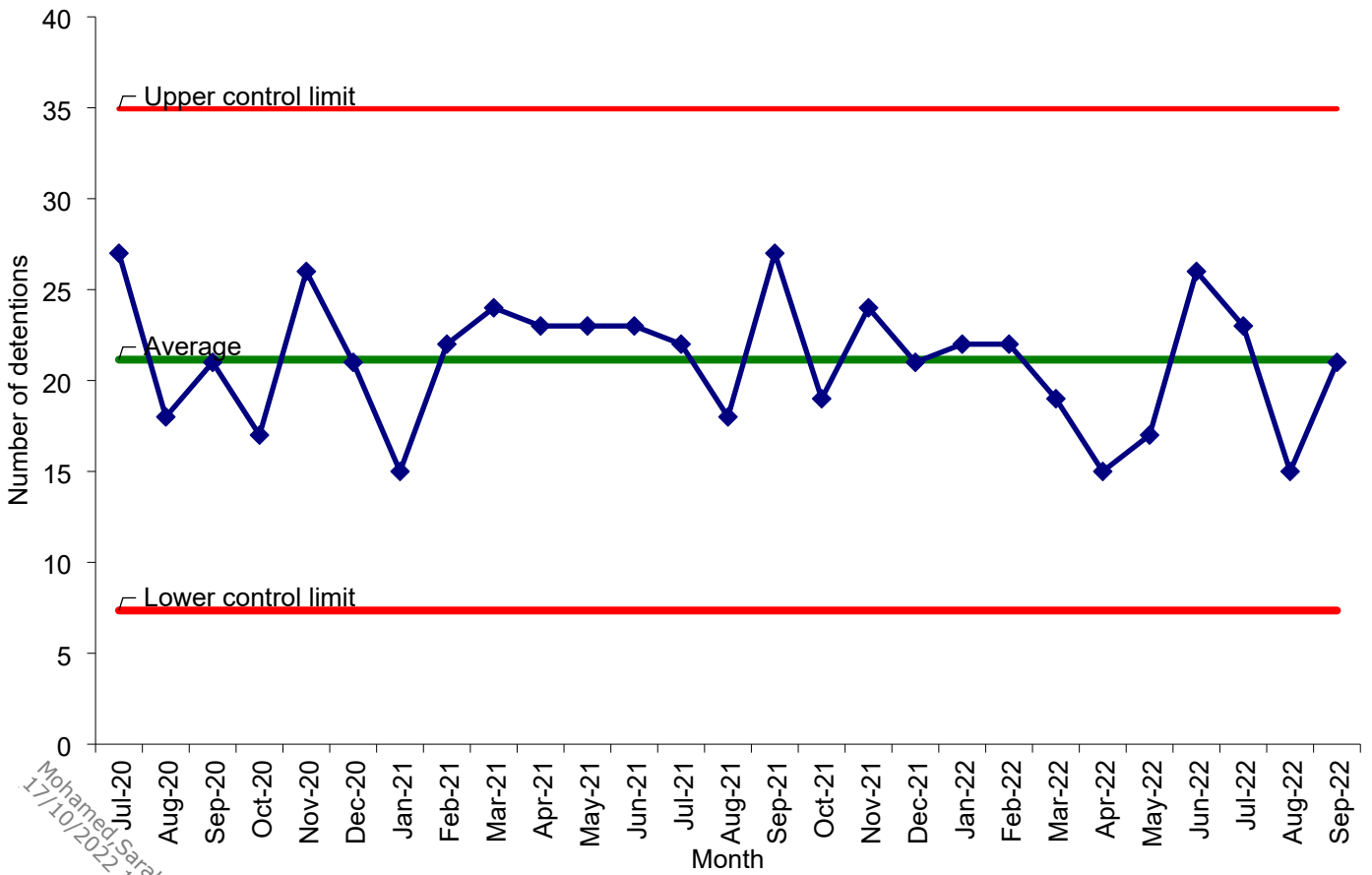
Section 3 – Admission for Treatment

Legal status prior to Section 3 during the period July- September 2022



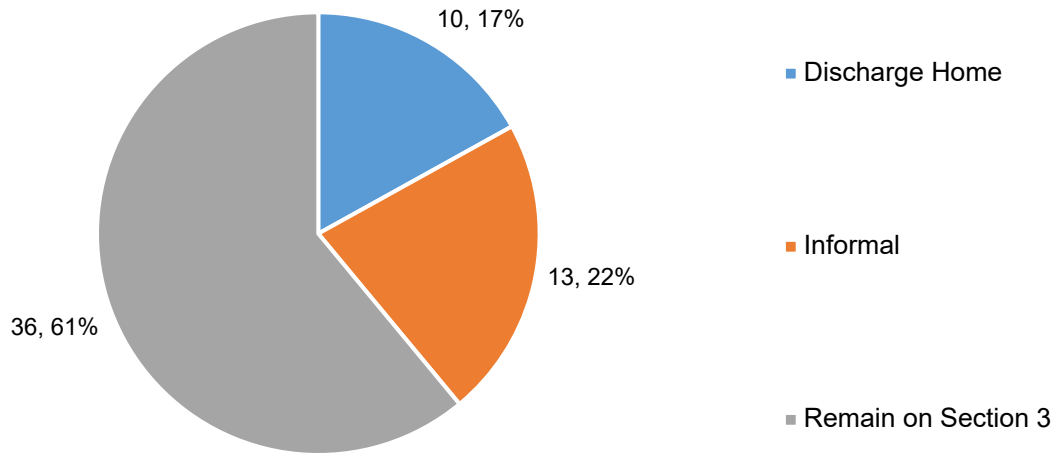
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Section 3- Admission for treatment



The above data would include those under 18 years of age.

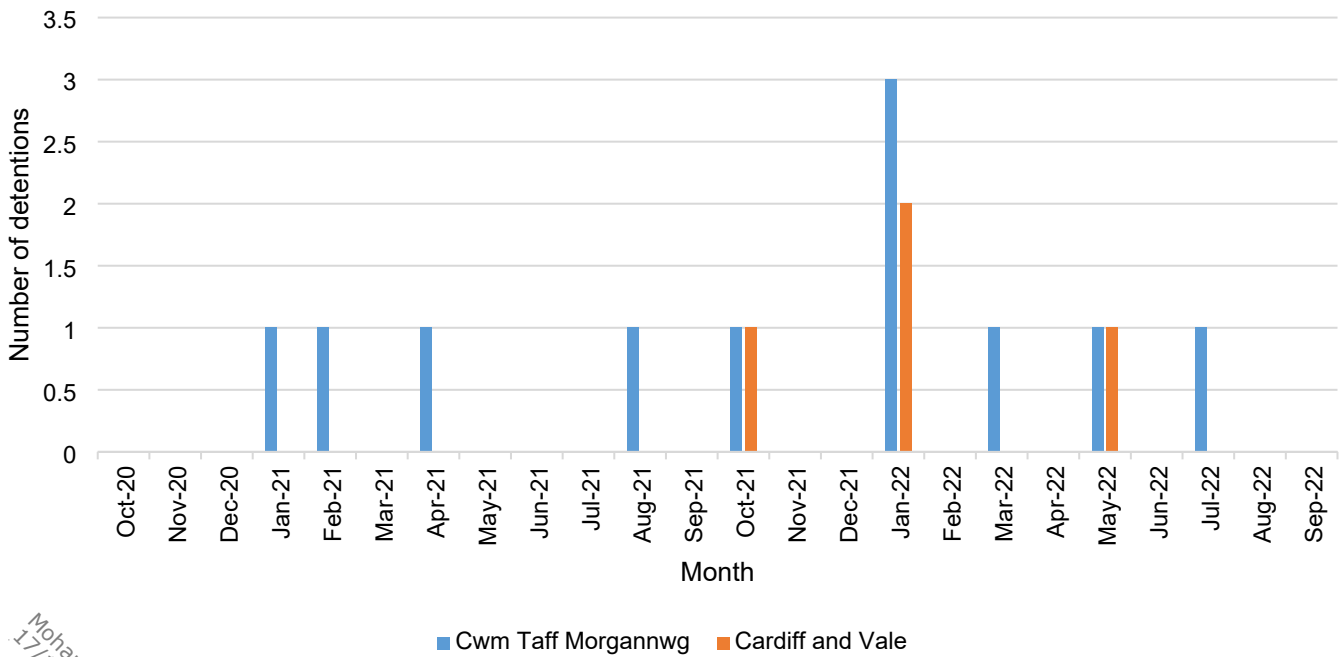
Outcome following Section 3 during the period July- September 2022



CAMHS Commissioned Inpatient Data

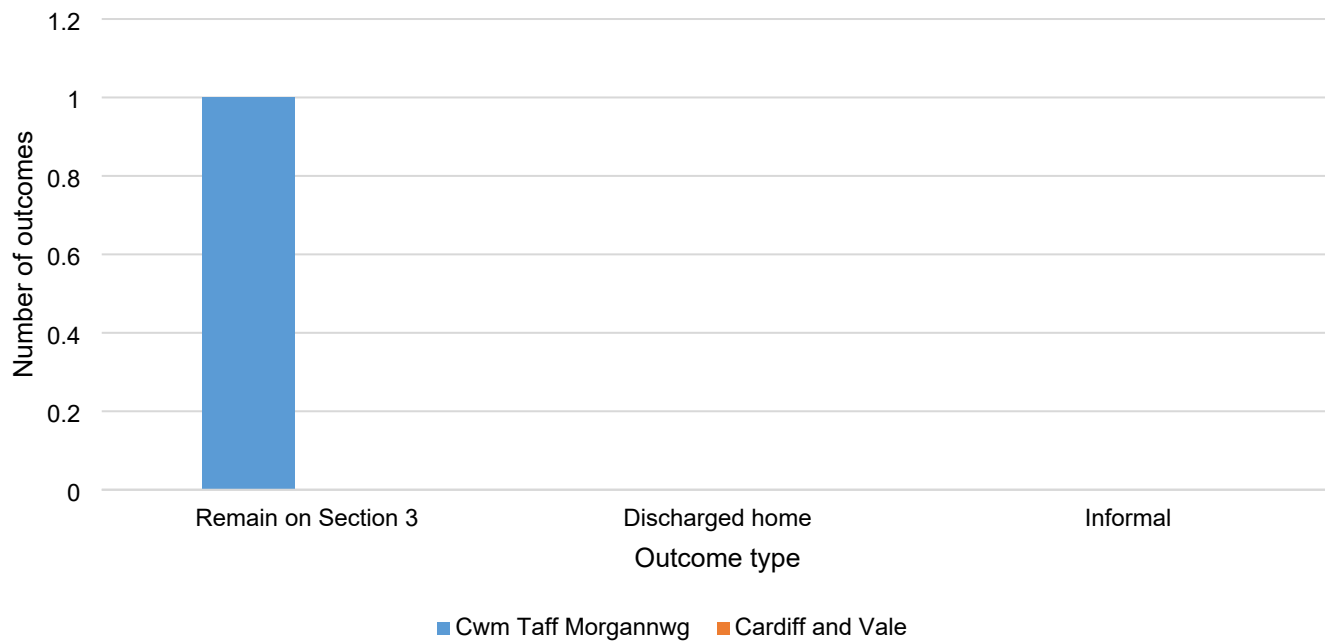
Cwm Taf Morgannwg UHB are commissioned to perform the role of Inpatient CAMHS for Cardiff and Vale UHB area patients.

Use of Section 3 on those under 18 years of age by detaining authority



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Outcome of Section 3 for those under 18 years of age

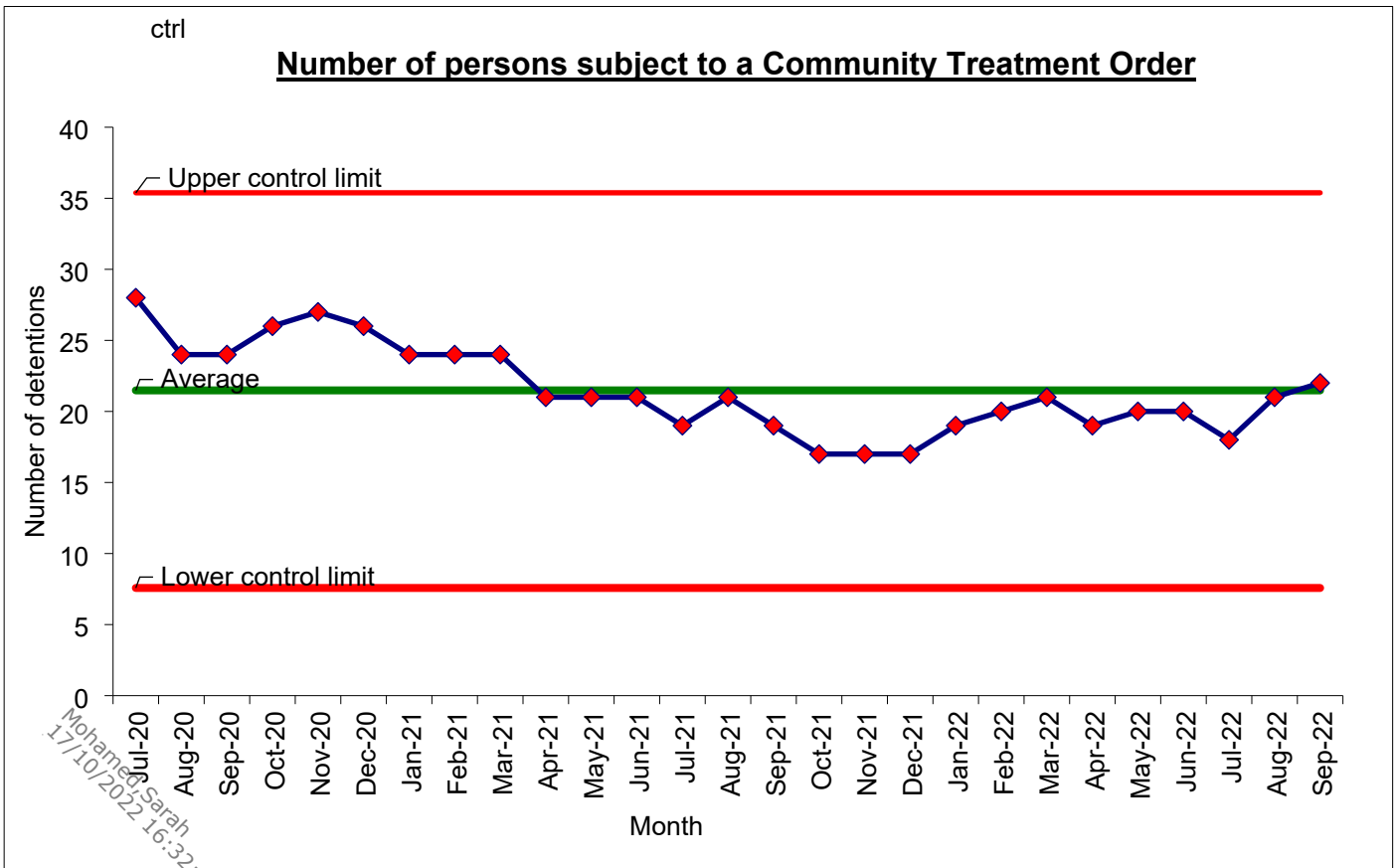
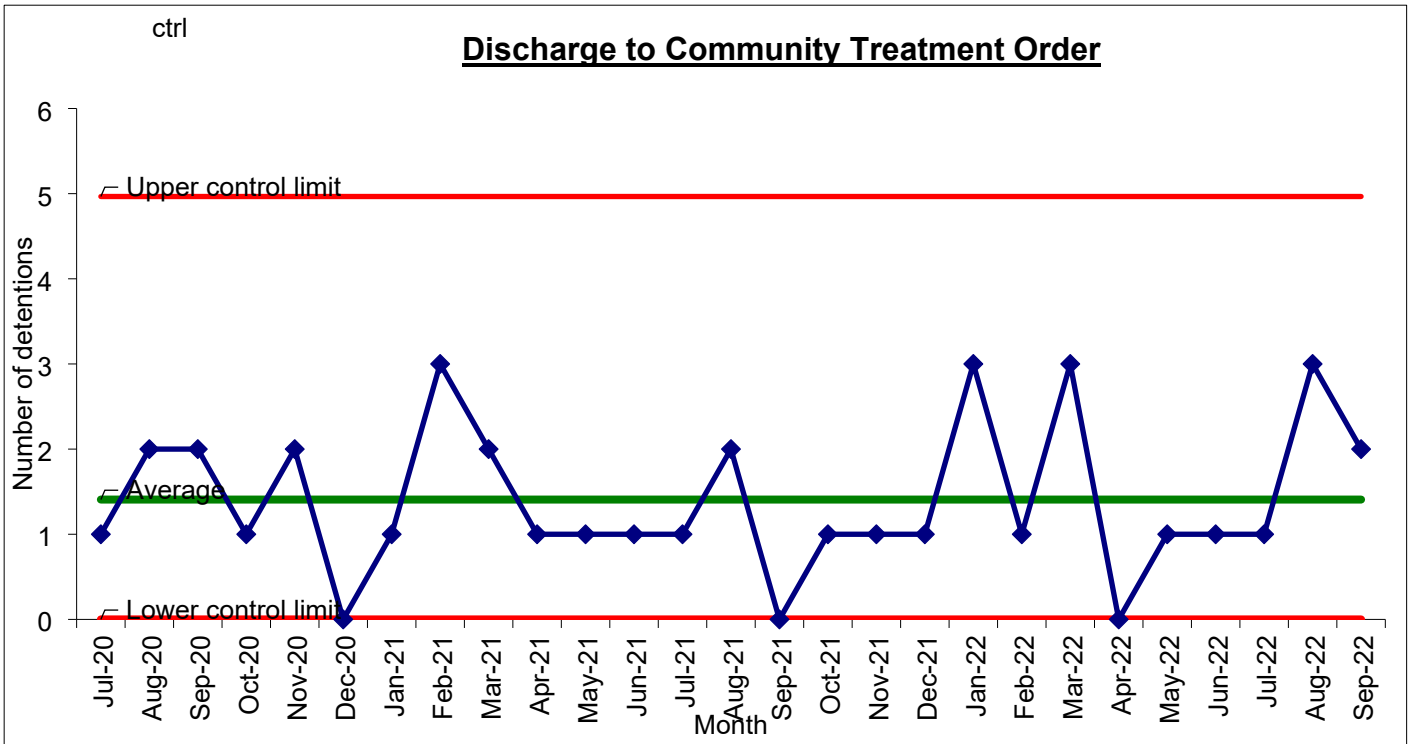


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Community Treatment Order

During the period July- September 2022 six patients were discharged to Community Treatment Order.

As at 30th September 2022, 22 patients were subject to a Community Treatment Order (CTO).



Recall of a community patient under Section 17E

During the period, the power of recall was used twice. One patient was subsequently admitted informally under their CTO. One persons CTO was revoked and they were returned to hospital.

CAMHS Commissioned Inpatient Data

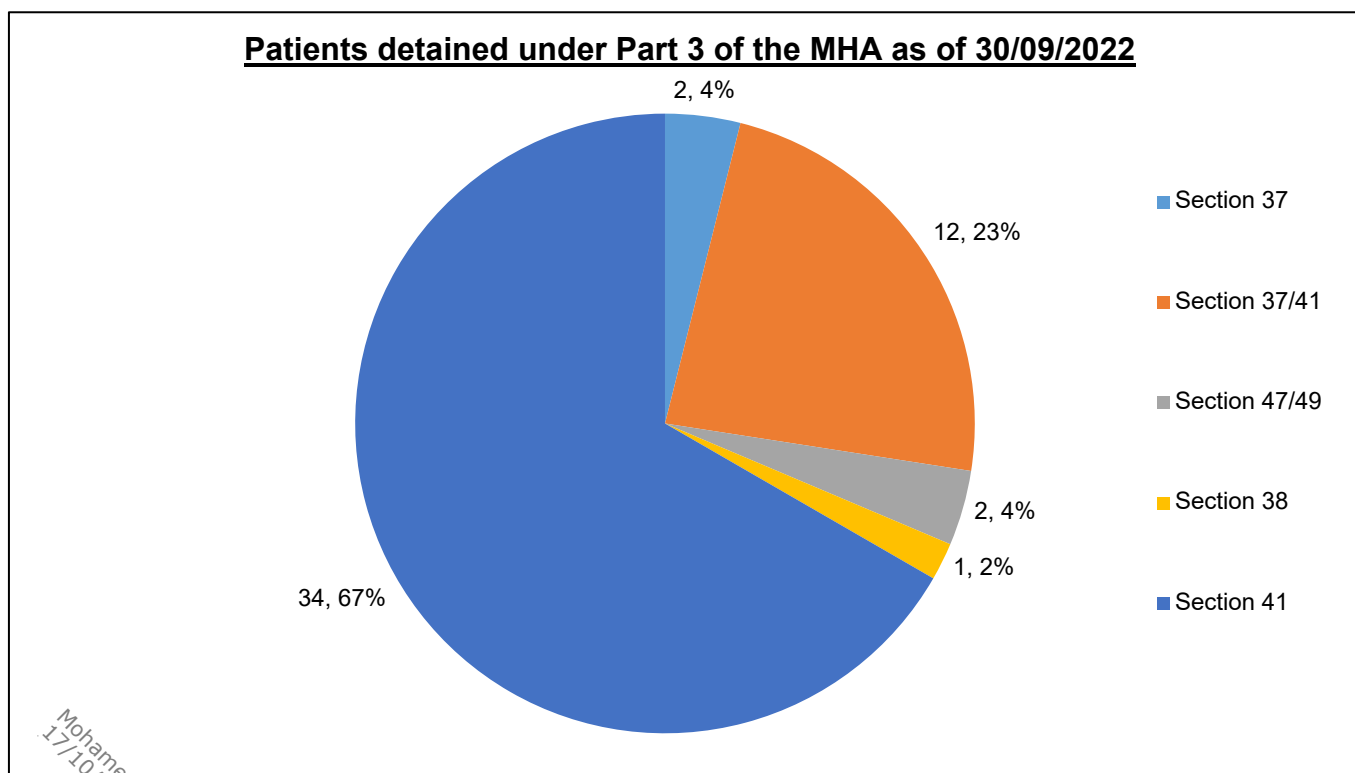
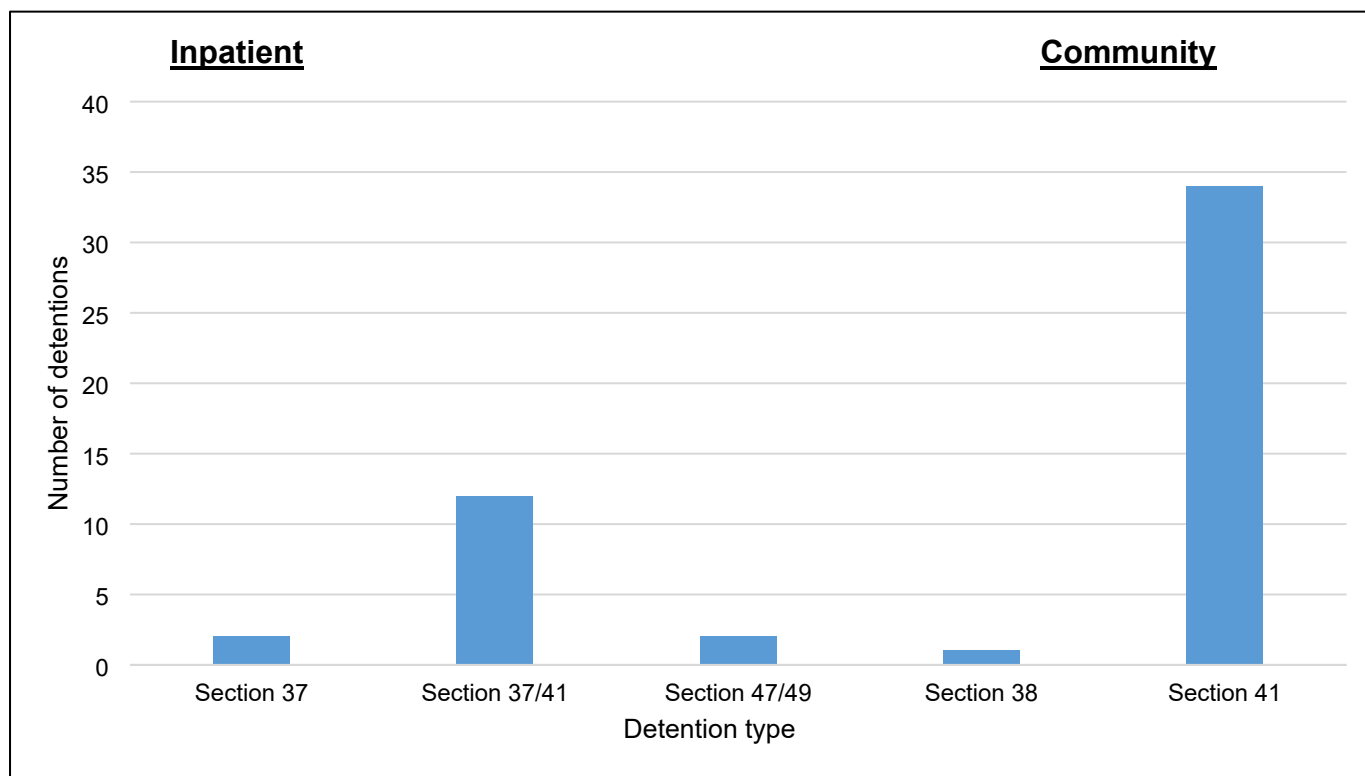
Cwm Taf Morgannwg UHB are commissioned to perform the role of Inpatient CAMHS for Cardiff and Vale UHB area patients.

During this period there were no CAMHS patients who became subject to a Community Treatment Order

Mohamed, Sarah
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Part 3 of the Mental Health Act 1983

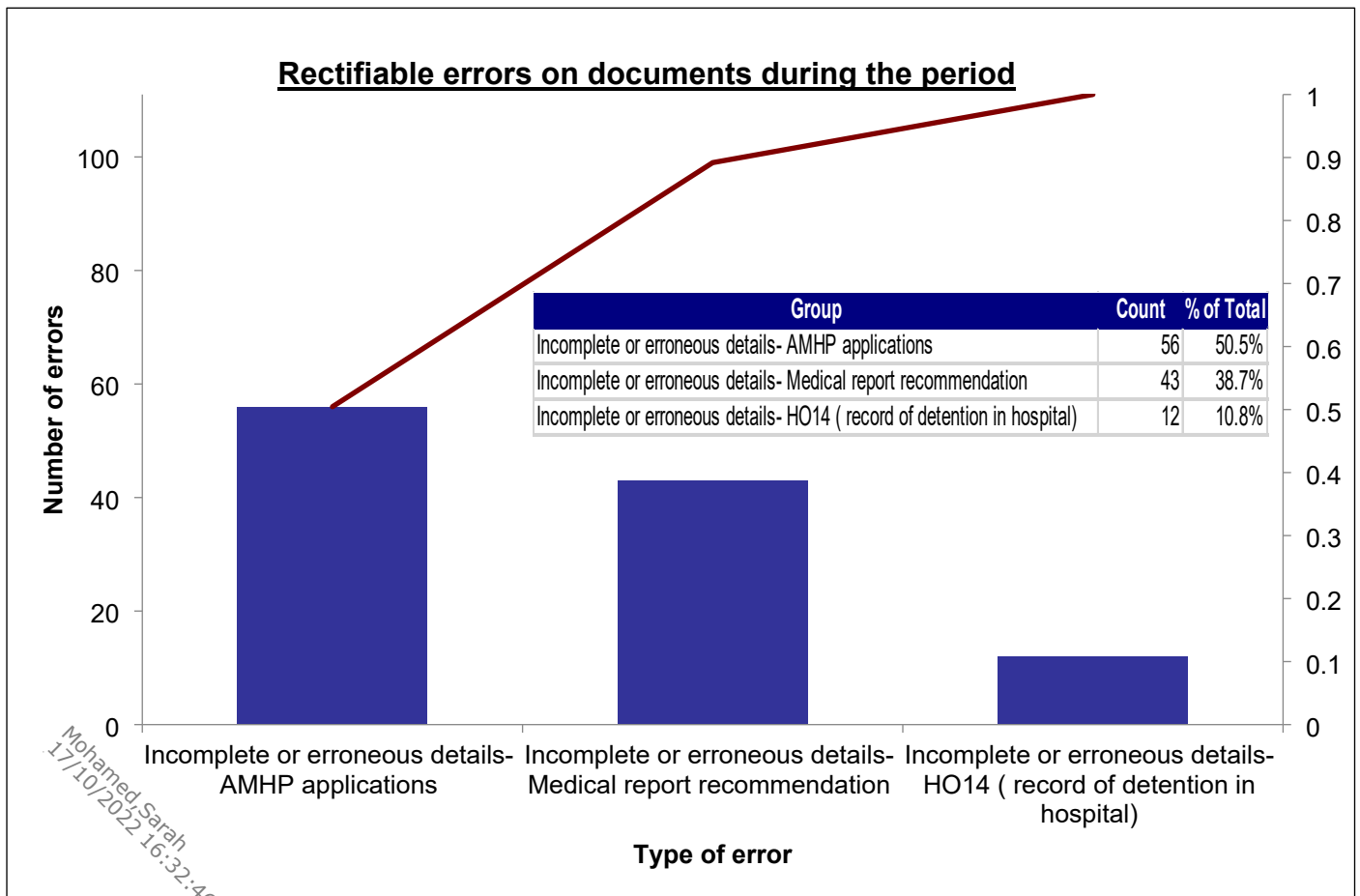
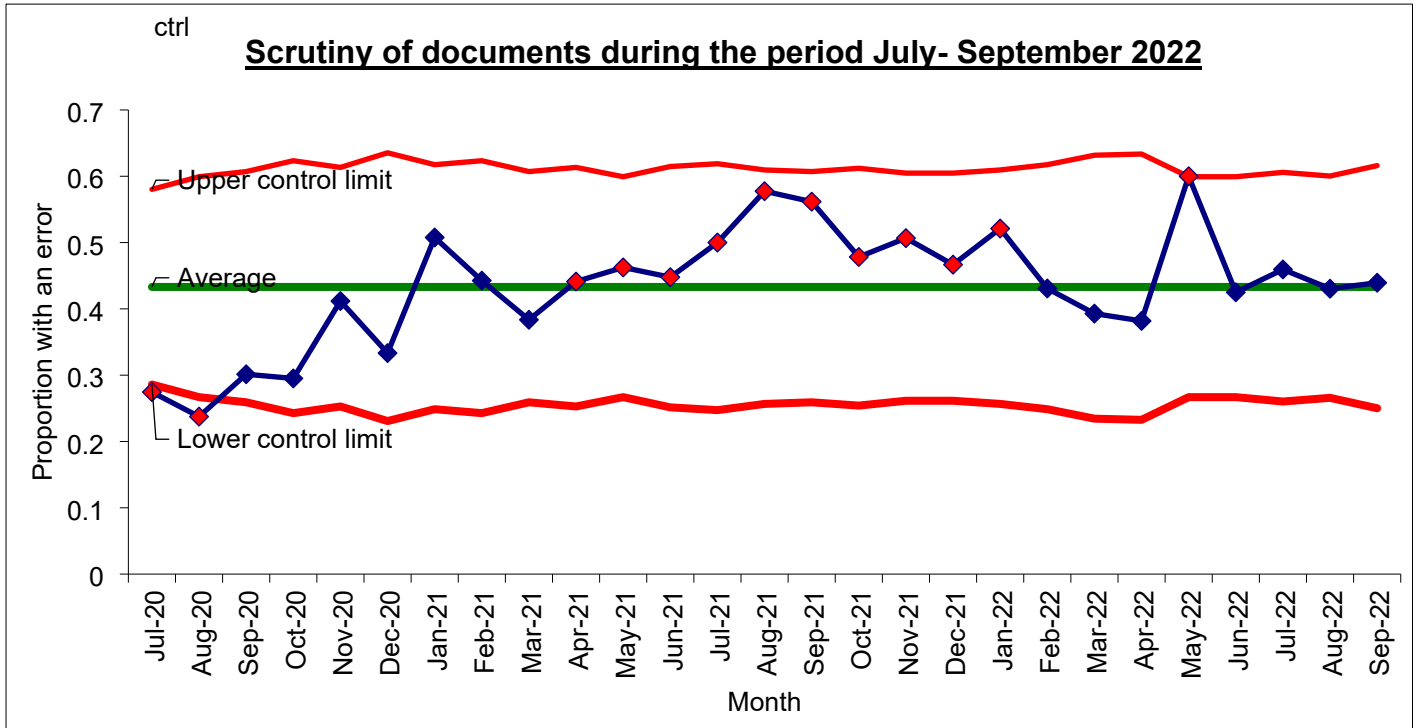
The number of Part 3 patients detained in Cardiff and Vale University Health Board Hospitals or subject to Community Treatment/Conditional Discharge in the community as at 30th September 2022.



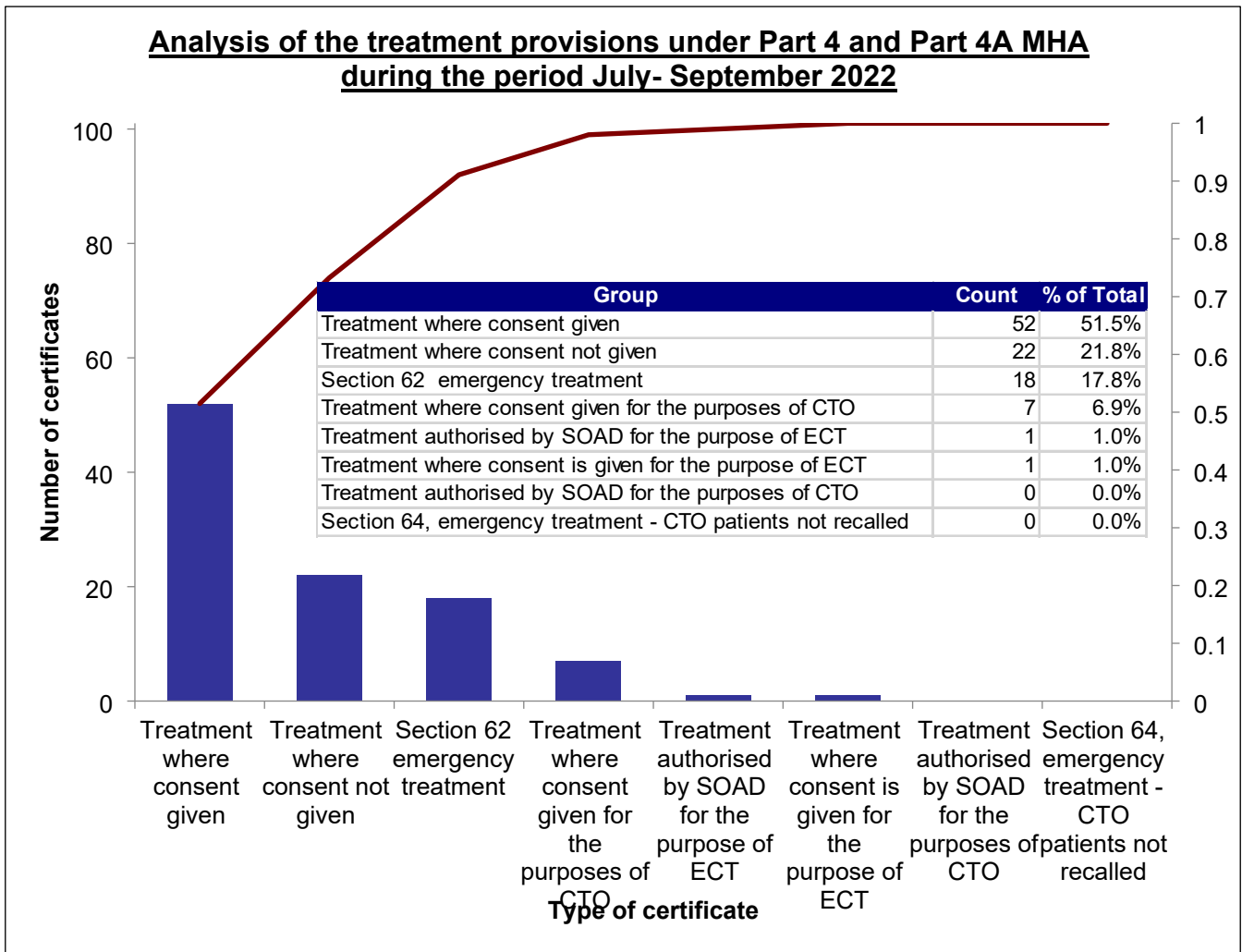
Mohamed Sarah
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Scrutiny of documents during the period

The chart above is a different type of control chart (P Chart) which looks at the proportions. The width of the control limits is dictated by the size of the denominator, so a larger denominator will have a narrower limit.



Consent to Treatment



Urgent Treatment

There are some circumstances in which the approved clinician may authorise a detained patient's urgent treatment under section 62 however this applies only to patients whose treatment is covered by Part 4 of the Act which is concerned with the treatment of detained patients and Part 4A supervised community treatment patients recalled to hospital.

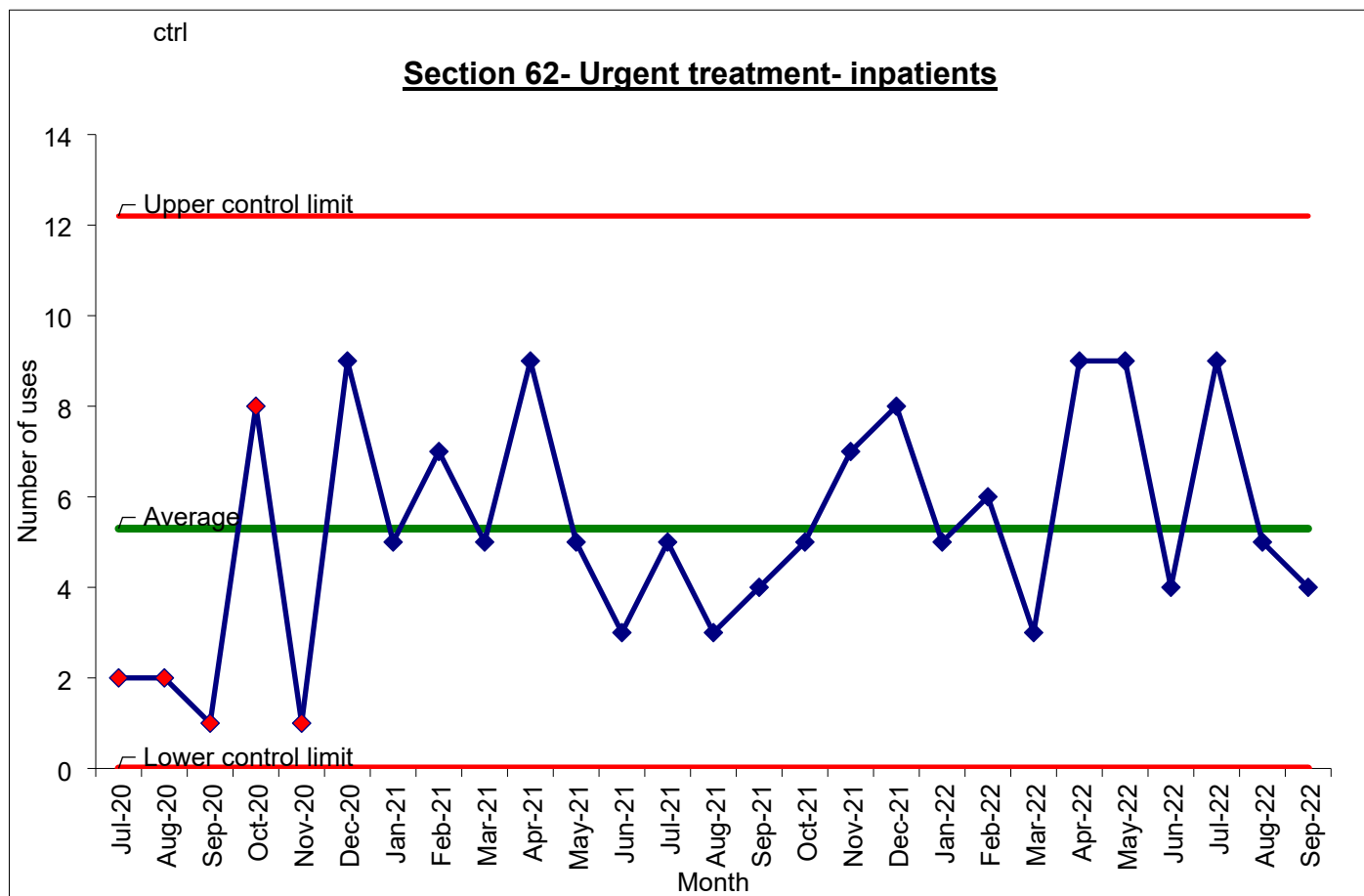
Urgent treatment is defined as treatment that is:

- Immediately necessary to save the patient's life; or
- That is not irreversible but is immediately necessary to prevent a serious deterioration of the patient's condition; or
- That is not irreversible or hazardous but is immediately necessary to alleviate serious suffering by the patient; or
- That is not irreversible or hazardous but is immediately necessary and represents the minimum interference to prevent the patient from behaving violently or being a danger to himself or others.

A patient's treatment may be continued pending compliance with s.58, if discontinuation would cause serious suffering to the patient.

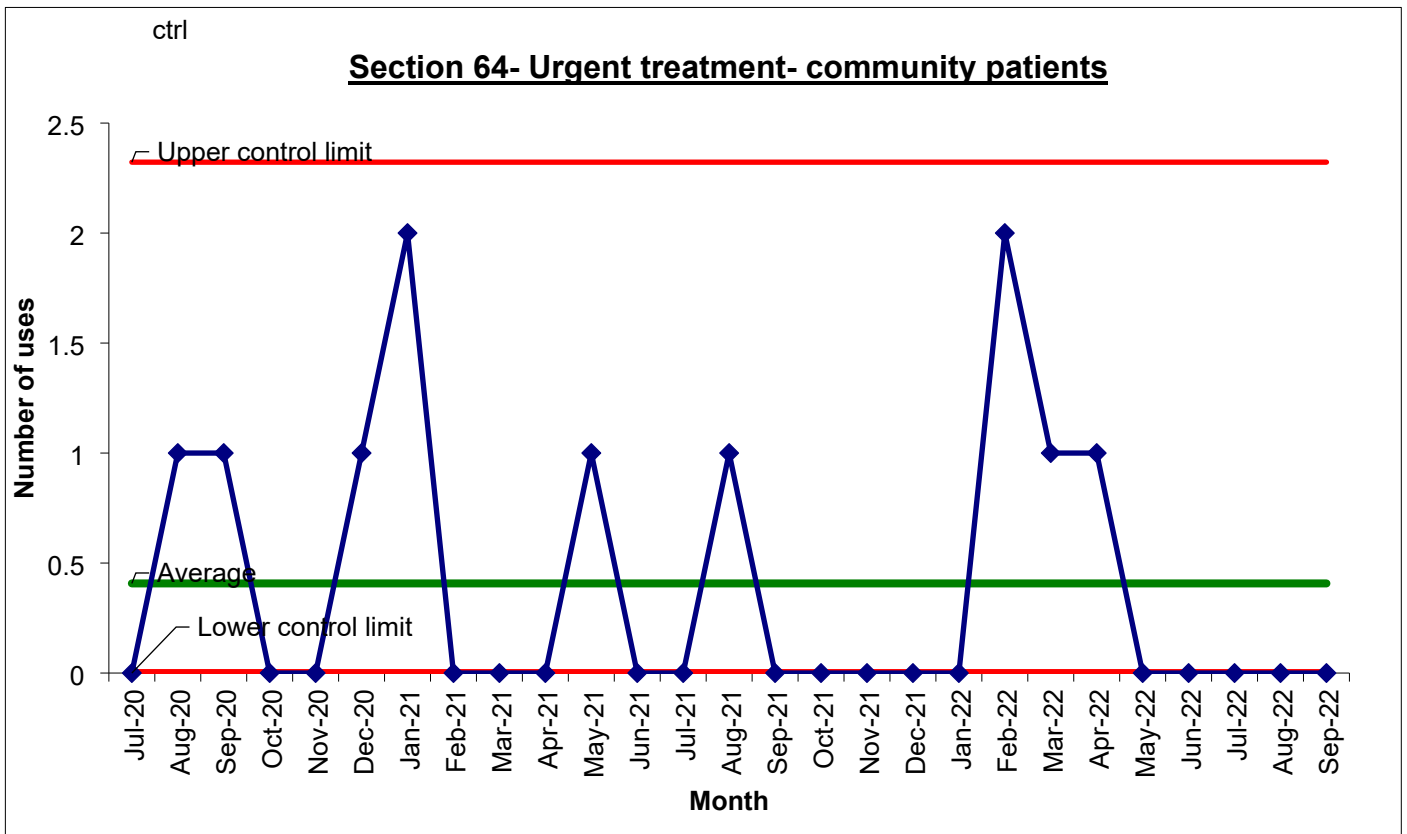
Urgent treatment can be used in any of the following instances:

- Where the SOAD has not yet attended to certify treatment within the statutory timeframe.
- Where the SOAD has not yet certified treatment for ECT which needs to be administered as a matter of urgency.
- Where medication is prescribed outside of an existing SOAD certificate.
- Where consent has been withdrawn by the patient and the SOAD has not yet attended to certify treatment.
- Where the patient has lost capacity to consent to treatment and the SOAD has not yet attended for certification purposes.



The above chart highlights that Section 62 was used on eighteen occasions for the following reasons:

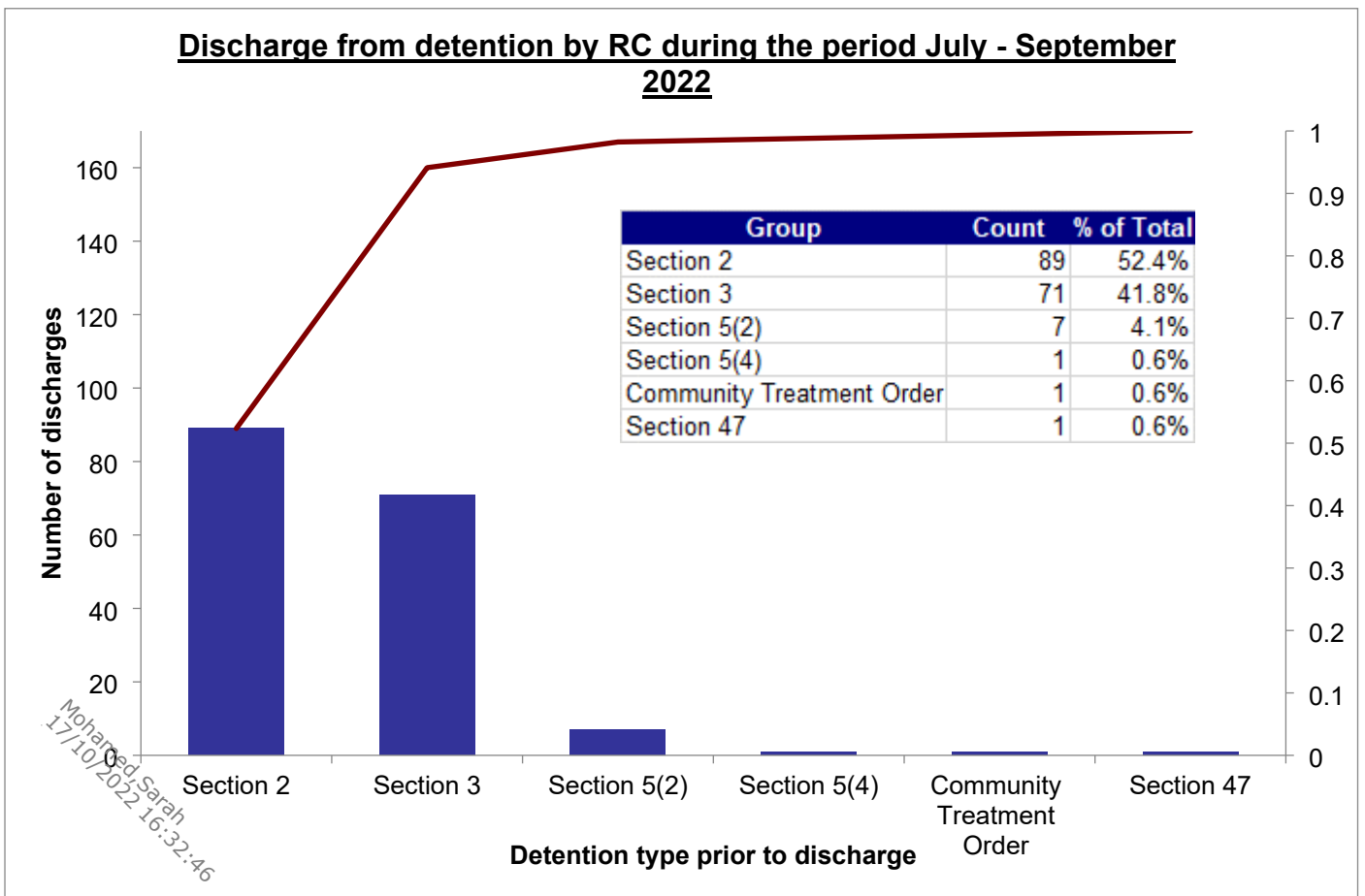
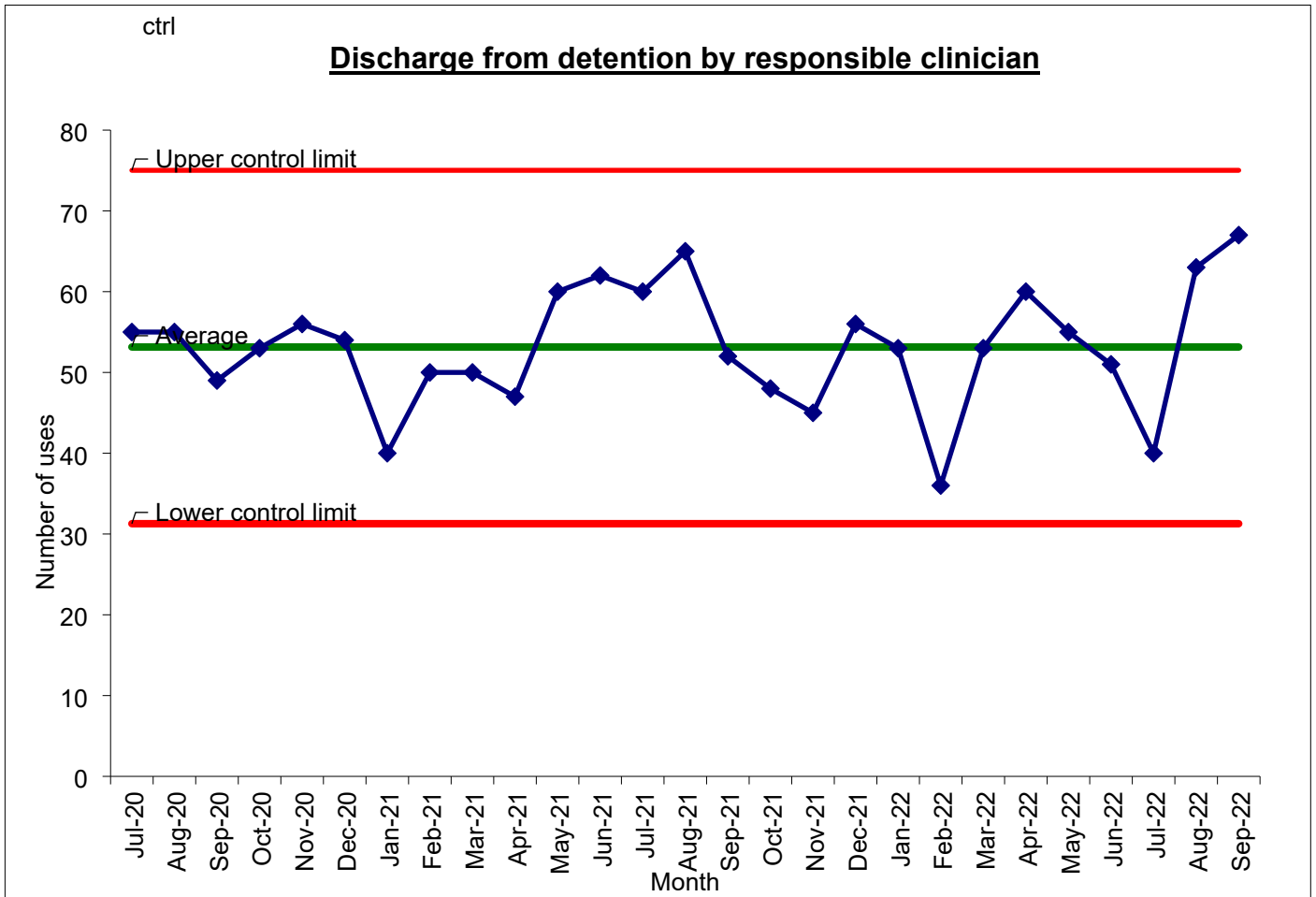
- Pending SOAD – 3 month rule x 8
- Change of capacity to consent x 3
- Change of medication x 3
- Consent withdrawn x 1
- ECT x 1
- One off use x 1
- Time limited certificate- awaiting SOAD x 1



The above chart highlights that Section 64 was not used during the period.

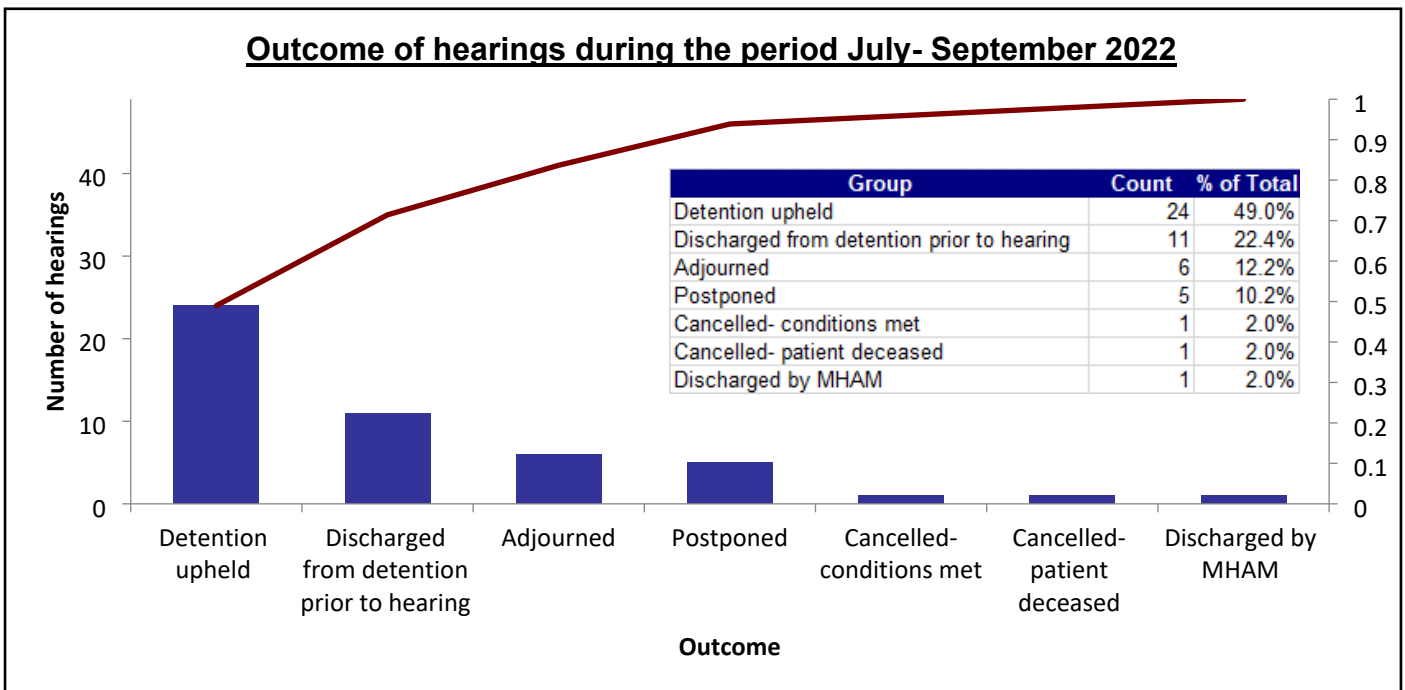
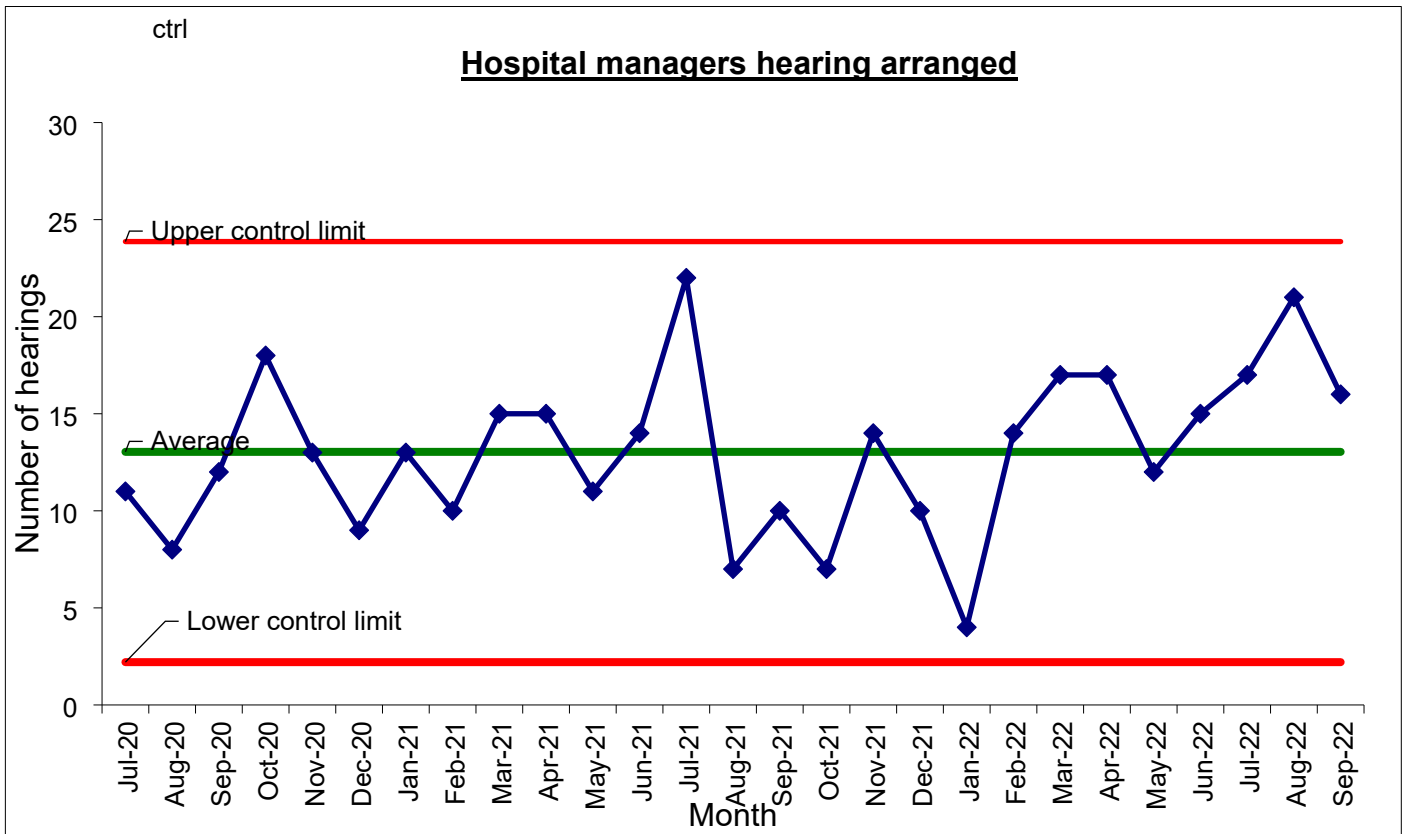
Mohamed Sarah
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Discharge



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17/10/2022 16:32:46

Hospital Managers – Power of Discharge



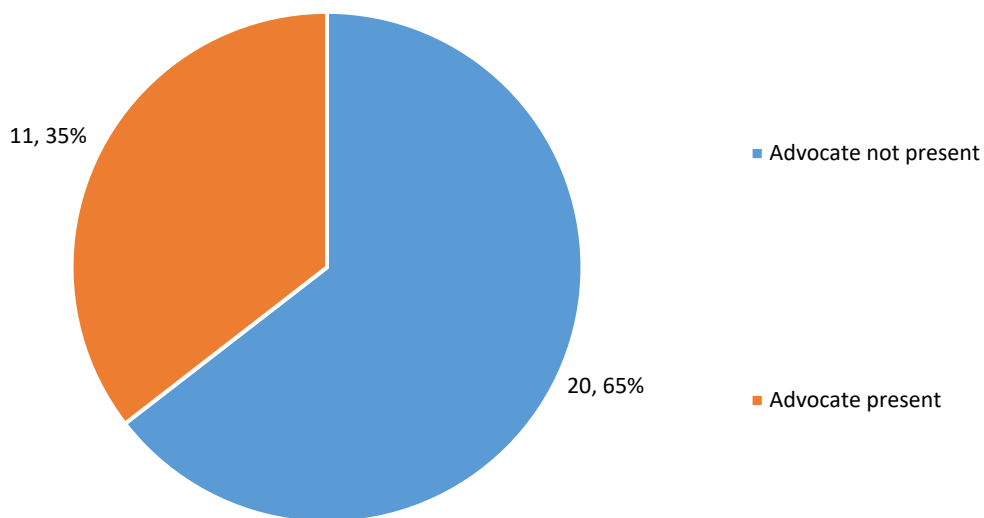
Five hearings were postponed for the following reasons:

- Responsible clinician had changed x1
- Responsible clinician availability x2
- Community Treatment Order was revoked x1
- Solicitor availability x1

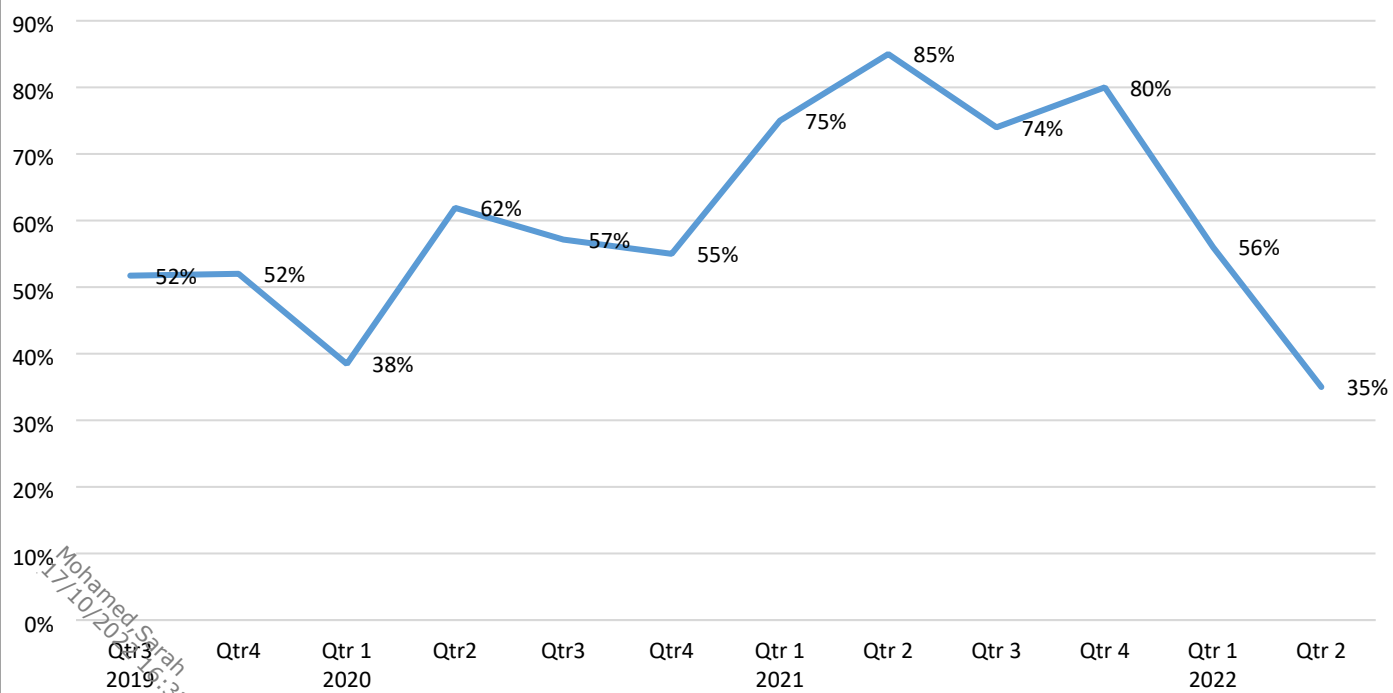
Six hearings were adjourned for the following reasons:

- Panel had split decision x1
- Responsible clinician was unwell x1
- Out dated reports x2
- More information needed on discharge planning x1
- Patient requested face to face hearing x1

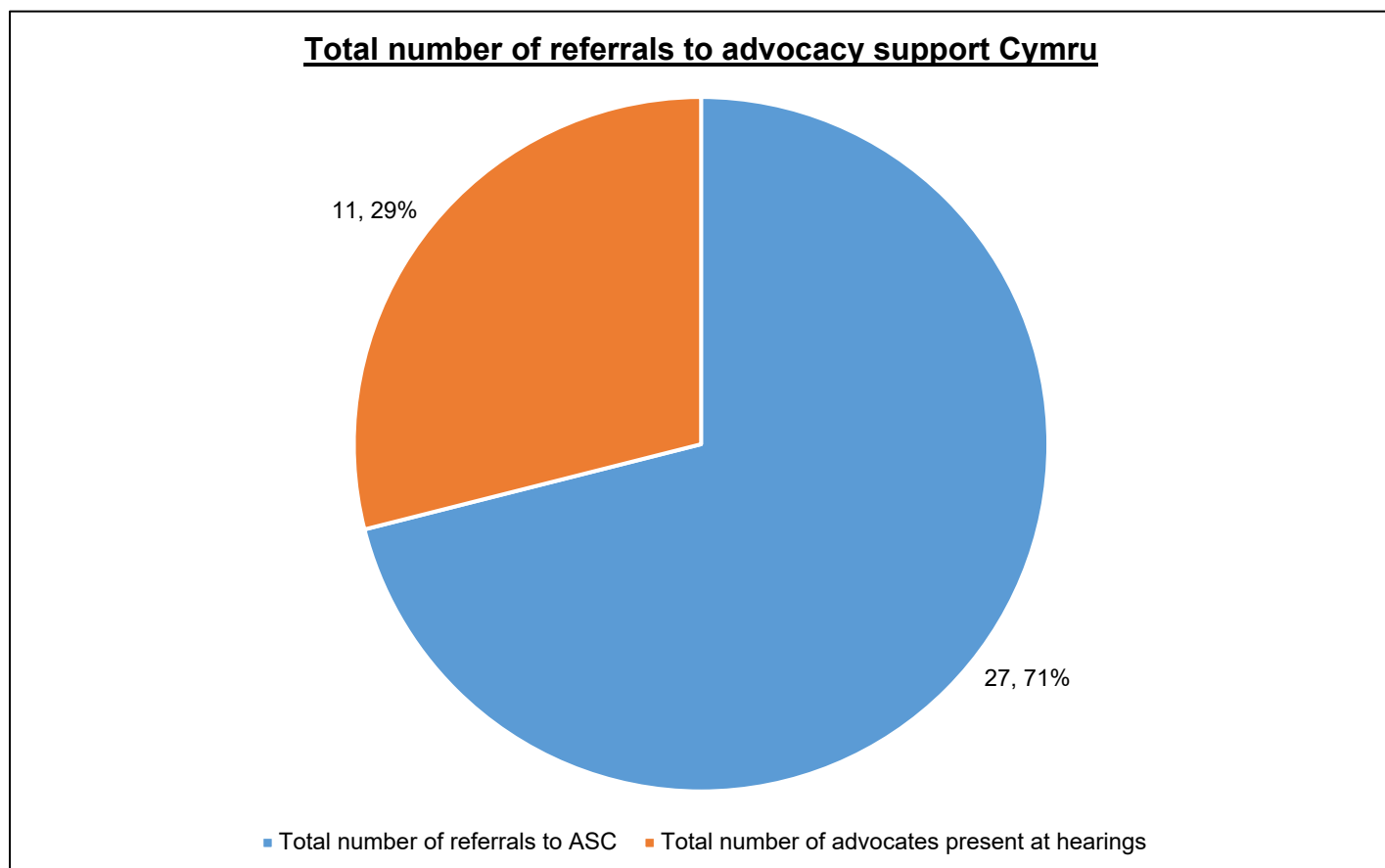
Number of patients represented by Advocacy Support Cymru



Percentage with independant mental health advocate present



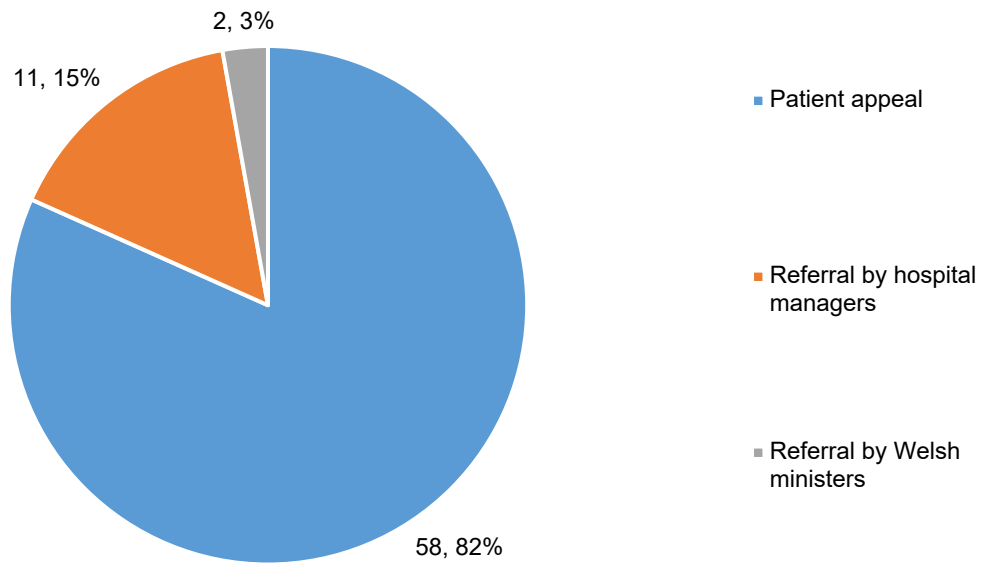
During the period the Mental Health Act Office made twenty-seven referrals to Advocacy Support Cymru where the patient was deemed not to have capacity to make this decision. Ten of the hearings were either postponed/cancelled and therefore weren't attended by an advocate.



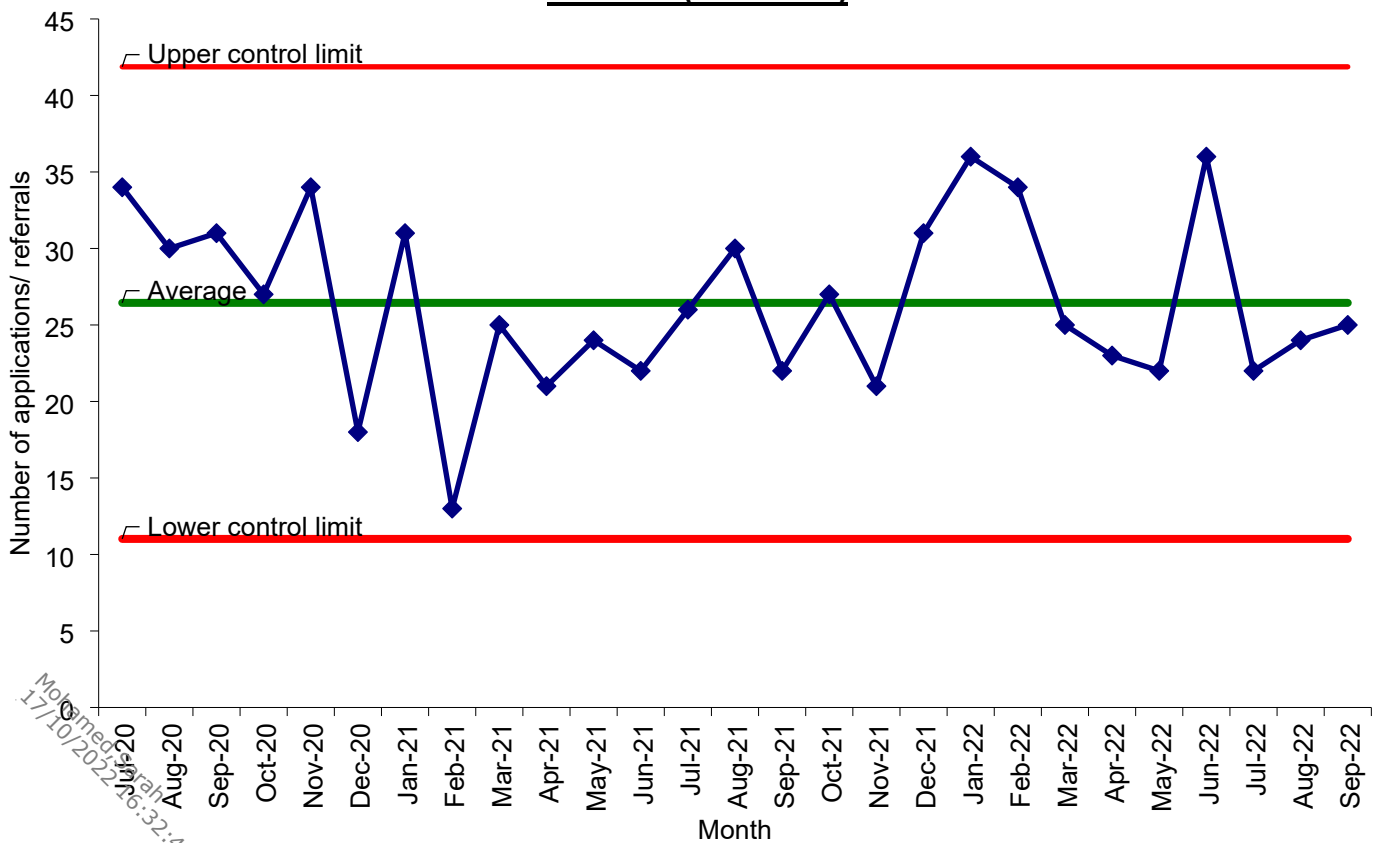
Mohamed Sarah
17/10/2022 16:32:46

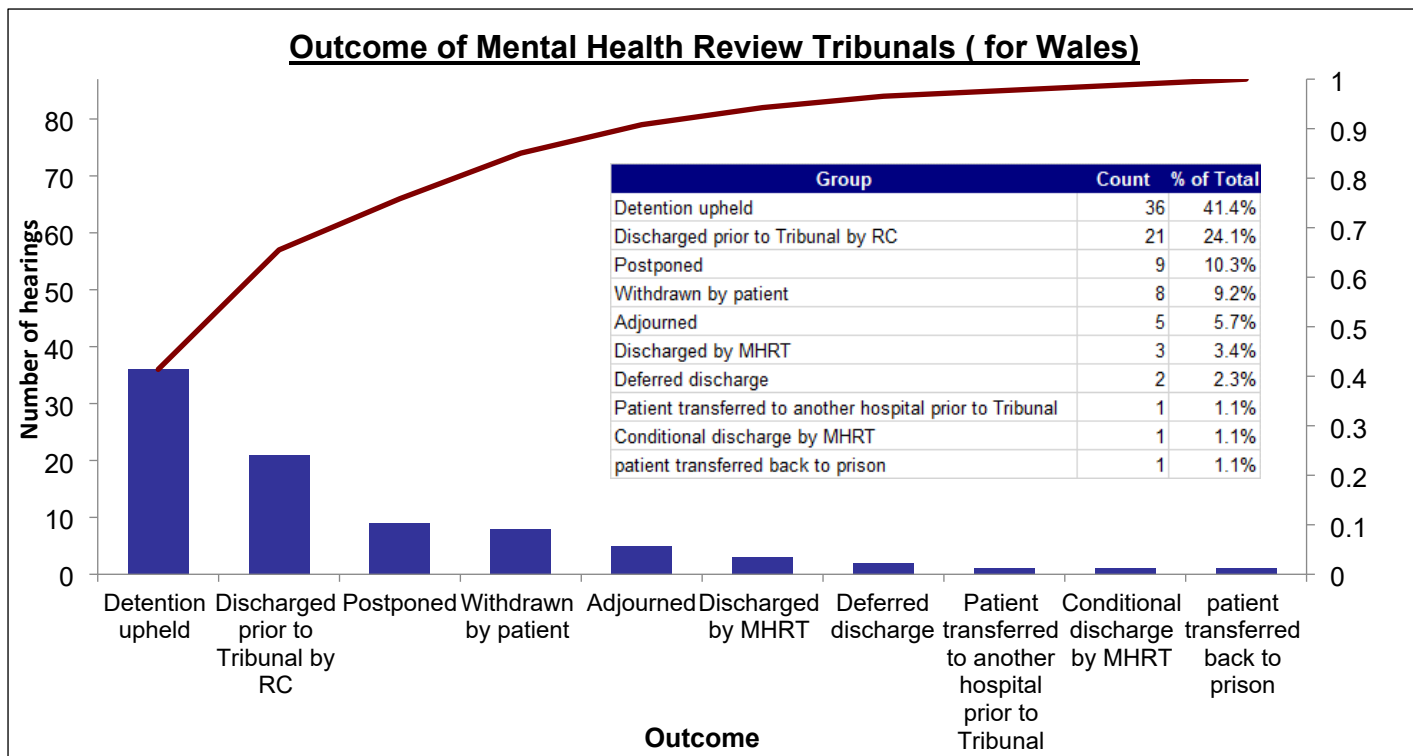
Mental Health Review Tribunal (MHRT) for Wales

Source of applications to the Mental Health Review Tribunal (for Wales)



Number of applications and referrals to the Mental Health Review Tribunal (for Wales)





Five hearings were adjourned for the following reasons:

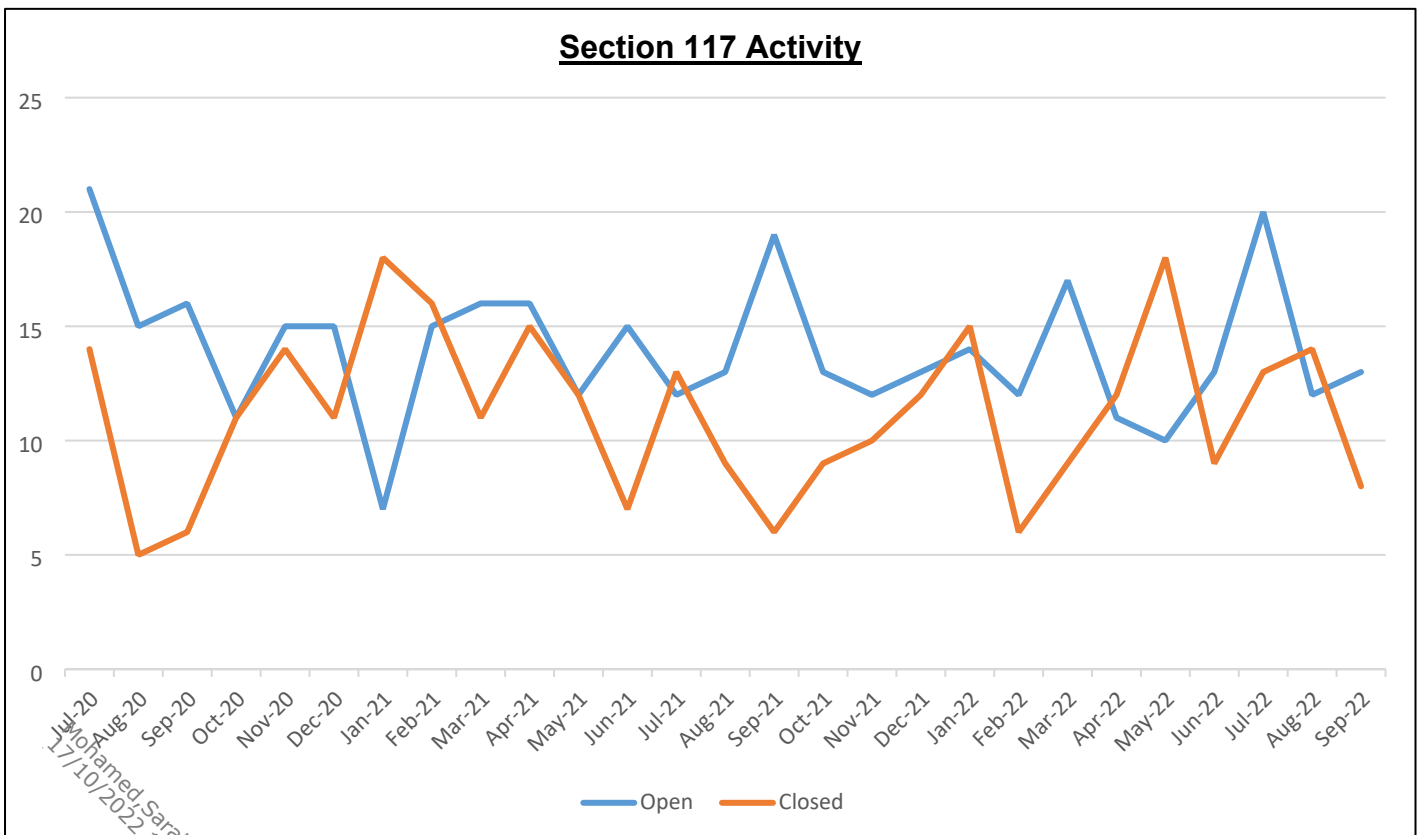
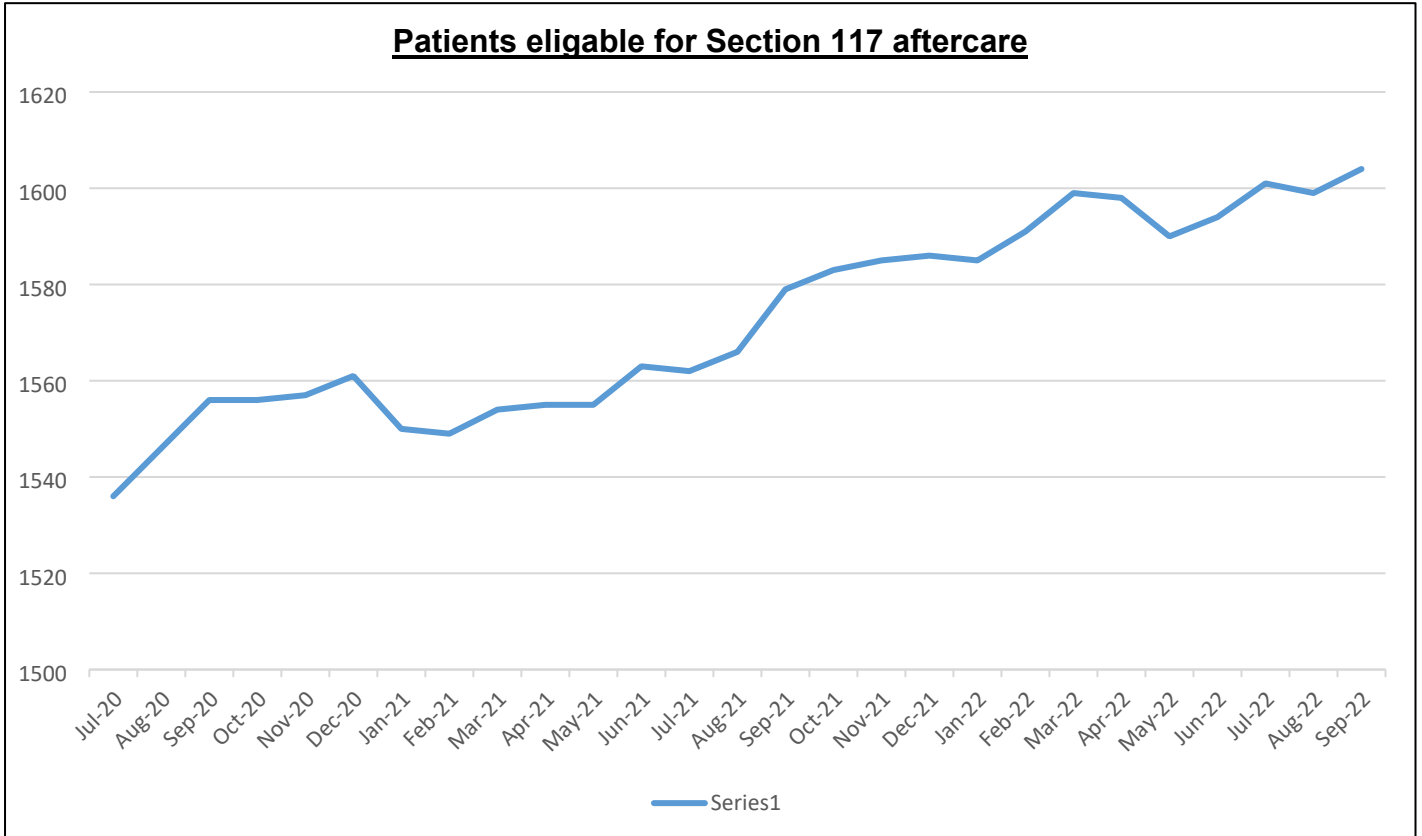
- More information needed in reports x3
- More information needed on identifying a placement x1
- Patients capacity queried – no legal representative present x1

Nine hearings were postponed for the following reasons:

- Judge unavailable x1
- Social worker availability x2
- Solicitor availability x2
- Lay member availability x1
- Nearest relative availability x1
- Responsible clinician unwell x1
- Responsible clinician availability x1

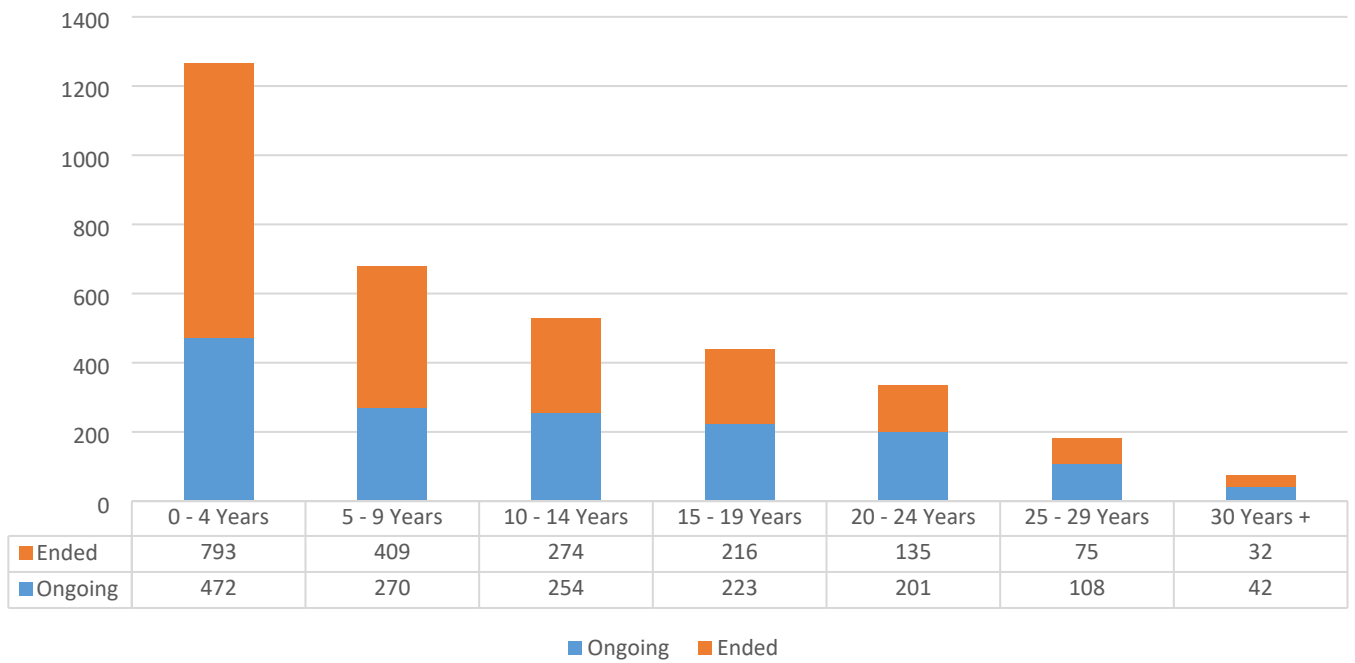
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Section 117 Aftercare



Mohamed, Sarah
 17/10/2022 16:32:46

Periods of time that patients remain eligible for Section 117 aftercare



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Section 19 transfers to and from Cardiff and Vale UHB

During the period:

Eight patients detained under Part 2 of the Mental Health Act were transferred from Cardiff and Vale UHB to a hospital under a different set of Managers for the following reasons:

- Three to return to their home area
- One to a CAMHS bed
- Four to an out of area PICU bed

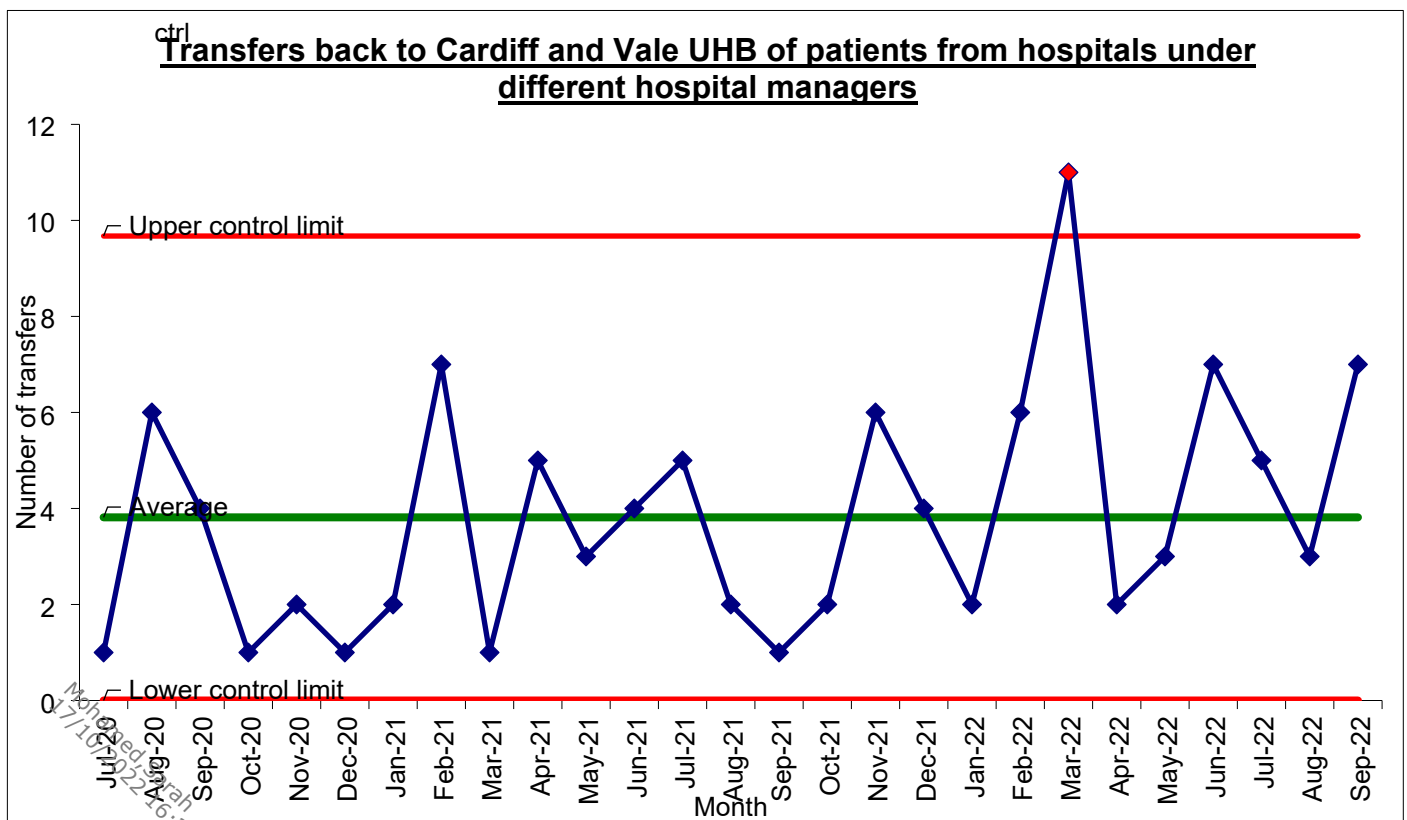
One patient detained under Part 3 of the Mental Health Act was transferred from Cardiff and Vale UHB back to prison.

Thirteen patients detained under Part 2 of the Mental Health Act were transferred into Cardiff and Vale UHB from a hospital under a different set of Managers for the following reasons:

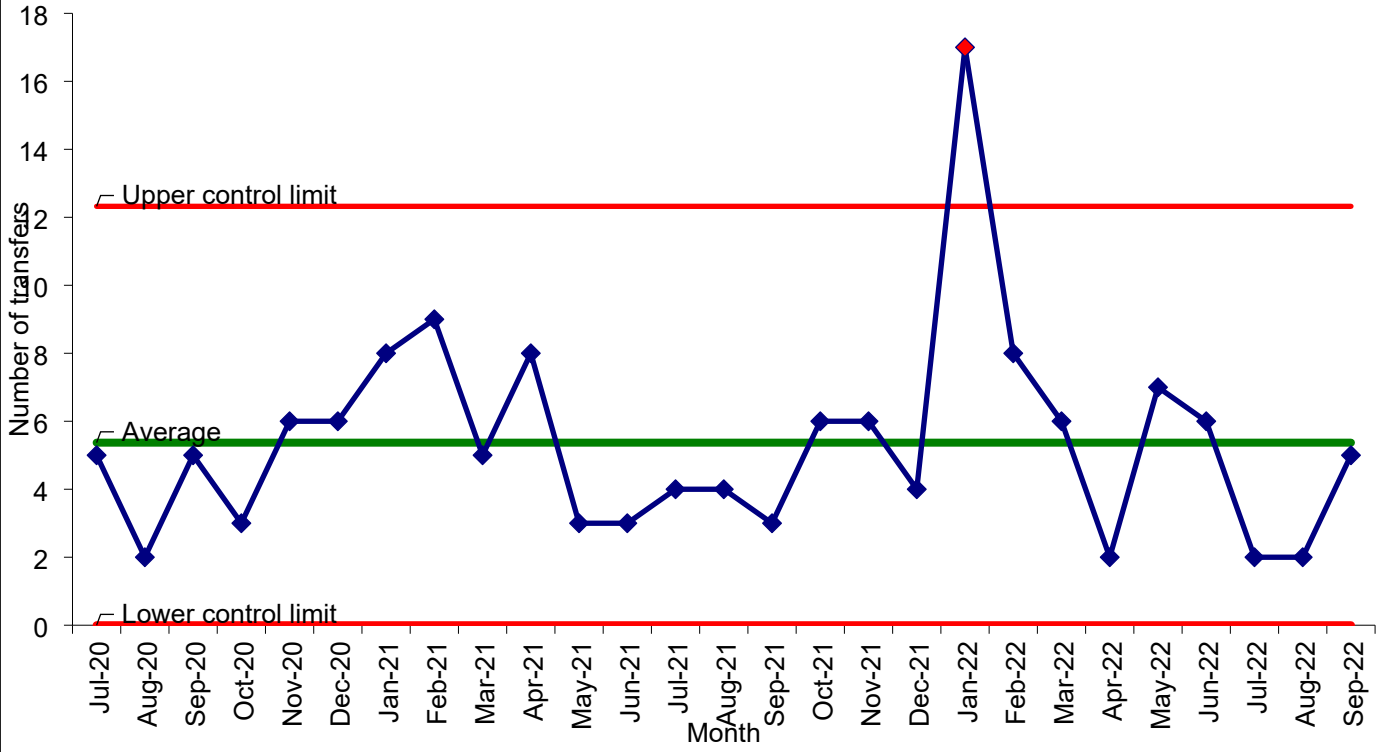
- Eleven from an out of area PICU bed
- One from an out of area old people bed
- One to facilitate discharge to placement

Two patients detained under Part 3 of the Mental Health Act were transferred into Cardiff and Vale UHB from a hospital under a different set of Managers for the following reasons:

- Step down from medium secure



^{ctrl}
Transfers out of Cardiff and Vale patients to hospitals under a different set of hospital managers



Mohamed Sarah
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Summary of other Mental Health Activity which took place during the period

July – September 2022

Exclusion of visitors

Visiting on wards at Hafan Y Coed are allowed but by strict appointment only. This is managed through a booking in system. This is due to the ongoing global pandemic.

Death of detained patients

During the period there were two deaths of detained patients.

Mohamed Sarah
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Glossary of Terms

Definition	Meaning
Informal patient	Someone who is being treated for mental disorder in hospital and who is not detained under the Act.
Detained patient	A patient who is detained in hospital under the Act or who is liable to be detained in hospital but who is currently out of hospital e.g. on section 17 leave.
Section 135	Allows for a magistrate to issue a warrant authorising a policeman to enter premises, using force if necessary, for the purpose of removing a mentally disordered person to a place of safety for a period not exceeding 72 hours, providing a means by which an entry which would otherwise be a trespass, becomes a lawful act.
Section 135(1)	Used where there is concern about the well being a person who is not liable to be detained under the Act so that he /she can be examined by a doctor and interviewed by an Approved mental Health Professional in order that arrangements can be made for his/her treatment or care.
Section 135(2)	Used where the person is liable to be detained, or is required to reside at a certain place under the terms of guardianship, or is subject to a community treatment order or Scottish legislation. In both instances, the person can be transferred to another place of safety during the 72 hour period.
Section 136	Empowers a policeman to remove a person from a public place to a place of safety if he considers that the person is suffering from mental disorder and is in immediate need of care and control. The power is available whether or not the person has, or is suspected of having committed a criminal offence. The person can be detained in a place of safety initially for up to 24 hours so that he /she can be examined by a doctor and interviewed by an Approved mental Health Professional in order that arrangements can be made for his/her

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	<p>treatment or care. The detention can be extended by a further 12 hours by a Registered Medical Professional. The detained person can be transferred to another place of safety as long as the maximum time period has not expired.</p>
<p>Part 2 of the Mental Health Act 1983</p>	<p>This part of the Act deals with detention, guardianship and supervised community treatment for civil 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.</p> <p>A part 2 patient is a civil patient who became subject to compulsory measures under the Act as a result of an application for detention by a nearest relative or an approved mental health professional founded on medical recommendations.</p>
<p>Section 5(4)</p>	<p>Provides for registered nurses whose field of practice is mental health or learning disabilities to invoke a holding power for a period of not more than 6 hours by completing the statutory document required.</p> <p>During this period, the medical practitioner or approved clinician in charge, or his or her nominated deputy should examine the patient with a view to making a report under section 5(2).</p> <p>Alternatively a patient can be detained under section 2 or 3 if a full Mental Health Act assessment is achieved during the 6 hour period.</p>
<p>Section 5(2)</p>	<p>Enables an informal inpatient to be detained for up to 72 hours if the doctor or approved clinician in charge of the patient's treatment reports that an application under section 2 or 3 ought to be made.</p> <p>The purpose of this holding power is to prevent a patient from discharging him/herself from hospital before there is time to arrange for an application under section 2 or</p>

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	<p>section 3 to be made. As soon as the power is invoked, arrangements should be made for the patient to be assessed by a potential applicant and recommending doctors.</p>
<p>Section 4</p>	<p>In cases of urgent necessity, this section provides for the compulsory admission of a person to hospital for assessment for a period of up to 72 hours.</p> <p>An application under this section should only be made when the criteria for admission for assessment are met, the matter is urgent and it would be unsafe to wait for a second medical recommendation i.e. where the patient's urgent need for assessment outweighs the alternative of waiting for a medical recommendation by a second doctor.</p> <p>A psychiatric emergency arises when the mental state or behaviour of a patient cannot be immediately managed. To be satisfied that an emergency has arisen, there must be evidence of:</p> <ul style="list-style-type: none"> • An immediate and significant risk of mental or physical harm to the patient or to others • And/or the immediate and significant danger of serious harm to property • And/or the need for physical restraint of the patient. <p>Section 4 cannot be renewed at the end of the 72 hour period. If compulsory detention is to be continued, the application must either be converted into a section 2 (admission for assessment) with the addition of a second medical recommendation, in which case the patient can be detained for a maximum of 28 days under that section beginning with the date of admission under section 4 or an application for treatment under section 3 should be made.</p> <p>The Act does not provide for a section 4 to be converted into a section 3 because the criteria for admission under each of these sections are different.</p>

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<p>Section 2</p>	<p>Authorises the compulsory admission of a patient to hospital for assessment or for assessment followed by medical treatment for mental disorder for up to 28 days. Provisions within this section allow for an application to be made for discharge to the Hospital Managers or Mental Health Review Tribunal for Wales.</p> <p>If after the 28 days have elapsed, the patient is to remain in hospital, he or she must do so, either as an informal patient or as a detained patient under section 3 if the grounds and criteria for that section have been met.</p> <p>The purpose of the section is limited to the assessment of a patient's condition to ascertain whether the patient would respond to treatment and whether an application under section 3 would be appropriate.</p> <p>Section 2 cannot be renewed and there is nothing in the Act that justifies successive applications for section 2 being made.</p> <p>The role of the nearest relative is an important safeguard but there are circumstances in which the county court has the power to appoint another person to carry out the functions of the nearest relative:</p> <ul style="list-style-type: none">• The patient has no nearest relative within the meaning of the Act• It is not reasonably practicable to find out if they have such a relative or who that relative is• The nearest relative is unable to act due to mental disorder or illness• The nearest relative of the person unreasonably objects to an application for section 3 or guardianship.• The nearest relative has exercised their power to discharge the person from hospital or guardianship without due regard to the persons welfare or the public interest <p>This procedure may have the effect of extending the authority to detain under section 2 until the application to the county court to appoint another person is finally disposed of.</p>
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	<p>Patients admitted under section 2 are subject to the consent to treatment provisions in Part 4 of the Act.</p>
Section 3	<p>Provides for the compulsory admission of a patient to a hospital named in the application for treatment for mental disorder. Section 3 provides clear grounds and criteria for admission, safeguards for patients and there are strict provisions for review and appeal.</p> <p>Patients detained under this section are subject to the consent to treatment provisions contained in Part 4 of the Act below.</p>
Community Treatment Order (CTO)	<p>Provides a framework to treat and safely manage suitable patients who have already been detained in hospital in the community. CTO provides clear criteria for eligibility and safeguards for patients as well as strict provisions for review and appeal, in the same way as for detained patients.</p>
Section 17E (recall of a community patient to hospital)	<p>Provides that a Responsible Clinician may recall a patient to hospital in the following circumstances:</p> <ul style="list-style-type: none"> • Where the RC decides that the person needs to receive treatment for his or her mental disorder in hospital and without such treatment there would be a risk of harm to the health or safety of the patient or to other people. • Where the patient fails to comply with the mandatory conditions set out in section 17B (3).
Revocation	<p>Is the rescinding of a CTO when a patient needs further treatment in hospital under the Act. If a patients' CTO is revoked the patient is detained under the powers of the Act in the same way as before the CTO was made.</p>
Part 3 of the Act	<p>Deals with the circumstances in which mentally disordered offenders and defendants in criminal proceedings may be admitted to and detained in hospital or received into guardianship on the order of the court. It also allows the Secretary of State for Justice to transfer</p>

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	<p>people from prison to detention in hospital for treatment for mental disorder.</p> <p>Part 3 patients can either be "restricted", which means that they are subject to special restrictions on when they can be discharged, given leave of absence and various other matters, or they can be unrestricted, in which case they are treated for the most part like a part 2 patient.</p>
Section 35	Empowers a Crown Court or Magistrates Court to remand an accused person to hospital for the preparation of a report on his mental condition if there is reason to suspect that the accused person is suffering from a mental disorder.
Section 36	Empowers a Crown Court to remand an accused person who is in custody either awaiting trial or during the course of a trial and who is suffering from mental disorder, to hospital for treatment.
Section 37	Empowers a Crown Court or magistrates' court to make a hospital or guardianship order as an alternative to a penal disposal for offenders who are found to be suffering from mental disorder at the time of sentencing.
Section 38	Empowers a Crown Court or Magistrates Court to send a convicted offender to hospital to enable an assessment to be made on the appropriateness of making a hospital order or direction.
Section 41	<p>Empowers the Crown Court, having made a hospital order under s.37, to make a further order restricting the patients discharge, transfer or leave of absence from hospital without the consent of the Secretary of State for Justice.</p> <p>Section 41 can also operate as a community section for people who were originally on section 37/41. When a section 37/41 is conditionally discharged it leaves the power of Section 41 in place. This means that the person</p>

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	can leave hospital and live in the community but with a number of conditions placed upon them.
Section 45A	This is a court sentence to hospital for someone with a mental disorder at any time after admission, if the Responsible Clinician considers that treatment is no longer required or beneficial, the person can be transferred back to prison to serve the remainder of their sentence.
Section 47	Enables the Secretary of State to direct that a person serving a sentence of imprisonment or other detention be removed to and detained in a hospital to receive medical treatment for mental disorder.
Section 48	Empowers the Secretary of State for Justice to direct the removal from prison to hospital of certain categories of unsentenced mentally disordered prisoners to receive medical treatment.
Section 49	Enables the Secretary of State for Justice to add an order restricting the patients discharge from hospital to a s.47 or s.48.
CPI Act	<p>Criminal Procedure (Insanity) Act 1964. This Act as amended by the Criminal Procedures (Insanity and Unfitness to Plead) Act 1991 and the Domestic Violence, Crime and Victims Act 2004 provides for persons who are found unfit to be tried or not guilty by reason of insanity in respect of criminal charges. The court has three disposal options:</p> <ul style="list-style-type: none"> • To make a hospital order under section 37 of the MHA 1983 which can be accompanied by a restriction order under section 41. • To make a supervision order so that the offenders responsible officer will supervise him only to the extent necessary for revoking or amending the order. • Order the absolute discharge of the accused.
CTO (section 37)	Once an offender is admitted to hospital on a hospital order without restriction on discharge, his or her position

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	is the same as if a civil patient, effectively moving from the penal into the hospital system. He or she may therefore be suitable for CTO
Administrative scrutiny	The University Health Board has formally delegated its duty to administratively scrutinise admission documents to officers identified in the scheme of delegation. Medical scrutiny is undertaken by Consultant Psychiatrists.
	<p>Compliance with the Consent to Treatment provisions under Part 4 & 4A of the Act is related to treatments requiring the patient's consent or a second opinion.</p> <p>If a patient has capacity but refuses treatment a Second Opinion Appointed Doctor (SOAD), i.e. a Registered Medical Practitioner appointed for the purposes of Part 4 of the Act can authorise treatment having consulted two Statutory Consultee's who have been professionally concerned with the medical treatment of the patient for mental disorder.</p> <p>If the patient lacks capacity to consent SOAD authorisation is required.</p>
Section 58(3)(a)	Certificate of consent to treatment (RC)
Section 58(3)(b)	Certificate of second opinion (SOAD authorisation)
Section 58A(3)(c)	Certificate of consent to treatment, patients at least 18 years of age (RC)
Section 58A(4)(c)	Certificate of consent to treatment and second opinion, patients under 18 years of age (SOAD)
Section 58A(5)	Certificate of second opinion (patients not capable of understanding the nature, purpose and likely effects of the treatment). (SOAD)
Part 4A	Certificate of appropriateness of treatment to be given to a community patient (SOAD)

<p>Section 62 – Urgent treatment</p>	<p>Where treatment is immediately necessary, a statutory certificate is not required if the treatment in question is:</p> <ul style="list-style-type: none"> • To save the patient's life • Or to prevent a serious deterioration of the patients condition, and the treatment does not have unfavourable physical or psychological consequences which cannot be reversed • Or to alleviate serious suffering by the patient, and the treatment does not have unfavourable physical or psychological consequences which cannot be reversed and does not entail significant physical hazard • Or to prevent the patient behaving violently or being a danger to themselves or others, and the treatment represents the minimum interference necessary for that purpose, does not have unfavourable physical or psychological consequences which cannot be reversed and does not entail significant physical hazard.
<p>Section 23</p>	<p>Provides for the absolute discharge from detention, guardianship or from a community treatment order of certain patients, by the Responsible Clinician, the Hospital Managers (or Local Social Services Authority for guardianship patients) or the patients nearest relative. The discharge must be ordered; it cannot be affected by implication.</p> <p>Section 23 does not apply to patients who have been remanded to hospital by the courts or to patients subject to interim hospital orders.</p> <p>The Secretary of State for Justice has powers to discharge restricted patients under section 42(2).</p> <p>If at any time Responsible Clinicians conclude that the criteria justifying the continued detention or community treatment order are not met, they should exercise their power of discharge and not wait until such time that the detention order or CTO is due to expire.</p>

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Section 117	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.
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Report Title:	Section 49 Requests		Agenda Item no.	9.3	
Meeting:	Mental Health Legislation and Mental Capacity Act Committee	Public	X	Meeting Date:	25/10/22
		Private			
Status <i>(please tick one only):</i>	Assurance	X	Approval	Information	X
Lead Executive:	Chief of Operations				
Report Author (Title):	Director Of Operations Mental Health Clinical Board				

Main Report

Background and current situation:

The UHB is receiving increasing numbers of Court of Protection Section 49 instructions for Capacity assessments, for which, to date, it has no system in place to either administrate and commission, or undertake internally.

The Act states:

“The Mental Capacity Act 2005 (MCA 2005) is an Act of Parliament, applying to England and Wales, that provides a legal framework for acting and making decisions on behalf of adults who lack the capacity to make particular decisions for themselves. Under section 49 (pilot order) of the MCA 2005, launched in 2016, the Court of Protection can order reports from National Health Service (NHS) health bodies and local authorities when it is considering any question relating to someone who may lack capacity, and the report must deal with ‘such matters as the court may direct’. This change has caused significant ethical challenges for psychiatrists.”

<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6327294/pdf/S2056469418001080a.pdf>

To date, the UHB has dealt with requests, on an ad hoc basis, with a small number of psychiatrists undertaking the work. In the case of capacity assessments deemed to require an LD consultant psychiatrist, the UHB has usually paid for private assessments.

In the case of patients in physical health settings, the onus of S49 reports is on the treating clinicians who will be preparing the report on behalf of the UHB.

Executive Director Opinion and Key Issues to bring to the attention of the Board/Committee:

Like most NHS organisations, Cardiff and Vale UHB does not have mature arrangements for undertaking or commissioning such work, but the responsibility on the Health Board is clear, as is the growing need.

On UHB receipt of such court instructions, the time frames to identify a suitable person to undertake the reports, and let the court know, is challenging (usually 7 days). The request is nearly always for a Consultant Psychiatrist, though in some instances other professionals (such as psychologists maybe suitable). Requests often require Mental Health Services for Older People when an MHSOP Consultant is adjudged most suitable. If an LD consultant psychiatrist is required (and this is not infrequent) this adds further complexity, as LD mental health services are managed through a clinical network provided by Swansea Bay UHB.

Frequently the person in question is usually not known to the MHCB. The associated assessment work is considerable it requires:

- reading a court bundle and any separate accompanying assessments,
- reviewing diagnoses,
- working to agree the information needing to be retained and weighed up by the subject.

The above activities are required prior to any face to face contact. The assessment visit is lengthy, and often involves multiple questions. For some conditions, it is necessary to make more than one

visit. Attempts / consideration should be made to support capacity. The court may also ask other questions which are about both their broader capacity or not about capacity at all, and may include the implications of, say a DOLS, such as the subject's capacity to:

- i. Conduct proceedings;*
- ii. Make decisions regarding his residence;*
- iii. Make decisions regarding his care and treatment, including medical treatment;*
- iv. Make decisions as to his finances.*

- *Whether XX is likely to or could be supported to regain capacity in the domains above, and if so, the steps that could and should be put in place for this to be achieved and the likely timescales;*

Recent examples of other queries have included and assessment of:

- *The nature and extent of any impact on XX's mental health and wellbeing of being deprived of his liberty at Z Care Home; and*
- *Any steps which could be taken in order to mitigate against the negative impact of XX being deprived of his liberty at Z Care Home.*
- *The impact of changes of placement upon XX's mental health, wellbeing and behaviour;*
- *Recommendations as to steps which should be taken in order to mitigate against the negative impacts of any change of placements for XX."*

The preparing of such reports is time consuming and the generated reports usually lengthy – and required to follow a fixed format. Having prepared said report – the court may occasionally ask clinicians to attend in person to answer questions on the report.

Essentially, this work closely resembles expert witness work. However, in the courts' eyes such work is not, and they will not pay for the work in the traditional expert witness manner. The NHS body in question is expected to both arrange or pay. Other NHS bodies have been to court before to argue as much:

<https://courtofprotectionhandbook.com/2015/08/29/section-49-reports-the-thorny-issues/>

the elements of the judgement, will look familiar in requests we have received.

Advocates, and subsequent litigation friends, as well as providers, are referring to the Court of Protection, and so we can expect court directions to the UHB to increase. Of note other Health Boards have raised this issue among the Directors' Peer Group and with Welsh Government and are looking to each other for support and direction.

It is clear that the UHB needs to be able to reliably receive directions, and allocate to individuals judged to be capable of the work, and respond to the COP in the expected timeframes.

Considering allocation:

1. The UHB may attempt to channel this work through private providers, and pay for expert witness reports, as and when the work comes in. We will need to check the availability of such individuals, to undertake the work, and then pay the usual rate (limited experience to date suggests this work is approximately £4-5000). It is unclear presently that there is reliable availability of psychiatrists to undertake this work. Wait times consequently are growing.
2. The courts view is likely to be, that the UHB has available its own body of Consultant Psychiatrists. The UHB consultants may argue that such report work is both outside their area of expertise, and may have issue with the nature of the work – though this remains contentious. The body of consultants may also consider this work, probably rightly, to be Category 2 work, especially where they have no prior knowledge of the person in question.

It is recommended that:

The UHB needs to develop a system and protocol for COP capacity assessment requests. This should include central receipt, as in theory requests may come in requiring the expertise of other professionals within the UHB.

It is recommended that the UHB pursues both internal and external capability for assessments. I.e.

- A) Through private providers as for expert reports
- B) By training and supporting its own clinicians, so they and the UHB can be assured that reports are of required quality. This will require:
 - Periodic training (the MHCB has already provided one round of training with support network) – an offer to informally check and offer legal advice on the form – for the first three – with payment thereafter
 - Time / money: the consultant body was approached around an offer of time to do this (professional leave has been suggested – max 2 days) or direct payment of extra sessions (to a max of 4 sessions), with further allowance for any court attendance. The MHCB consultant body did not feel they could be compelled to undertake such court reports (often on individuals not known to MH services) - their preferred option being for the UHB to offer the agreed BMA rate for such work:
<https://www.bma.org.uk/pay-and-contracts/fees/fees-for-doctors/fees-for-consultants>
 agreeing at the outset on likely timescales and hence costs for the report preparation with a volunteering individual practitioner. The Psychiatric Consultant group continued to feel – that the work fell outside the usual practice – without being written into new job descriptions, and the current infrequent nature not warranting addition into job plans)
 - Developing a list of interested and willing individuals (the UHB may want to consider writing the necessity for report preparation into future job descriptions, if requests become more frequent)
 - Access to UHB legal advice

Developing both private and local resource provides the most reliable provision for this work. There remains a small financial risk which will need monitoring, and other approaches may be necessary if this work becomes very regular.

And lastly:

- Enter dialogue with Swansea Bay UHB about Cardiff and Vale of Glamorgan residents with assessments most suitable for LD psychiatrists
- Maintain communication with other UHBs to ensure comparable approaches

Robust legal support needs also to be provided for clinicians who sometimes have limited access to legal expertise in dealing with further requests and clarifications from the individuals' legal teams.

Recommendation:

The Board / Committee are requested to:

Note the recommendations

Link to Strategic Objectives of Shaping our Future Wellbeing:

Please tick as relevant

1. Reduce health inequalities	X	6. Have a planned care system where demand and capacity are in balance	X
2. Deliver outcomes that matter to people	X	7. Be a great place to work and learn	X
3. All take responsibility for improving our health and wellbeing	X	8. Work better together with partners to deliver care and support across care sectors, making best use of our people and technology	X

4. Offer services that deliver the population health our citizens are entitled to expect	X	9. Reduce harm, waste and variation sustainably making best use of the resources available to us	X
5. Have an unplanned (emergency) care system that provides the right care, in the right place, first time		10. Excel at teaching, research, innovation and improvement and provide an environment where innovation thrives	

Five Ways of Working (Sustainable Development Principles) considered

Please tick as relevant

Prevention		Long term		Integration		Collaboration	X	Involvement	X
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Impact Assessment:

Please state yes or no for each category. If yes please provide further details.

Risk: Yes/No

n/a

Safety: No

n/a

Financial: Yes

n/a

Workforce: Yes

n/a

Legal: Yes

n/a

Reputational: Yes

n/a

Socio Economic: Yes

n/a

Equality and Health: Yes

n/a

Decarbonisation: No

n/a

Approval/Scrutiny Route:

Committee/Group/Exec	Date:

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Report Title:	Mental Health Measure (Wales) 2010 incl. Part 2			Agenda Item no.	10.1
Meeting:	Mental Health Legislation and Mental Capacity Act Committee	Public	X	Meeting Date:	25 th October 2022
		Private			
Status <i>(please tick one only):</i>	Assurance	X	Approval	Information	
Lead Executive:	Chief Operating Officer				
Report Author (Title):	Director of Operations, Mental Health				

Main Report

Background and current 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. For the information of the Committee the Delivery Unit has restarted its 90 day cycle of mental health services reviews across Wales to discuss performance against the various mental health specific targets. Cardiff and Vale has been visited with no exceptional issues to report.

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

Executive Director Opinion and Key Issues to bring to the attention of the Board/Committee:

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 Risk Implications (Safety, Financial, Legal, Reputational etc.):

For Parts 1, 2, 3 & 4 of the Measure, local activity and compliance information is collated and submitted to WG via standard reporting templates.

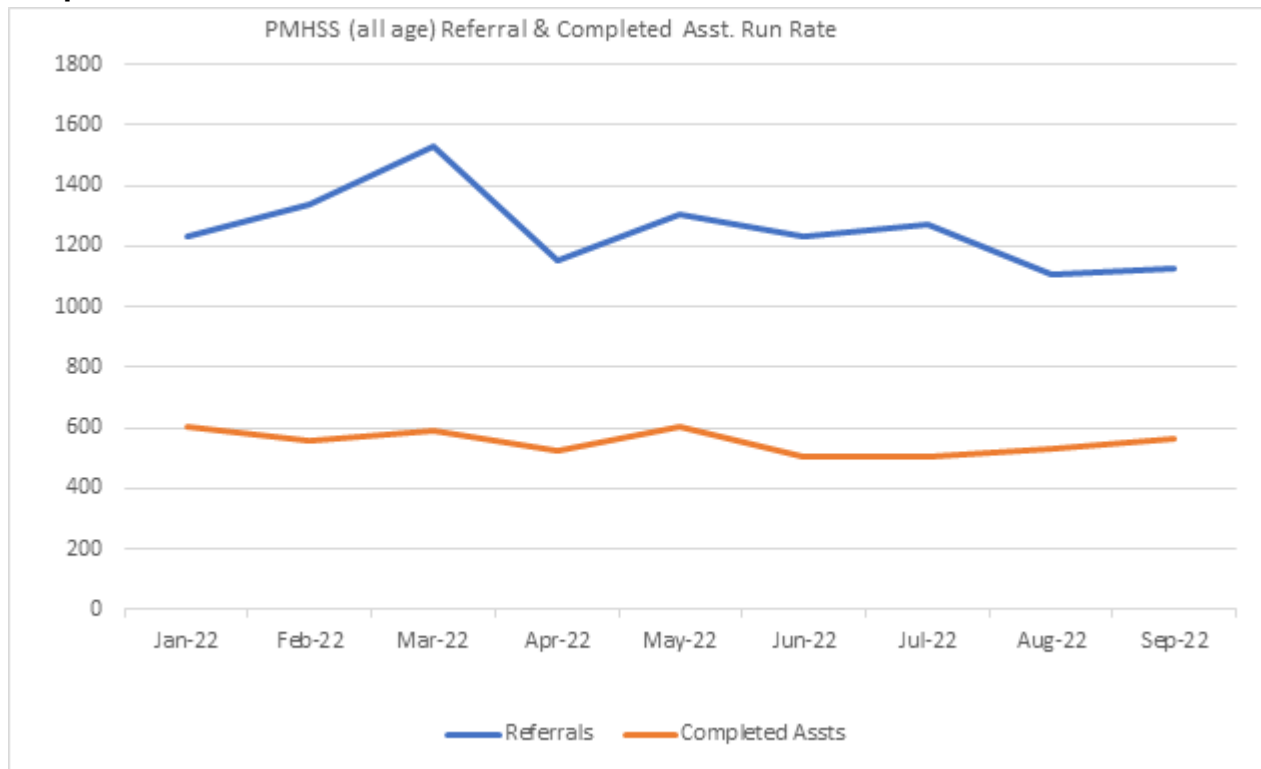
Part 1: PMHSS

Part 1a – target: 28-day referral to assessment compliance target of 80% (Adult)

Referrals into the service were slightly lower than forecast, with 2866 referrals during Q2. This is a 3.5% increase on last year's Q2 referrals (adult only). The service is at full clinical recruitment and sickness absence remains low; this allows for ongoing high levels of assessment activity – PMHSS assessed 1420 (adults) in Q2, very similar to Q1 (graph 1).

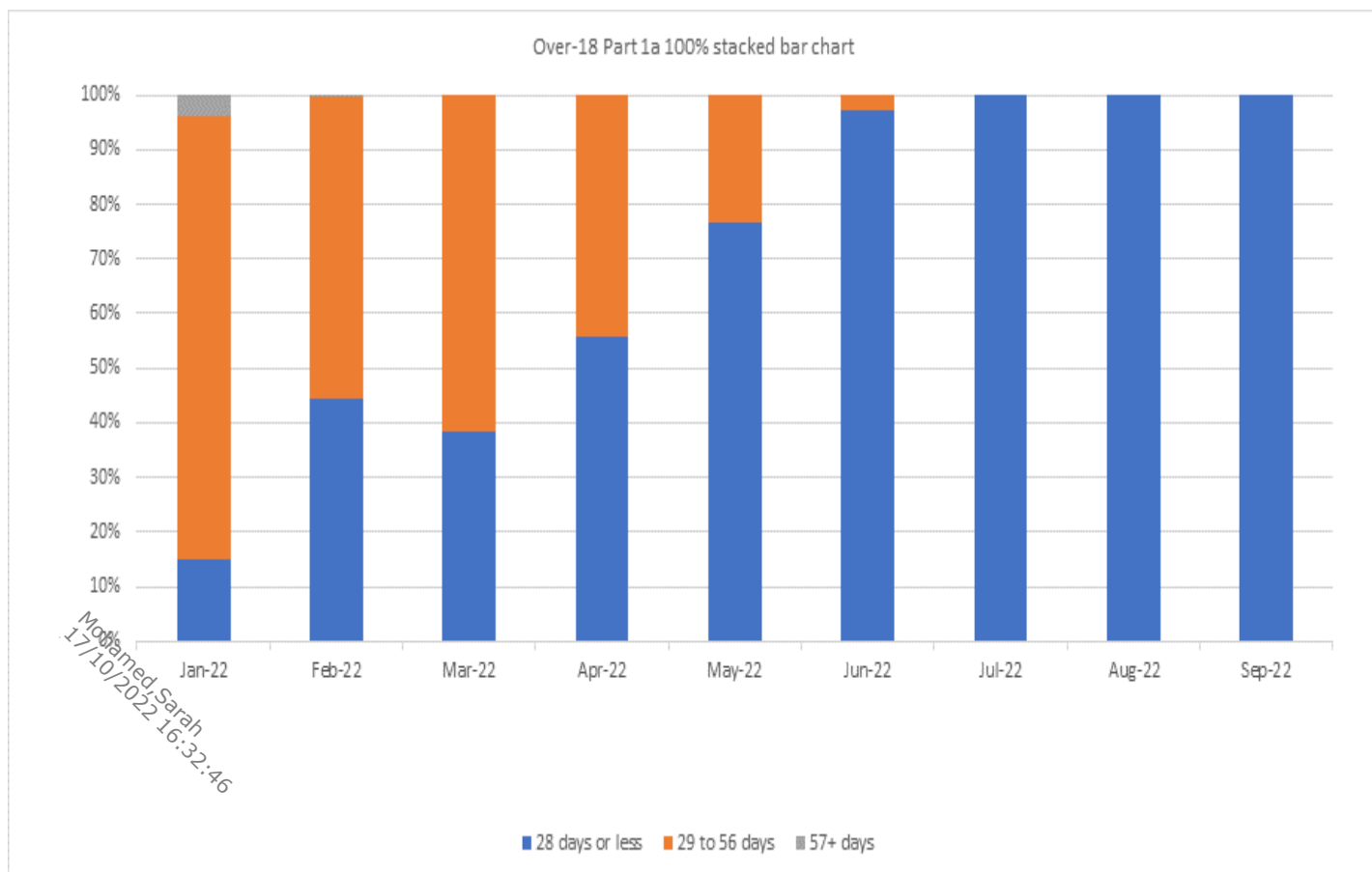
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Graph 1



This activity meant that the service maintained Part 1a compliance (graph 2). Throughout the quarter overall numbers waiting for assessment has dropped further from 166 on 30/06/2022 to 73 on 30/09/2022. Average wait time for assessment has dropped from 9 days on 30/06/22 to 4 days on 30/09/2022. The service reported 100% compliance since July 2022. Early indications are for a busy Q3/Q4 with very high levels of activity. We forecast continuing to meet target.

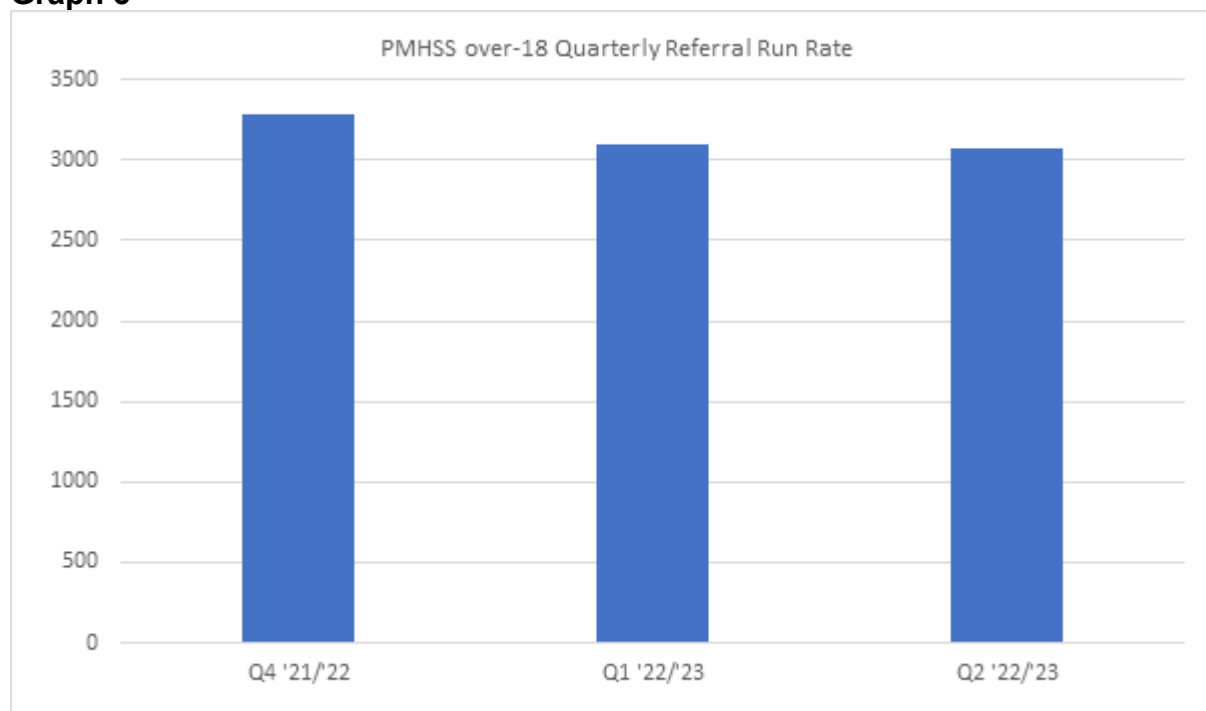
Graph 2



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Estimated referral rates remain above 3000 per quarter though indicate a gradual reduction before stabilising (Graph 3).

Graph 3



Actions to maintain compliance

- Investment into Tier 0 providers to deliver Tier 0 interventions (Stress Control and ACTION for Living) at scale to reduce referrals into PMHSS- groups running in Vale and running this quarter in Cardiff
- Developed automated opt in letter and immediate text message prompt for all referrals into PMHSS – started September 2022
- *My Clinical Outcomes* website link provided via email for collection of outcome data to evaluate quality impact of PMHSS
- Successful transformation bid of 2.0 WTE band 6 Practitioners and 1.0 WTE band 3 administrator to main compliance. Have been recruited into, awaiting enrolment.

Counselling waiting times have increased but remain under the 26 week Psychological Therapies waiting time target.

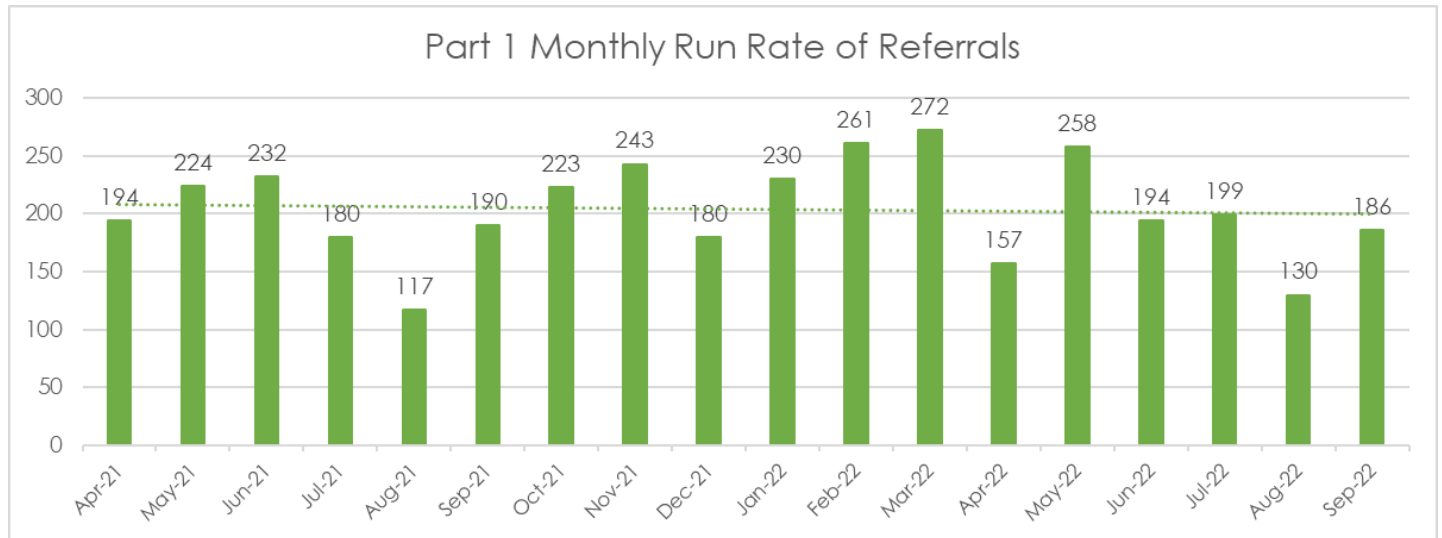
Part 1a – target: 28-day referral to assessment compliance target of 80% (Children & Young People)

Compliance against the Part 1A MHM target has been improved since August 2022 as a result of a waiting list initiative which is being undertaken in the service. However, the service continues to be impacted by vacancy, long-term sickness and operational issues facing Healios.

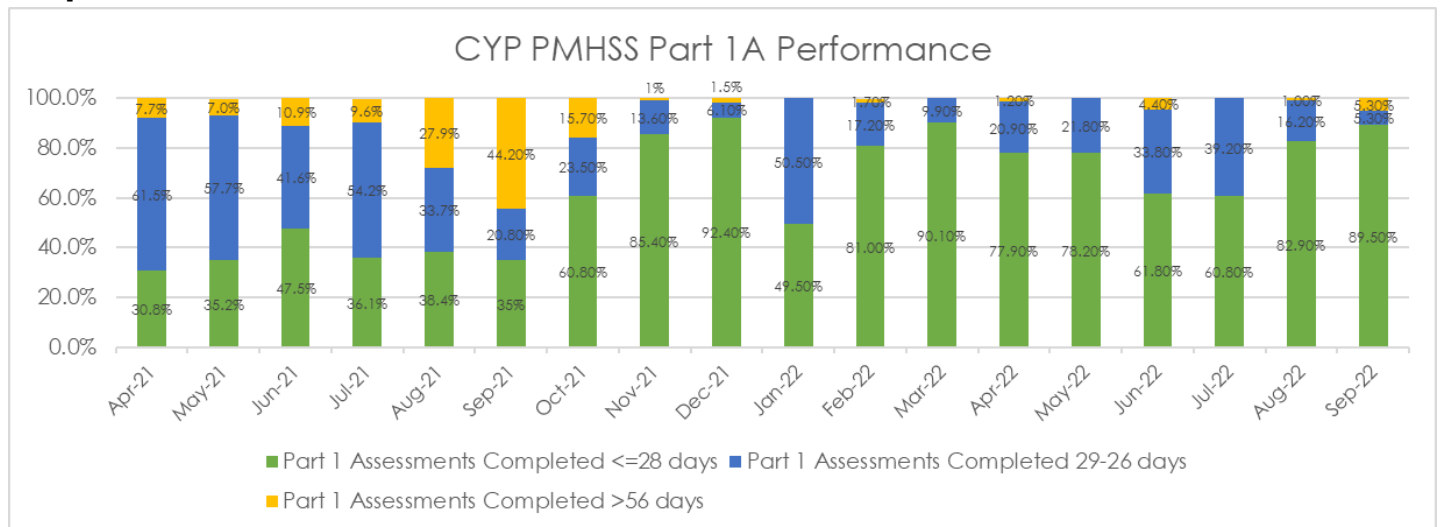
Since April 2021, the volume of referrals has increased and have remained significantly higher than pre-Covid levels. As expected, the service has seen a decrease in referrals over school holiday periods.

The average wait for assessment is currently 21 days as a result of the waiting list initiative and the start of the mobilization of the assessment team.

Graph 4



Graph 5

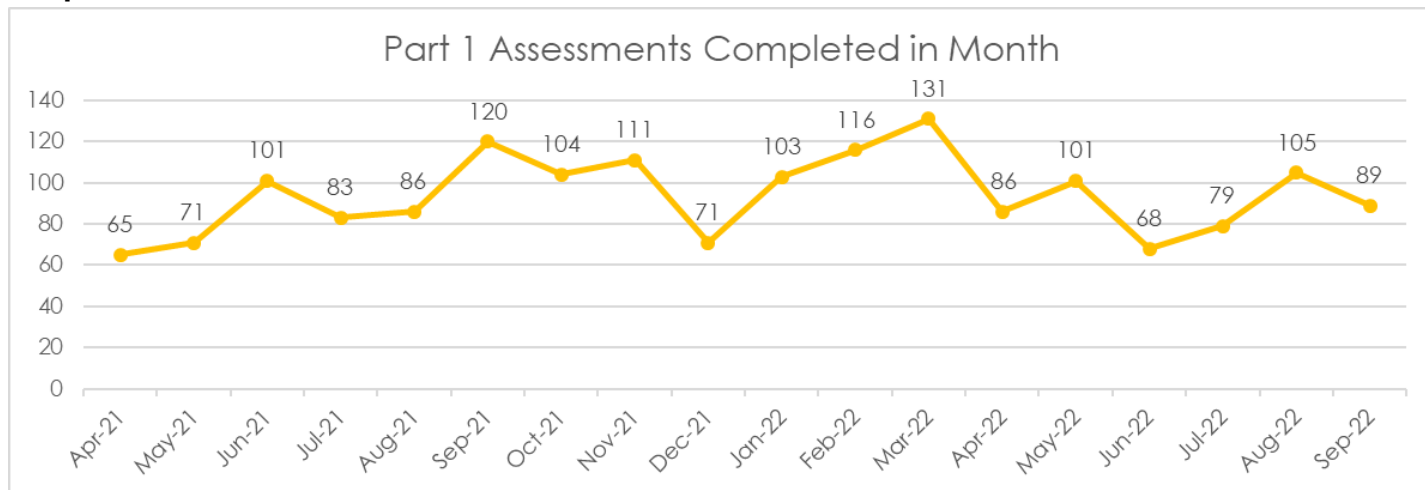


Capacity has been a challenge for the team, with a mixture of short and long-term sickness, the team has been operating on approximately 66% capacity since the beginning of December 2020. There is currently a recruitment drive with the development of new services as a result of COVID recovery monies but significant vacancy still remains within the service.

The service is continuing to deliver its full offer via virtual (telephone and video) and face-to-face means and expects to continue to utilise these mediums as part of a blended service offer post-Covid to better meet the needs of children and young people requiring support from the service. The service continues to closely monitor its capacity in order to meet the incoming demand and as such, we will be moving to a Joint Assessment team model which will combine CAMHS and PMH in its current format to create dedicated assessment capacity. This model is anticipated to be fully operationalised from the beginning of quarter 1 in 2023 with a soft launch in quarter 4 of 2022.

The Single Point of Access team was launched at the end of November and will help to manage referrals through improved processes and use of consultation with referrers.

Graph 6



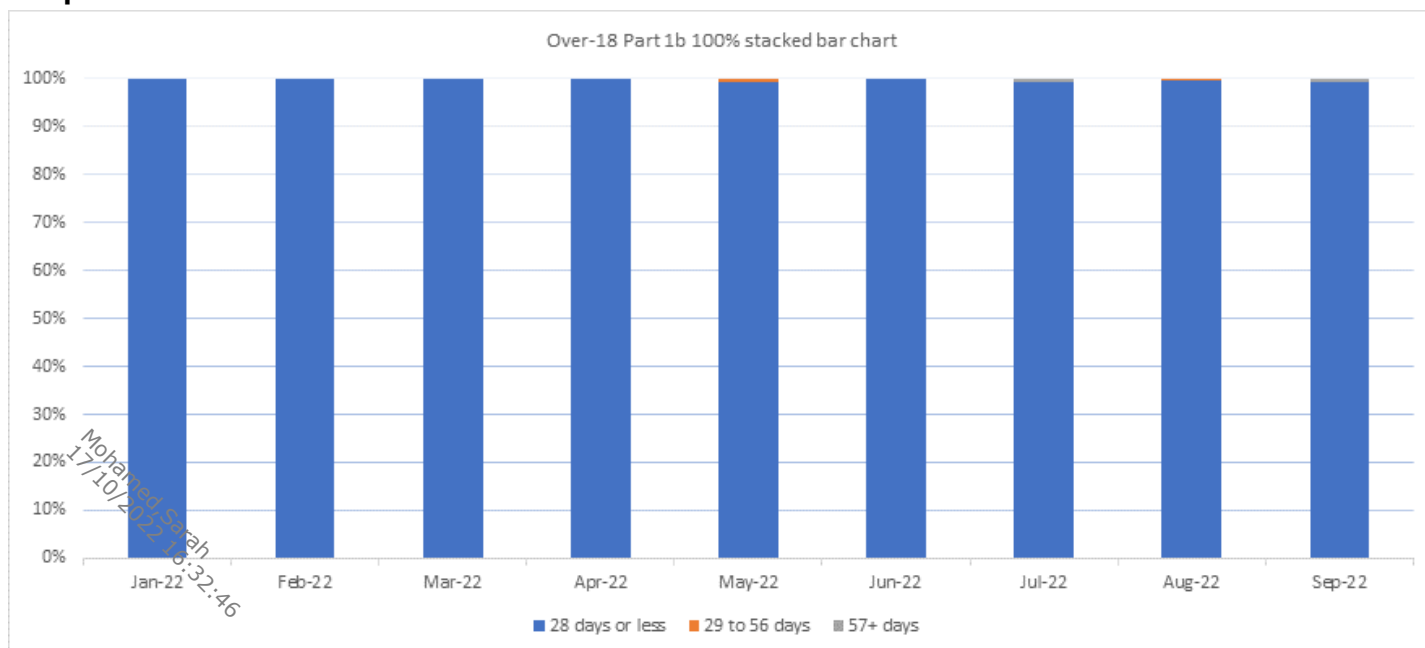
Actions to improve compliance against the target include:

- Active sickness monitoring and wellbeing support to the team
- Additional capacity through the use of partnership working with Healios to deliver Part 1 assessments and the use of agency staff to continue delivering the waiting list initiative.
- The Leadership Team are seeking to develop a new assessment team model, with dedicated capacity for assessment. It is anticipated that the joint assessment team will have a soft launch in January 2023 but will be fully operationalised from April 2023.
- Recruit to remaining vacancy within the service.

Part 1b – 28 day assessment to intervention compliance target of 80% (Adult)

PMHSS continues compliance with Part 1b performance target (See Graph 7). Overall a range of interventions for around 100 participants are running this reporting period.

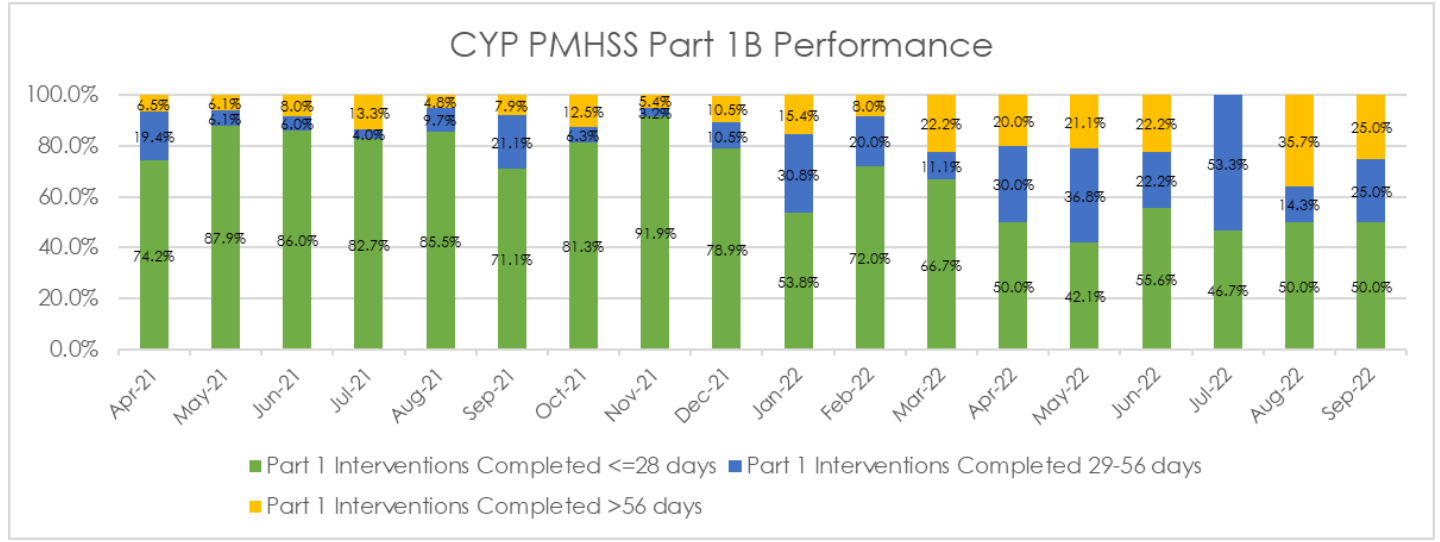
Graph 7



Part 1b – 28-day assessment to intervention compliance target of 80% (Children & Young People)

Compliance against Part 1B of the target has not been achieved since December 2021 as a result of focus on the external waiting list for assessment and reduced capacity over school holiday periods. January 2022 was a challenging month for the service with significantly reduced capacity due to sickness, maternity leave and annual leave. As part of the move towards a Joint Assessment Team model, a brief intervention pathway will be created to ensure that young people are seen within 28 days of the commencement of their treatment, following assessment.

Graph 8



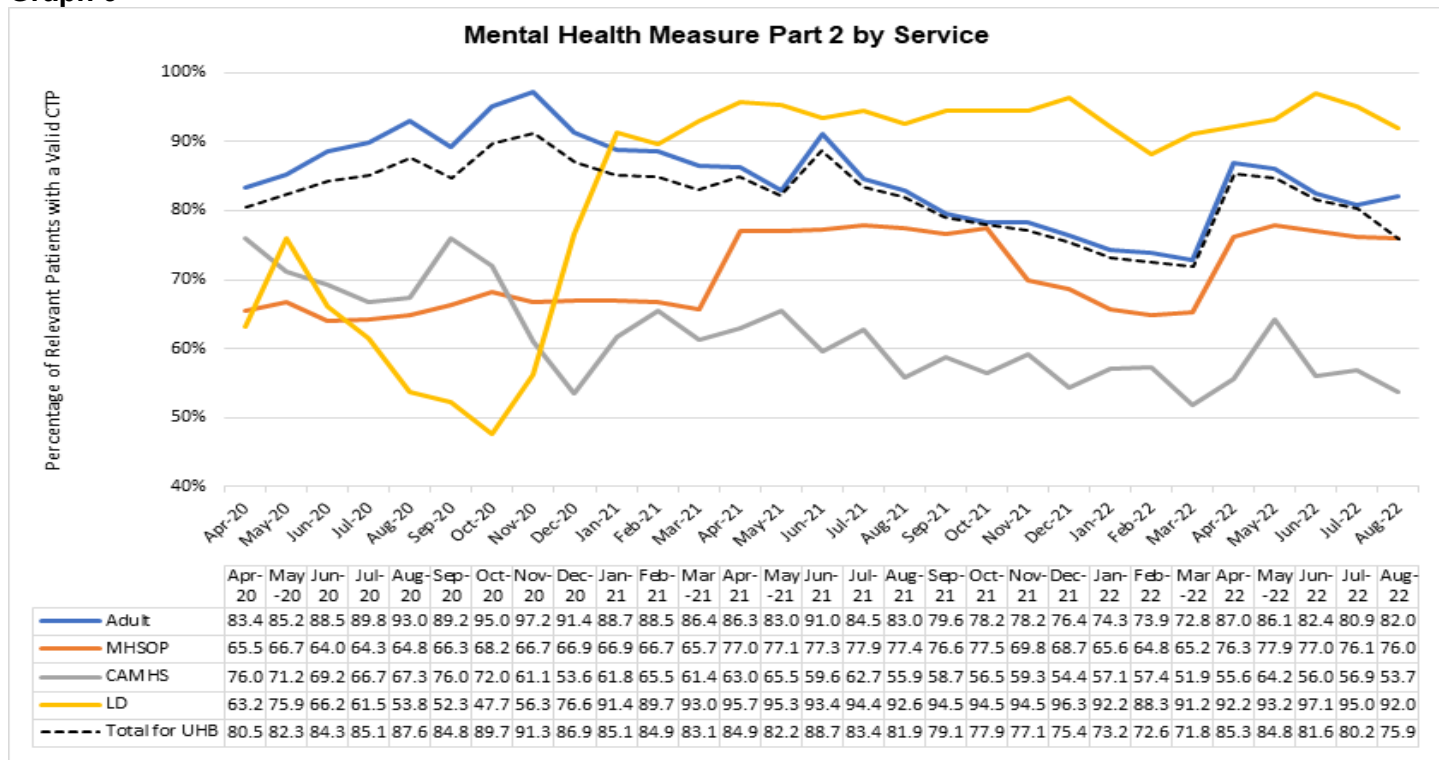
We are currently focusing on internal waiting lists as part of the new waiting list initiative with dedicated capacity allocated to tackle this demand. Therefore, the service should start making progress towards achieving compliance with the Part 1B target over the coming months.

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Part 2 – Care and Treatment Planning (over 18)

Standard for all relevant service users in secondary care to have an outcomes based holistic co-produced care plan

Graph 9



New reporting mechanisms have been developed to more accurately reflect the Part 2 target, a discussion with the DU has been requested to ensure that any changes are in line with approaches across Wales. The formula previously developed for reporting is the number of Care and Treatment Plans in the electronic record divided by the number of patients. This formula is then adjusted by the number of new admissions to teams minus the number of discharges.

There are some challenges to this approach:

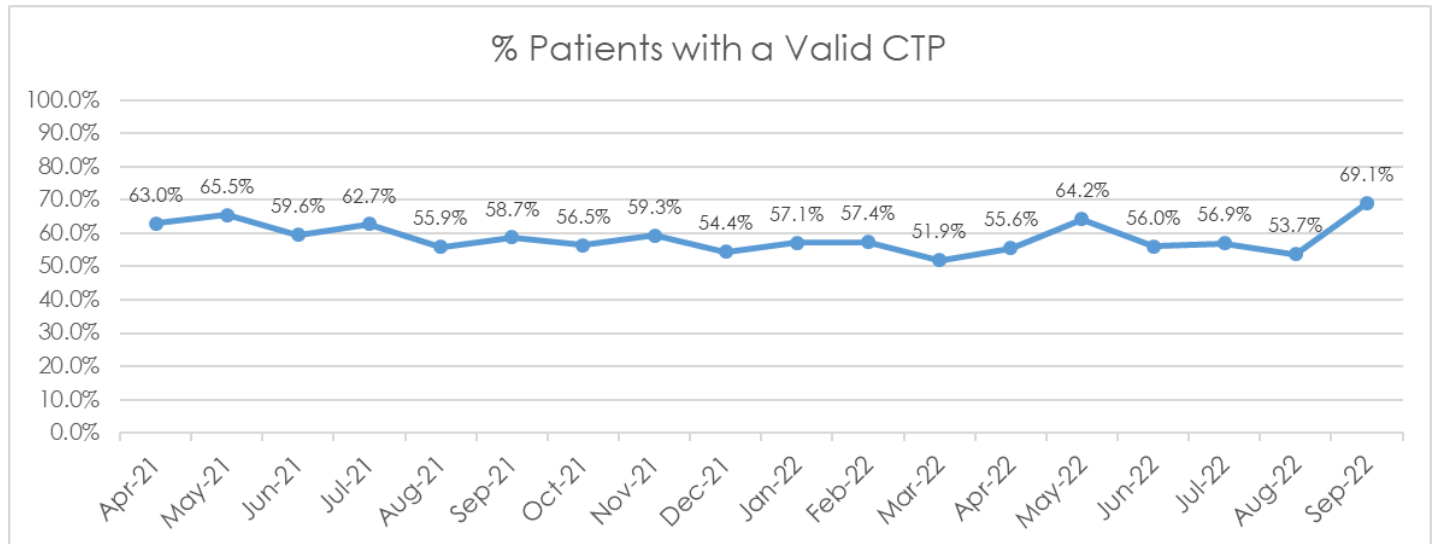
1. Only signed off (and therefore inactive) Care and Treatment plans are counted. As these are dynamic documents that should change with the needs of the service user, this make the CTP less clinically useful
2. Large numbers of service users require outpatient support only and do not require a Care and Treatment Plan as they are referred to in the Measure as 'stable severe'. Currently they are counted as eligible patients breaching compliance
3. There are large numbers of service users in secondary care (between 10% and 20% of medical caseloads in some cases) who have ADHD diagnoses but do not require a Care and Treatment Plan, but are required to see a Psychiatrist for repeat medication every 6 months. These are currently counted as eligible patients who are breaching.

To manage this the Part 1 Scheme (a document each Health Board holds to define what services are included as a Part 1 service) needs to be revisited and adjusted. A multidisciplinary working group has been formed to develop this and present for ratification at the MHMCLC.

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Part 2 – Care and Treatment Planning (Children & Young People)

Graph 10

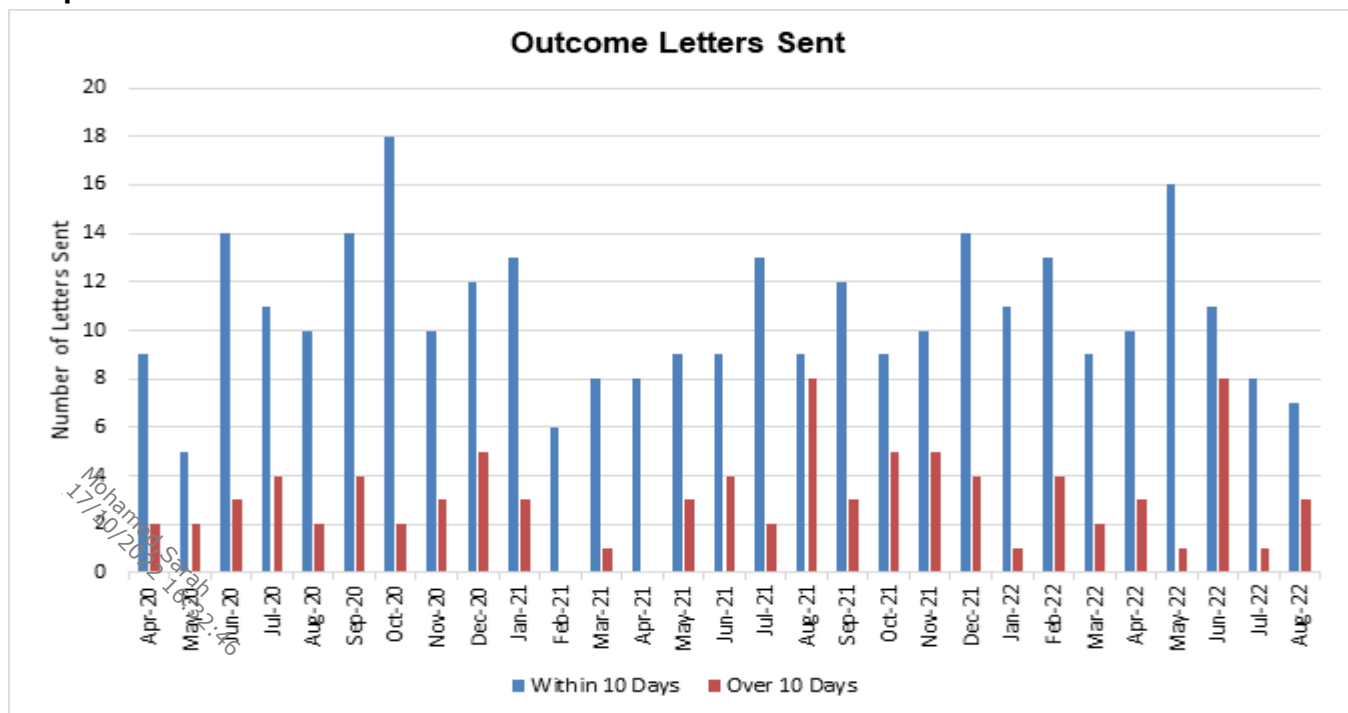


The service continues to underperform against the target, challenges to achievement have included poor engagement from patients in the CTP process and a high number of new patients requiring one. There are number of particularly complex cases that require a CTP where these have been unable to be facilitated as a result of wider system issues e.g. social care placements not being in agreed leading to delays in completion. The team are working hard to ensure that the process can be completed in a meaningful manner through a range of options including face to face, telephone and VC where appropriate and in a supportive multi-agency approach. Improvement in compliance remains a priority for the service.

Part 3 - Right to request an assessment by self –referral.

The target relates to service users who have self-referred, having a confirmation letter regarding the outcome of their assessment within 10 days. Graph 11 details our compliance of the target time of within 10 working days for an assessment outcome letter to be sent to the patient.

Graph 11



Three breaches were reported at 11 days. Teams are receiving an automated report indicating eligible patients for Part 3 sent on a weekly basis. Teams breaching have been notified for improvement.

Part 4 – Advocacy – standard to have access to an IMHA within 5 working days

Part 4 continues with 100% Compliance.

The table below reflects the quarterly submission to Welsh Government June 2022.

Number of new qualifying patients accepted into IMHA services during the quarter: [quarterly count]	Compulsory patients	3
	Informal/voluntary patients	0
	Total number of new qualifying patients accepted into IMHA services during the quarter	3
Number of qualifying patients currently in receipt of IMHA services at the end of the quarter - i.e. the caseload: [end of quarter snapshot]	Compulsory patients	3
	Informal/voluntary patients	15
	Total number of qualifying patients currently in receipt of IMHA services at the end of the quarter	18
Number of qualifying patients discharged from IMHA services during the quarter: [quarterly count]	Compulsory patients	5
	Informal/voluntary patients	0
	Total number of qualifying patients discharged from IMHA services during the quarter	5
Of the qualifying compulsory patients who had their first contact with an IMHA during the quarter, how many had waited: [quarterly count]	Up to and including 5 working days following their request for an IMHA	3
	6 working days or more following their request for an IMHA	0
	Total number of qualifying compulsory patients who had their first contact with an IMHA during the quarter	3
Of the qualifying informal/voluntary patients who had their first contact with an IMHA during the quarter, how many had waited: [quarterly count]	Up to and including 5 working days following their request for an IMHA	0
	6 working days or more following their request for an IMHA	0
	Total number of qualifying informal/voluntary patients who had their first contact with an IMHA during the quarter	0

With regards to Part 1-4 of the Measure, Committee Members are updated as follows:

Part 1:

Maintain progress and monitor performance.

Text Notification system now in place in Adult. Quality Measures integrated in this through *My Clinical Outcomes*.

Part 2:

PARIS report changes now being reviewed. A Part 1 Scheme Task and Finish group has been set up to support future compliance.

Part 3:

Continue to flag any performance issues to teams locally for improvement.

Part 4:

100% compliance, no further actions.

Recommendation:

The Committee is requested to:

- a) **note** the contents of the report

Link to Strategic Objectives of Shaping our Future Wellbeing:*Please tick as relevant*

1. Reduce health inequalities	X	6. Have a planned care system where demand and capacity are in balance	
2. Deliver outcomes that matter to people	X	7. Be a great place to work and learn	
3. All take responsibility for improving our health and wellbeing	X	8. Work better together with partners to deliver care and support across care sectors, making best use of our people and technology	X
4. Offer services that deliver the population health our citizens are entitled to expect	X	9. Reduce harm, waste and variation sustainably making best use of the resources available to us	
5. Have an unplanned (emergency) care system that provides the right care, in the right place, first time	X	10. Excel at teaching, research, innovation and improvement and provide an environment where innovation thrives	

Five Ways of Working (Sustainable Development Principles) considered*Please tick as relevant*

Prevention	X	Long term	X	Integration	X	Collaboration	X	Involvement	X
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Impact Assessment:*Please state yes or no for each category. If yes please provide further details.*

Risk: Yes/No

Safety: Yes/No

No

Financial: Yes/No

No

Workforce: Yes/No

No

Legal: Yes/No

No

Reputational: Yes/No

Yes

Socio Economic: Yes/No

No

Equality and Health: Yes/No

Yes

Decarbonisation: Yes/No	
n/a	
Approval/Scrutiny Route:	
Committee/Group/Exec	Date:

Mohamed Sarah
17/10/2022 16:32:46

Report Title:	Draft Mental Health Bill		Agenda Item no.	11.1
Meeting:	Mental Health Legislation & Mental Capacity Act Committee	Public	X	Meeting Date: 25 th October 2022
		Private		
Status <i>(please tick one only):</i>	Assurance	Approval	Information	X
Lead Executive:	Chief Operating Officer			
Report Author (Title):	Mental Health Act Manager			

Main Report

Background and current situation:

In 2017, the government asked Professor Sir Simon Wessely to lead the Independent Review of the Mental Health Act 1983 (MHA), to propose recommendations for modernisation and reform. The final report was published in December 2018 and made over 150 recommendations. The UK Government published its response in the form of a White Paper, which went out for a 14-week public consultation, receiving more than 1700 responses. Following the consultation, the UK Government set out its response to bring forward a Mental Health Bill. The UK Government published a Draft Mental Health Bill in June 2022.

Executive Director Opinion and Key Issues to bring to the attention of the Board/Committee:

The Draft Mental Health Bill will look to change key aspects of the current Mental Health Act, these are listed below:

Autism and learning disability

Application of 1983 Act: autism and learning disability

Current

- People with a learning disability and/or autistic people can be detained under Part 2 for assessment and treatment under section 2 and for treatment under section 3.

Changes

- Autism or learning disabilities won't be considered conditions under Part 2 for which a person can be subject to compulsory treatment under section 3.
- People with a learning disability and/or autistic people will only be able to be detained under Part 2 for treatment under section 3 if they satisfy the criteria of section 3, which includes they are suffering from a co-occurring mental disorder which is not learning disability or autism.
- Inserts a new term, 'Psychiatric disorder', which covers mental disorder other than learning disability or autism.
- Inserts a new section that sets out, for the purpose of the MHA, a person's learning disability has 'serious behavioural consequences' if it is associated with abnormally aggressive or seriously irresponsible conduct by the person.
- The revised criteria under Part 2 will not apply to Part 3 patients therefore, people with learning disabilities or autism can still be detained for assessment or treatment under Part 3.

Reason

- people with learning disabilities and/or autistic people are often subject to length detentions, which often do not provide a therapeutic benefit and the change under Part 2 seeks to end the practice in being detained in unsuitable long-stay ward and is supported by the guiding principle of least restrictive.

Grounds for detention and community treatment orders

Grounds for detention

Current

- The criteria for section 2 is:
 - the patient is suffering from a mental disorder of a nature or degree which warrants the detention in hospital for assessment

AND

- ought to be so detained
 - in the interests of the patient's own health
 - in the interests of the patient's own safety
 - with a view to the protection of other persons.

Changes

- Amend the criteria for detention under section 2, 3 and 5 and criteria for renewal under section 20.
- Two new tests that must be met to fulfil the criteria for detention: firstly that 'serious harm may be caused to the health or safety of the patient or of another person' and secondly that the decision maker must consider 'the nature, degree and likelihood of the harm, and how soon it would occur'.

Reason

- To provide greater clarity as to the level of risk of harm that a person must present in order to be detained. Firstly, the 'serious harm' test sets out the severity of the harm a patient must pose in order to fulfil the criteria for detention under section 2. Secondly, the 'nature, degree and likelihood' test introduces a new requirement that the clinician must consider the likelihood that this harm will occur and how soon, when deciding to admit a patient under section 2.

Grounds for community treatment orders (CTO)

Current

- The criteria for a CTO is:
 - the patient is suffering from a mental disorder of a nature or degree which makes it appropriate for the patient to receive medical treatment,
 - it is necessary for: -
 - the patient's health;
 - the patient's safety;
 - the protection of other persons,

that the patient should receive such treatment

- 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 to recall the patient to hospital
- appropriate medical treatment is available to the patient.

Changes

- The criteria for making a CTO under section 17A and for extension of a CTO under section 20A to align with the new risk criteria for detention.
- Firstly that 'serious harm may be caused to the health or safety of the patient or of another person' and secondly that the decision maker must consider 'the nature, degree and likelihood of the harm, and how soon it would occur'.

Reason

- To provide greater clarity as to the level of risk of harm that a person must present in order to be liable to be detained. Firstly, the 'serious harm' test sets out the severity of the harm a patient must pose in order to fulfil the criteria for detention. Secondly, the 'nature, degree and likelihood' test introduces a new requirement that the clinician must consider the likelihood that this harm will occur and how soon, when deciding to put a patient onto a CTO.

Grounds for discharge by the tribunal

The grounds will change in line with the revised grounds for detention and CTO. The tribunal must discharge a patient where the patient no longer satisfies the revised detention criteria relevant to their detention.

Appropriate medical treatment

Therapeutic benefit

Current

- The existing definition of 'medical treatment' currently requires any medical treatment for mental disorder to have a therapeutic benefit purpose.

Changes

- New definition of 'appropriate medical treatment' will be added so where medical treatment is required, it will be 'appropriate'. The treatment must have a reasonable prospect that the outcome would have a therapeutic benefit for that patient in terms of alleviating, or preventing the worsening of the patient's mental disorder or one or more of its manifestations.

Reason

- To move 'medical treatment' to the front of the MHA alongside the new 'appropriate medical treatment' definition so that both definitions and therefore the need for therapeutic benefit have a prominent position and to ensure that therapeutic benefit is considered both in relation to the purpose and likely outcome of the treatment.

The responsible clinician

Nomination of the responsible clinician

Current

- Local protocols are in place to identify and allocate a patient's responsible clinician.

Changes

- To add a new term of 'relevant hospital' to mean either the hospital that a patient is liable to be detained in or, for a patient on a CTO, the hospital which is responsible for them.
- To extend the definition of 'responsible clinician' to specify that the RC has overall responsibility for a patient's care as now, but with the added provision that this is because the managers of the 'relevant hospital' have nominated the RC.

Reason

- The draft Bill hasn't given a reason for the 'relevant hospital' addition but I think it is to provide legal clarity to the definition as some parts of the Act refer to the term 'relevant hospital' without any definition of this.
- The draft Bill hasn't given a reason for extending the definition of 'responsible clinician' but I think it's to create a more robust process of nominating and recording a responsible clinician.

Treatment

Making treatment decisions

Current

- Section 56 identifies which patients Part 4 (consent to treatment provision) applies to. Section 56A is a new addition.

Changes

- Inserts new section 56A to introduce a duty on the clinician in charge of the patient's treatment to have a 'clinical checklist' to consider the patient's wishes and feelings as far as reasonably ascertainable, taking reasonably practicable steps to assist and to encourage the patient to participate in treatment decisions, consult with those close to the patient, and identify and evaluate any available forms of medical treatment.
- Where the patient lacks the relevant capacity or competence, the clinician must consider what they think the patient might have wanted, if they had the relevant capacity or competence.
- Section 56A would apply to all treatment given under Part 4 (consent to treatment provision)

Reason

- The intention of this new section is to help ensure that, as far as possible, clinical decisions are based around the patient's wishes, preferences and individual needs along with supporting the guiding principle of choice and autonomy.

Appointment of doctors to provide second opinions

Current

- A second opinion appointed doctor (SOAD) is referred to as a 'registered medical practitioner appointed for the purpose of this Part of the MHA by the regulatory authority'.

Changes

- Insert new section 56B to clarify the role of the regulatory authority (CQC & HIW) where this function under this Part is to be performed by a 'second opinion appointed doctor' (SOAD).

Reason

- The SOAD acts independently and under the draft Bill will also be assessing that the patient's treatment has therapeutic benefit and that the new section 56A above, of a 'clinical checklist' has been applied by the SOAD.

Section 58 (medicine) – background

Current

- Section 58 requires that after three months have passed either an approved clinician or SOAD must certify in writing that a patient has capacity or competence and consents or is refusing medication or the patient lacks the capacity or competence to consent.

Changes

- Section 58 to be amended so that rather than all patients being certified in writing after three months, there will be three new categories of safeguard (see below). These will be organised around whether the patient has or lacks the capacity or competence to consent to the treatment in question.

Reason

- The draft Bill hasn't given a reason for this amendment.

Medicine etc.: treatment conflicting with a decision by or on behalf of a patient

Current

- A patient can be given treatment without consent as long as a SOAD certifies that treatment. Section 57A is a new addition of which, treatment without consent requiring a second opinion must have a 'compelling reason'.

Changes

- Introduces new safeguards for patients who are refusing treatment either with capacity or competence at the time, or in a valid and applicable advance decision or where treatment is in conflict with a decision made by a donee or deputy or the Court of Protection. These safeguards only apply to medical treatment for mental disorder falling in the scope of section 58.
- Section 57A sets out that a patient may not be given any forms of medical treatment unless there is a 'compelling reason' to give the treatment and a SOAD has provided certification.
- A 'compelling reason' constitutes either that no other alternative forms of appropriate medical treatment are available for the patient's mental disorder or that alternative forms of appropriate medical treatment are available but the patient has not consented or they are in conflict with a valid and applicable advance decision or a decision made by a donee or a deputy or the Court of Protection.
- Where the approved clinician considers that the 'compelling reason' test is met, a certificate provided by the SOAD must confirm the following in order for treatment to be given;
 - That the treatment in questions is appropriate (under the new definition of 'appropriate medical treatment')
 - That the decision to give treatment was made by the approved clinician in line with section 56A ('clinical checklist')
 - And that in respect of any available alternative treatment/s either the patient has not given valid consent or that they appear to conflict with a valid and applicable advance decision or a decision made by a donee or a deputy or the Court of Protection.
- The SOAD must still consult with two other people who have been professionally concerned with the patient's medical treatment as the current MHA requires.

Reason

- The intention of these new safeguards is to strengthen the right of the patient to inform their own care and treatment, thereby further supporting the principle of choice and autonomy.

Medicine etc.: treatment in other circumstances

Current

- Any patient that comes within the scope of section 58 must have their treatment authorised after a period of three months of that treatment starting either by an approved clinician or a SOAD, depending on whether the patient has capacity or competence and is consenting or refusing or if they lack capacity or competence.

Changes

- Section 58 rules will be shortened to two months. This new time period applies where the patient has capacity or competence and consents, or where they patient lacks capacity or competence (and there is no conflict with any valid and applicable advance decision or a decision made by a donee or a deputy or the Court of Protection).
- Summary of the amended section 58 to create three categories of safeguard.

Category	Patient presentation	Conditions for administering treatment
1	Consenting with capacity or competence at the time	The effect of clause 12 is that, if the patient is consenting to treatment, after a period of two months an AC or SOAD must certify that: <ul style="list-style-type: none">• The patient is validly consenting and• the treatment is appropriate (within the new meaning)
2	Refusing treatment with capacity or competence	The effect of clause 11 is that treatment can be given only if there is 'compelling reason' to do so and

	at the time, or the patient lacks capacity and treatment is in conflict with any valid and applicable advance decision or a decision made by a donee or deputy or by the Court of Protection.	certification has been provided by a SOAD, which must provide that: <ul style="list-style-type: none"> • the treatment in question is appropriate; • the decision to give treatment was made by the AC in line with the duties under section 56A and • in respect of any available alternative treatment/s either the patient has not given valid consent, or they appear to conflict with a valid and applicable advance decision, or a decision made by a donee or deputy or the Court of Protection.
3	Lacks capacity or competence and cannot validly consent to treatment	The effect of clause 12 is that treatment can be given but, after a period of two months, a SOAD must certify that: <ul style="list-style-type: none"> • the patient lacks the relevant capacity or competence to consent; • the treatment is appropriate.

Reason

- By strengthening checks and safeguards this amendment embeds the principles of choice and autonomy and the person as an individual.

Electro-convulsive therapy (ECT) etc.

Current

- Under section 58A it is the responsibility of the SOAD to confirm that the decision to administer ECT is not in conflict with any valid and applicable advance decision, or a decision of an attorney or deputy or the Court of Protection.

Changes

- The amendment will mean the above will need to be established prior to the referral to the SOAD, which would indicate it is the role of the approved clinician to confirm this.
- The SOAD must certify that the patient lacks capacity or competence to consent, that the treatment is appropriate (in line with the new definition of 'appropriate medical treatment') and that the decision to give treatment was made in line with the new section 56A ('clinical checklist').

Reason

- The draft Bill hasn't given a reason for this amendment.

Review of treatment

Current

- Approved clinicians periodically review the treatment given to patients who have capacity or competence and are refusing or patients who lack capacity or competence by submitting the review forms to Healthcare Inspectorate Wales.

Changes

- Plan to amend section 61 to include the review of treatment of patients who have capacity or competence and are consenting. The review forms for these patients will also need to be submitted to Healthcare Inspectorate Wales.

Reason

- The draft Bill hasn't given a reason for this amendment.

Urgent treatment to alleviate serious suffering

Current

- Under section 62 urgent treatment can be administered to patients with capacity or competence on the basis it is considered immediately necessary to alleviate serious suffering by the patient.

Changes

- The amendment sets to remove the above power of administering treatment with the relevant capacity or competence based on alleviating serious suffering by the patient. This amendment won't apply to patients who lack capacity or competence, including those who made an advance decision.

Reason

- This amendment will allow patients who have capacity or competence at the time to decide on the degree of suffering they are willing to accept, offering patients greater autonomy over their treatment and supporting the principle of choice and autonomy.

Urgent electro-convulsive therapy etc.

Current

- Under section 62 urgent ECT may be given to a captious patient who is refusing if the below criteria apply-
 - Is immediately necessary to save the patient's life; or
 - Is immediately necessary to prevent a serious deterioration of his condition.

Changes

- This amendment will require that in order for the approved clinician to administer treatment, a SOAD must first issue a certificate which certifies-
 - The patient's capacity or competence;
 - The decision to give treatment conflicts with their refusal at the time or in a valid and applicable advance decision or by a donee or deputy or the Court of Protection;
 - The decision to give treatment was made by the clinician in charge in accordance with section 56A ('clinical checklist'); and
 - The urgent criteria in section 62 are met.
- The SOAD, before issuing a certificate, must consult with-
 - A nurse who has bene professionally concern with the patient's medical treatment, who is neither the responsible clinician or approved clinician in charge of the treatment; and
 - The patient's NP.
- Due to the urgent nature of the SOAD's role, the request must be submitted as soon as is reasonably practicable.
- New powers mean that the appropriate national authority can amend the MHA to set out circumstances where the approved clinician can certify the use of urgent ECT, instead of the SOAD. This is to allow the treatment to go ahead in exceptional circumstances.
- Where a SOAD is required to interview or examine a patient for urgent ECT, they may conduct this interview by live video or audio link, if appropriate.

Reason

- This introduces additional safeguard for patients who have capacity or competence who have refused urgent treatment either at the time or in a valid and applicable advance decision, or where the urgent treatment would conflict with the valid decision of a donee or deputy, or a decision of the Court of Protection.

Capacity to consent to treatment

Current

- Under the current MHA, a patient's mental capacity or competence to consent or refuse treatment is referenced on whether a patient is 'capable of understanding the nature, purpose and likely effects' of that treatment. In clinical practice, this is understood to refer to capacity or competence.

Changes

- It's planned to amend the wording to reference 'has capacity or competence to consent to' or 'lacks capacity to consent to'.

Reason

- It's not expected to create a practical change in assessing capacity or competence, this change confirms the shared legal framework between the MHA and MCA. It also brings Part 4 (consent to treatment provisions) in line with Part 4A (treatment of community patients) of the MHA, which already uses this terminology.

Care and treatment plans

This part applies to England only as Wales has the Mental Health Measure.

Community treatment orders (CTO)

Consultation of the community clinician

Current

- It is down to the responsible clinician to make a CTO along with an approved mental health professional (AMHP). All of the below decisions regarding a person on a CTO are the duty of the responsible clinician:
 - Vary or suspend conditions
 - Extend a patient's CTO
 - Recall a community patient to hospital
 - Revoke the CTO
 - Discharge from a CTO

Changes

- To make a new distinction between a patient's responsible clinician with overall responsibility for them including in hospital and a community clinician responsible for them in the community. The amendment imposes specific duties on the community clinician where this is not the responsible clinician.
- If different, the community clinician must be consulted before any of the above decisions could be agreed and implemented.

Reason

- By introducing a further professional opinion on whether people really need the support of a CTO and in requiring more evidence that a person otherwise presents a risk, or needs the CTO to support a benefit to their mental health, the principle of least restriction and therapeutic benefit is supported.

Conditions of community treatment orders (CTO)

Current

- Under section 17B conditions on a CTO can be made only if the responsible clinician, with the agreement of an AMHP thinks them necessary or appropriate for 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;
- Protecting other persons.

Changes

- The amendment is to delete the words 'or appropriate' from the phrase 'necessary or appropriate' under section 17B.

Reason

- To ensure that conditions of a CTO are only made when they are actually necessary to serve one or more of the purposes specified above.

Nominated persons (NP)

Current

- The MHA provides a safeguard role of the nearest relative (NR). It sets out a hierarchy list of 'relatives' and includes a number of rules for identifying the NR from this list. The NR has specific duties under the MHA, including-
 - The right to require an assessment to be made with a view to admitting the patient to hospital.
 - The right to apply for compulsory admission or guardianship (sections 2,3,4 and 7).
 - The right to be consulted or informed before an AMHP makes an application for detention under section 3 or guardianship.
 - The right to object to section 3 admission or guardianship.
 - The right to order discharge of the patient.
 - The right to information given to the detained patient or patient subject to a CTO.
 - The right to apply to the Mental Health Review Tribunal for Wales (in specific circumstances)

Changes

- New statutory role of nominated person (NP) to replace the nearest relative (NR).
- The intention is for a patient to personally select the NP to represent them and exercise the statutory functions.
- An NP can be selected by the patient at any time when they have capacity or competence to do so. Typically, it is thought that nominations would be made:
 - In advance of the detention – this could be done via a document signed by the patient, the NP and 'validated' by a health or social care professional. This would include when a patient has been admitted to hospital informally.
 - At the time of a MHA assessment – the AMHP would be required to check if a valid nomination has been made, and if not they could explain the nomination process and see if the patient wanted to make a nomination (assuming the relevant capacity or competence).
 - Following detention – a patient would be able to nominate someone to be their NP at any time when they have capacity or competence to do so and this would be 'validated' by a health or social care professional.
- If someone lacks the capacity or competence to make a nomination at detention or at any other time and has not previously nominated anyone, a NP can be appointed by an AMHP. This NP can be in place until the patient has the capacity or competence to make their own nomination.
- The existing functions of the NR above will be transferred to the NP in addition to the following powers-
 - A right to be consulted about statutory care and treatment plans;
 - A right to be consulted about transfers between hospitals, renewals and extensions to the patient's detention or CTO; and
 - The power to object to the use of a CTO.

Reason

- The Independent Review highlighted the current model of family and carer involvement outdated and insufficient
- NP supports the policy objective of improving support for detained patients.
- Linked to the wider policy intention to ensure the views, experiences and expertise of patients are taken into account more fully and more seriously in their care and treatment.
- Allowing individuals to express their wishes through someone they know and trust and in doing so, these measures support the principle of choice and autonomy.

Applications for admission or guardianship: role of nominated person

Current

- An AMHP must consult with the NR (unless consultation is not reasonably practicable or would involve unreasonable delay) for admissions under section 3 and if the NR exercises their power to block this but the AMHP believes the grounds for this are unreasonable, the only means of overruling them is to remove or displace them as the NR. This can prevent the NR from continuing in their statutory role in supporting the patient while they are detained, even though they may be best equipped to protect and promote the patient's interest.

Changes

- The NP power will sometimes be temporarily overruled as opposed to the NP being removed or displaced permanently. Overruling would apply to the following-
 - The right to object to section 3 admission or guardianship;
 - The new right to object to the use of a CTO; and
 - The right to order discharge of the patient from detention, CTO, or guardianship
- Where a NP objects to the application of a section 3, if the AMHP makes a report certifying that, in their opinion, if the patient was not admitted for treatment or received into guardianship, would likely to act in a manner that is dangerous to other persons or to themselves the application can continue.

Reason

- Allowing the NP to be temporarily overruled rather than being removed or displaced is to ensure where appropriate they continue to have a role in the patient's care and treatment while they are detained.

Discharge of patients: role of nominated person

Current

- If a NR orders the discharge of a patient and it is blocked by the responsible clinician, the NR cannot make another order for six months from the date of the original discharge order.

Changes

- This time limit has been amended to three months.

Reason

- This is to reflect the change in detention periods from six to three months.

Community treatment orders: role of nominated person

Current

- A responsible clinician can make a CTO with the agreement of an AMHP, without the NR being consulted.

Changes

- The responsible clinician must consult the NP (unless consultation is not reasonably practicable or would involve unreasonable delay) before making the CTO and if the NP objects, the only way the responsible clinician can continue is to certify in writing, in their

opinion should the patient be discharged without a CTO, the patient would be likely to act in a manner that is dangerous to other persons or to themselves.

Reason

- The draft Bill hasn't given a reason for this amendment.

Transfer of patients: role of nominated person

Current

- Patients can be transferred to different hospital without the NR being consulted.

Changes

- Before deciding to transfer a patient, the person responsible for making that decision must consult the NP (unless consultation is not reasonably practicable or would involve unreasonable delay).

Reason

- The draft Bill hasn't given a reason for this amendment.

Detention periods

Current

- Admission for treatment (section 3) runs for six months and can be renewed for a further six months then yearly thereafter.

Changes

- The proposed amendment will see admission for treatment to run for three months, can be renewed for a further three months then renewed for six months, then yearly thereafter.

Reason

- This amendment will mean the patients initial detention will expire sooner and if the patient's detention must continue, it will be reviewed more frequently.

Periods for applications and references

Periods for tribunal applications

Current

- A patient admitted to hospital for assessment has fourteen days in which to appeal their detention, from the first day of admittance.
- A patient admitted to hospital for treatment has six months in which to appeal their detention, from the first day of admittance.
- A patient who has been conditionally discharged without conditions that amount to a DoLs can appeal their detention between the expiration of twelve months and expiration of two years from the date the patient was conditionally discharged or ceased to be subject to DoLs conditions.

Changes

- The amendment changes the appeal period to twenty-one days for patients admitted to hospital for assessment from the day of admittance.
- The amendment changes the appeal period to three months for patients admitted to hospital for assessment from the day of admittance.
- The amendment clarifies the appeal period for patients who have been conditionally discharged without conditions that amount to a DoL.
- The amendment inserts a new section to provide patients who are conditionally discharged with conditions that amount to a DoL, have the right to appeal between six months and twelve

months from the date on which the patient became subject to the DoL conditions and thereafter every two years.

Reason

- These amendments are intended to ensure patients have greater access to a Tribunal hearing and the safeguard of increased independent judicial scrutiny. This is informed by the principle of least restrictive.

References to the tribunal

Current

- Hospital managers must refer a section 3 patient six months from the day on which the patient was first detained under section 3, including any period in which a patient was detained under section 2 and thereafter every three years.
- Hospital managers must refer a community patient if their CTO has been revoked by the responsible clinician.

Changes

- The amendment changes the referral period to three months from the day on which the patient was first detained under section 3, including any period in which a patient was detained under section 2 and thereafter every twelve months.
- Inserts a new subsection which sees the hospital managers referring a CTO patient on the expiry of six months, twelve months and thereafter every period of twelve months.
- It is set to remove the referral of a community patient that has had their CTO revoked.

Reason

- These amendments are intended to ensure patients have greater access to a Tribunal hearing and the safeguard of increased independent judicial scrutiny. This is informed by the principle of least restrictive.

References to tribunal for patients concerned in criminal proceedings etc.

Current

- Part 3 patients with restrictions are referred to the Tribunal by the Secretary of State every three years where the patient's case hasn't been reviewed within that time.

Changes

- Referral for Part 3 patients with restrictions will be amended to twelve months.
- New powers for the Tribunal to impose conditions that amount to a DoL where the following criteria is met-
 - that conditions amounting to a deprivation of the patient's liberty are necessary for the protection of another person from serious harm while the patient remains discharged from hospital; and
 - that for the patient to remain discharged subject to those conditions would be no less beneficial to their mental health than for them to be recalled to hospital.
- To refer conditionally discharged patients whose conditions, amount to a DoL, at twelve months, from when the conditions were imposed where the patient's case hasn't been reviewed within that time, and thereafter each two-year period.
- To refer conditionally discharged patients whose conditions don't amount to a DoL, at two years where the patient's case hasn't been reviewed within that time, and thereafter each four-year period.
- If DoL conditions are removed, the referral period will be two years from the date the conditions are removed.

Reason

- These amendments provide additional safeguards to ensure that no conditionally discharged patient can be detained for a period of more than four years without their detention being reviewed by the Tribunal.

Patients concerned in criminal proceedings or under sentence **Conditional discharge subject to deprivation of liberty conditions**

Current

- Restricted patients can be discharged into the community with conditions set by the Tribunal or Secretary of State but these conditions cannot amount to a DoL.

Changes

- A new section provides for the lawful imposition of conditions that amount to a DoL. The Tribunal or Secretary of State must be satisfied the conditions are necessary for the protection of others.

Reason

- There are a small number of high-risk cases where the mental disorder persists but are no longer benefitting from hospital detention and the Tribunal or Secretary of State must be satisfied the conditions are necessary for the protection of others from serious harm, and by imposing conditions that amount to a DoL they are beneficial or more beneficial for the patient than detention in hospital.

Transfer from prison to hospital

Current

- Prisoners and other detainees can be transferred from prison or an immigration removal centre to hospitals for treatment under Part 3 of the MHA. Currently there is no statutory time limit for this to be completed, unless a warrant has already been issued.

Changes

- This amendment introduces a new 28-day transfer window from the point of the initial referral for assessment.
- The new transfer window does not apply where there are exceptional circumstances which make it inappropriate or unsafe to do the transfer in this period, for example;
 - A prison riot;
 - Hospital provision becomes unavailable due to fire, flood or another unexpected event, or;
 - Clinically exceptional or complex cases where a longer time period is required to properly understand an individual's needs and appropriate treatment.

Reason

- This amendment supports the principle of least restrictive by reducing maximum length of time that a patient may have to wait to access inpatient treatment.

Transfer directions for persons detained in youth detention accommodation

Current

- The Secretary of State has the power to make a transfer direction allowing for individuals on remand in a prison or remand centre or remanded in custody by a magistrate's court, and civil and immigration detainees, to be transferred to hospital if they are suffering from a mental disorder requiring inpatient care.

Changes

- Remand centres have not been utilised in the criminal justice system and children arrested for or formally charged with a crime have instead been remanded to youth detention accommodation. Consequentially, where the Crown Court remands children to youth detention accommodation, there is currently no provision for the Secretary of State to make a transfer direction in respect of them under section 48.

Reason

- The amendment rectifies this, and makes a consequential amendment to remove a defunct entry referring to this provision in Schedule 8 to the Criminal Justice and Court Services Act 2000.

Help and information for patients **Independent mental health advocates**

This part applies to England only as Wales has the Mental Health Measure.

Information about complaints for detained patients/community patients/conditionally discharged patients

Current

- Hospital managers supply patients and their NP with complaints information as instructed by the Code of Practice.
- No duty to record the patients understanding of the complaint's information

Changes

- This will now be a duty under the MHA.
- Hospital managers must now ensure patients have understood the complaints information

Reason

- The draft Bill hasn't given a reason for this amendment.

After-care **Tribunal power to recommend after-care**

Current

- The Tribunal can make certain recommendations regarding a patient's care, with a view towards facilitating the discharge of a patient on a future date. The Tribunal can also reconvene to reconsider a case in the event that any such recommendation is not complied with.

Changes

- The amendment looks to extend the Tribunal powers, where it doesn't direct the discharge of a patient, it would be able to recommend to the responsible after-care bodies that they make plans for the provision of after-care services for a patient (after-care services in this context means care to which a patient may be entitled to under section 117 of the MHA).

Reason

- This amendment is to aid the facilitating of a patient's future discharge.
- The Tribunal can reconvene and challenge the responsible after-care bodies if the recommendations are not complied with.

After-care services

Current

- Section 117 places a duty on the NHS and local social services authorities to provide after-care to patients detained in hospital for treatment under sections 3, 37, 45A, 47 or 48 of the MHA, who then cease to be detained and leave hospital.

- Section 117 after-care lasts until the NHS body and the local authority jointly give notice to the person that they are satisfied that the person is no longer in need of such services.

Changes

- The amendment makes reforms to the identification of which particular NHS body and local authority is responsible for arranging section 117 aftercare to an individual patient, by applying the 'deeming rules' under social care legislation to the determination of ordinary residence. It provides that,
 - in relation to those aged under 18 section 105(6) of the Children Act 1989 applies for the purposes of determining the ordinary residence. This means that, for example, any periods should be disregarded when the child was living in accommodation provided by a local authority; and
 - in respect of adults, the deeming rules under the Care Act 2014 and the Social Services and Well-being (Wales) Act 2014 apply.

Reason

- The draft Bill hasn't given a reason for this amendment.

Recommendation:

The Committee is requested to:

- (a) Note** the key legislative changes proposed by the Draft Mental Health Bill, as set out in this report.

Link to Strategic Objectives of Shaping our Future Wellbeing:

Please tick as relevant

1. Reduce health inequalities	X	6. Have a planned care system where demand and capacity are in balance	X
2. Deliver outcomes that matter to people	X	7. Be a great place to work and learn	X
3. All take responsibility for improving our health and wellbeing	X	8. Work better together with partners to deliver care and support across care sectors, making best use of our people and technology	X
4. Offer services that deliver the population health our citizens are entitled to expect	X	9. Reduce harm, waste and variation sustainably making best use of the resources available to us	X
5. Have an unplanned (emergency) care system that provides the right care, in the right place, first time	X	10. Excel at teaching, research, innovation and improvement and provide an environment where innovation thrives	X

Five Ways of Working (Sustainable Development Principles) considered

Please tick as relevant

Prevention		Long term	X	Integration	X	Collaboration	X	Involvement	
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Impact Assessment:

Please state yes or no for each category. If yes please provide further details.

Risk: No

Safety: No

Financial: Yes

Budget will need to be extended in order to provide a bigger workforce as per below.	
Workforce: Yes	
A bigger workforce will be needed in the Mental Health Act office in order to cope with the extra work the MHA reform will produce.	
Legal: Yes	
The Health Board will have to learn and adhere to new rules when the Mental Health Act reform becomes law.	
Reputational: No	
Socio Economic: No	
Equality and Health: /No	
Decarbonisation: No	
Approval/Scrutiny Route:	
Committee/Group/Exec	Date:

Mohamed Sarah
17/10/2022 16:32:46

Report Title:	Corporate Risk Register		Agenda Item no.	11.2	
Meeting:	Mental Health Legislation and Mental Capacity Act Committee	Public	<input checked="" type="checkbox"/>	Meeting Date:	25.10.2022
		Private	<input type="checkbox"/>		
Status <i>(please tick one only):</i>	Assurance <input type="checkbox"/>	Approval <input type="checkbox"/>	Information <input checked="" type="checkbox"/>		
Lead Executive:	Director of Corporate Governance				
Report Author (Title):	Head of Risk and Regulation				

Main Report

Background and current situation:

The Corporate Risk Register ('the Register') has been developed to enable the Board to have an overview of the key operational risks from the Health Board's Clinical Boards and Corporate Directorates. Whilst the Register and the overarching Board Assurance Framework and Risk Management Policy ('the Policy') were embedded in practice and consistency in application developed, the Register included those risks which were rated 15 and above to provide the Board and its committees with an overview of the Health Board's extreme Operational Risks.

Since the July 2021 Board meeting, where an updated version of the Policy was agreed, the Register has recorded those risks scoring 20 and above and those scoring 15 or above where they demonstrate a wider trend that may impinge on the delivery of Health Board strategy and objectives.

Each of these risks are linked to a Committee of the Board and the Board Assurance Framework. Those risks which are linked to Mental Health Capacity and Legislation Committee are attached at Appendix A for further scrutiny and to provide assurance to the committee that relevant risks are being appropriately recorded, managed and escalated.

Executive Director Opinion and Key Issues to bring to the attention of the Board/Committee:

The Risk and Regulation Team continue to work with clinical and corporate colleagues to refine risk descriptors, controls and actions within Risk Registers. Since the September 2021 Board meeting the Risk and Regulation Team have undertaken a 'Check and Challenge Process' with all Clinical Board and Corporate Directorate risk leads to ensure that those risks recorded within the Register are correctly recorded in line with the Risk Scoring Matrix detailed within the Policy.

This ensures that the Board and its Committees can take assurance that the risks detailed in the Register are consistent with agreed procedures and are a true reflection of the operational risks that the Health Board continues to manage.

Alongside this process the Risk and Regulation Team continue to provide ongoing support and training to risk leads across the Health Board.

At the September 2022 Board meeting 1 Extreme Risk reported to the Board was linked to the Mental Health Capacity and Legislation Committee for assurance purposes. The risks reported is summarised as follows:

M. O'Sullivan, Sarah
17/10/2022 16:32:46

Risk Description Summary	Risk Score (1 to 25)
Risk to the health and wellbeing of a minor inpatients following admission to adult mental health services	20

This risk has remained on the Clinical Board risk register following a review in September 2022. Whilst it was hoped that scheduled actions would lead to the de-escalation of the risk prior to this meeting the risk has been exacerbated by Covid with a number of additional contributory factors, including:

1. Increasing numbers of CAMHS admissions.
2. A lack of available beds and no external providers accepting CAMHS patients leading to delays in admission.
3. Staffing issues impacting on safety (each CAMHS patient requires 1:1 staffing).
4. Highly complex individuals with specific conditions that are unsuited to any environment in Hafan Y Coed or other facilities in the UHB (including by way of example, 3 CAHMS Patients admitted during the weekend commencing the 14th October who remained on site until discharged into other services on the 17th October).

The Risk and Regulation team will continue to work with the Mental Health Clinical Board (and other areas) to further integrate the Health Board's Risk Management policies and procedures to ensure that those entries detailed on the Register provide an accurate indication of the risks that the Health Board is dealing with operationally.

ASSURANCE is provided by:

- Ongoing discussions with the Mental Health Clinical Board regarding the scoring of risk.
- The provision of Risk Management training and support that the Head of Risk and Regulation and his team continue to deliver.

Recommendation:

The Committee is requested to:

NOTE the Corporate Risk Register risk entries linked to the Mental Health Legislation and Mental Capacity Act Committee and the Risk Management development work which is now progressing with Clinical Board.

Link to Strategic Objectives of Shaping our Future Wellbeing:

Please tick as relevant

1. Reduce health inequalities		6. Have a planned care system where demand and capacity are in balance	
2. Deliver outcomes that matter to people		7. Be a great place to work and learn	x
3. All take responsibility for improving our health and wellbeing	x	8. Work better together with partners to deliver care and support across care sectors, making best use of our people and technology	
4. Offer services that deliver the population health our citizens are entitled to expect		9. Reduce harm, waste and variation sustainably making best use of the resources available to us	
5. Have an unplanned (emergency) care system that provides the right care, in the right place, first time		10. Excel at teaching, research, innovation and improvement and provide an environment where innovation thrives	

Five Ways of Working (Sustainable Development Principles) considered

Please tick as relevant

Prevention		Long term		Integration		Collaboration	x	Involvement	x
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Impact Assessment:

Please state yes or no for each category. If yes please provide further details.

Risk: Yes

Ongoing risk management discussions and support provided to the Mental Health Clinical Board will strengthen the Clinical Board's risk management processes.

Safety: Yes/No

N/A

Financial: Yes/No

N/A

Workforce: Yes/No

N/A

Legal: Yes/No

N/A

Reputational: Yes/No

N/A

Socio Economic: Yes/No

N/A

Equality and Health: Yes/No

N/A

Decarbonisation: Yes/No

N/A

Approval/Scrutiny Route:

Committee/Group/Exec

Date:

N/A

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CORPORATE RISK REGISTER SEPTEMBER 2022

Clinical Board/Corporate Directorate	Risk Reference	Date risk added	Risk	Initial Risk Rating			Controls	Current Risk Rating			Actions	Target Risk Rating			Date of next review	Assurance Committee	Link to BAF
				Consequence	Likelihood	Total		Consequence	Likelihood	Total		Consequence	Likelihood	Total			
Mental Health Clinical Board	14	Aug-20	<p>Young People in Adult Mental Health Placement Young people with complex needs require admission to adult mental health services as no suitable alternative available. There is a risk that the patients will be in a sub-optimal clinical environment which will adversely impact on their safety and wellbeing. There is a further risk of staff having to act outside their competencies which may adversely impact on statutory duty and reputation.</p>	5	5	25	Additional staff allocated to the care of these patients.	5	4	20	<p>Safeguarding discussions ongoing with private care providers with no realistic placement available for the foreseeable future.</p> <p>Away day to plan alternatives to admission with C&W CB. Earmarked area in HYC to allow impact of Sanctuary to be evaluated while reducing impact on Cedar ward and CAMHS patients.</p>	5	2	10	Oct-22	Mental Health & Capacity Legislation Committee	Patient Safety

Mohamed Sarah
17/10/2022 16:32:46

MINUTES OF THE MEETING OF THE MENTAL HEALTH ACT HOSPITAL MANAGERS
POWER OF DISCHARGE SUB COMMITTEE HELD AT 10 AM ON OCTOBER 4th 2022
VIA Teams

Present:

Jeff Champney-Smith Chair, PoD Group
Elizabeth Singer - Vice Chair, PoD Group
Alex Nute - PoD member
Carol Thomas- PoD member
Peter Kelly – PoD member
John Copely – PoD member
Ceri Phillips – Vice -chair Health Board
Sarah Vetter - PoD member
Mair Rawle - PoD member
Mary Williams – PoD member
Wendy Hewitt-Sayer - PoD member
John Owen - PoD member
Alan Parker - PoD member
Amanda Morgan - PoD member

In attendance:

David Seward – Mental Health Act Manager
Morgan Bellamy – Deputy Mental Health Act Manager
Georgia Walsh – Assistant Mental Health Act Administrator
Nicola Jones – Assistant Mental Health Act Administrator
Margaret Jones – PoD member

Apologies:

Sharon Dixon - PoD member
Mike Lewis - PoD member

1. Welcome and Introductions

The meeting was held via Teams and the Chair welcomed all to the meeting.

2. New Members and Independent Members

The Chair welcomed Margaret Jones back as a PoD member.

3. Apologies

Apologies were received and noted.

4. Members points for open discussion

Opening statement from Advocate – there was a wide ranging discussion regarding the merits of asking the advocate to make such a statement. Overall PoD members were supportive of this but it was agreed that this would be left to the discretion of the Chair on the day in discussion with other panel members. **Action – Panel Chairs**

Medical Reports not written by the RC – the Chair confirmed that all medical reports must be counter-signed by the RC if they have not written the report. Further, if there was insufficient information to make a safe decision the Hearing should be adjourned.

Wherever possible, in order to prevent unnecessary adjournments, the Panel Chair should consider the reports well in advance of the Hearing and notify the office if changes were needed. **Action All**

5. Minutes of Meeting held on 5th July 2022

The minutes were confirmed as an accurate record of the meeting.

6. Matters Arising

- **WARNN Risk Assessment** – training of staff is on-going. Once complete training will be arranged for PoD members. **Action MHA Manager**
- **CTP/RA** – the Chair advised that he continues to raise the matter in the various committees he attends.
- **Feedback after hearings** – The Chair has reviewed a random sample of 12 feedback forms. They were not particularly valuable in terms of feedback on the Panel's performance. Many of the issues raised concerned the running of the Hearing. There was a wide ranging discussion with some in favour of scrapping the system whilst others wished to see it being developed. The Chair agreed to re-convene the working group to discuss how to take the issue forward. The Chair will report back at the next meeting. It was noted during the discussions that all aspects of the minutes were uploaded onto the PARIS system. There was concern that if the feedback was incorporated into the minutes this information would be widely available. **Action Chair and working group,**
- **Working with interpreters and people with communication difficulties** – information has been sent out to all PoD members. Panel agreed the information the Chair sent out was useful and no more training was needed.
- **Draft MHA Bill** – no update available at this time.

7. Operational Issues

- **Blind copied emails** – the Health Board (HB) has confirmed that PoD members will not be able to have HB email addresses. The Chair has spoken to the PoD member who has raised the issue as a concern. **No further action**
- **CTP reviews** -The Chair and Vice-Chair have reviewed the CTP's that had been updated following concerns raised at the Managers Hearings. The Chair was able to confirm that the CTP's had all been updated accordingly and the concerns raised by the panels had been addressed.

8. Lessons Learnt

There was a lively discussion regarding the attendance of a solicitor at a recent Hearing. The solicitor had Power of Attorney for the patient but had no Mental Health Act experience. He had been instructed by the family and not the patient. The MHA manager had sought legal advice regarding his attendance at the Hearing. Whilst he was allowed to attend, his attendance was as an observer although the Chair had allowed him to speak at the end of the hearing. Some interesting points were raised during the discussion.

9. MHA Activity Monitoring Reports

Activity reports were provided for the periods April to June 2022 and the period July to September 2022 for both Hospital Managers and Tribunals. It was noted that representation by advocacy in the period July to September 2022 had fallen to 35%. It was agreed that the MHA Manager would discuss with the Manager of the Advocacy Service. Nothing further of note to report. **Action MHA Manager to discuss with IMHA Manager**

10. Concerns/compliments from Power of Discharge group Hearings

These were noted and discussed. The Chair noted the increasing concerns raised regarding nearest relative and has been brought up in the MHLGG. He also thanked

members for complimenting the clinical teams when appropriate. The Annual Report of Concerns and Compliments had been completed. There were no questions or comments with regard to this report. The Chair and MHA Manager explained the process for following up any issues raised. However, if individual PoD members weren't satisfied with the response then this should be raised with the MHA office and include the Chair. **Action ALL**

11. **Committee and Sub-Committee Feedback**

The Chair had nothing further to add.

12. **Training**

The Chair to chase two PoD member's who may be able to help with training on the interaction of the Human Rights Act and MHA. WARNN training to be organised at a future date. **Action Chair and MHA Manager**

13. **A.O.B**

- **Face to face hearings** – there had been one in Cardiff recently that had gone without issue. Other HB's are offering patients the choice. Agreed that patients should have the choice. There is no evidence as to whether virtual hearings are any more or less stressful for the patient than face to face hearings. Clearly there were some benefits of virtual hearings especially as the professional team don't all have to travel. There is also the option of having a hybrid model. PoD members can expect to be asked to attend for face to face hearings in the future. The MHA office had examined the stats on whether there was greater patient participation when Hearings were face to face or virtual. More patients attended the virtual hearings although this was not statistically significant. The paper to be shared with PoD members. **Action MHA office and PoD members**
- **Face to face Business Meeting** – the January business meeting to be face to face followed by a post Christmas lunch. A member asked if the meeting could be a hybrid of face to face and virtual. This was agreed.
- **Paper review** – it was noted our first paper review was being held shortly. This was agreed as the patient was under the care of the Neuropsychiatry team with a diagnosis that won't change. The advocate and patient's nearest relative agreed to the paper review.
- **Xmas leave hearing** - There will be no Hearings during the w/c 26th December. The MHA office will try to avoid listing Hearings for the 22nd and 23rd December. The office will require the minutes to be completed on the same day for any Hearings w/c 19th December.
- **PoD papers** – it was noted that receiving the papers for PoD in several different attachments could be confusing. It will be looked into whether they can be combined into 1 attachment or not. **Action MHA Manager**

Date and time of next meeting – January 10th 2022 10.00 am

Mohamed Sarah
17/10/2022 16:32:46



Minutes of the Mental Health Legislation and Governance Group held at 10:00 on 06 October 2022 via Microsoft Teams

Present

Robert Kidd	(Chair) Consultant Psychologist
David Seward	Mental Health Act Manager
Bianca Simpson Lepore	Deputy Mental Health Act Manager
Morgan Bellamy	Deputy Mental Health Act Manager
Mary Lawrence	Consultant Representative, Adult Acute
Claire Louise Thomas	South Wales Police Representative
Katherine Lewis	Consultant Social Worker DOLS/ AMHP Lead
Lynda Woodley	Operational Manager, Vale of Glamorgan
Alex Allegretto	Independent Mental Health Advocacy Manager
Phillip Ball	Senior Nurse Manager, Cardiff North West Locality
Marianne Seabright	Lead Nurse, MHSOP
Sue Broad	DOL's Lead
Chloe Evans	Mental Capacity Act Lead
Callista Hettiarachichi	Consultant Representative, CAMHs
Andrea Sullivan	Senior Nurse for Quality, Safety & Education

Apologies

Ceri Lovell	Team Leader, CAMHs Crisis Liaison Team
Katie Fergus	Consultant Representative, Adult Acute
Louise Gibbons	South Wales Police Representative
Jeff Champney Smith	Chair, PoD Representative
Ceri Phillips	Vice Chair, Cardiff and Vale UHB
Charles Janczewski	Chair, Cardiff and Vale UHB
Mark Doherty	Director of Nursing (Mental Health)
Jayne Jennings	Senior Nurse Manager, Vale Locality
Darren Shore	Lead Nurse, Adult Mental Health

1 Welcome and Introductions

All those present were welcomed to the meeting. The terms of reference were discussed briefly. These were tweaked by the MHA Manager to hopefully allow them to better fit with the new structures within the Health Board- in particular adult services. These have gone to corporate and will be discussed at the Mental Health Legislation and Mental Capacity Act Committee (MHLMCAC). Discussions are currently being held regarding the locality structures and how they fit into wider groups. It was suggested that a mandatory representative from inpatient nursing would perhaps be beneficial.

2 Apologies for absence

Louise Gibbons- South Wales police and Jeff Champney-Smith, Chair, Power of Discharge Group was noted.

3 Minutes of meeting held on 07 July 2022

Not discussed at length at this meeting but previous minutes were disseminated some time ago and no suggestions for changes have been brought forward at present. Plan to use an action log to shape tasks between meetings agreed.

4 MHA Activity

The activity this quarter has included a small increase in Section 135's and a decrease in the use of Section 5(2). Section 4 was used once during the quarter.

It was pleasing to note that the number of rectifiable errors has decreased this quarter- this was thought possibly due to the push on training by the MHA office.

Work is being put into monitoring the number of times police bring people in for voluntary assessments each quarter. At present the numbers we provide are not totally reflective of the situation but its hoped that over the next couple of quarters this can be improved upon.

The exception report was discussed by the MHA manager. There was one fundamentally defective application this quarter and the rationale behind this was discussed. It was noted that the error that resulted in this defective application was not made by any of our AMHPs but was done by an AMHP from England. This incident has not currently been inputted into DATIX due to complications regarding the new structure of the DATIX system. This will be looked into further as quite a few areas are struggling with the new hierarchy within DATIX.

Action- MHA department to investigate DATIX further.

There was also one instance of a fundamentally defective holding power being used. This was used in UHW and it was discussed that this was potentially a training issue. Work is being done to deliver more training to general health staff about the use of the MHA but due to the high volume of staff turnover and time constraints by both the MHA Office and those in need of training this is a slow process. It was suggested that trying to target the wards that most often use Section 5(2) would perhaps be

beneficial. The MHA office is trying to tackle this issue as soon as possible as it has previously been brought up in the MHLMCAC.

The use of Section 136 has increased but is still within the control limits. One patient whose section lapsed due to the assessment not happening within the 24-hour period was briefly discussed. It was noted that this was an example of how the complications regarding the start of the 24-hour period could manifest. It would be beneficial if staff from A&E could attend this meeting if at all possible. The number of CAMHs Section 136s has decreased it was noted that the repeat presentations were deemed an appropriate use of the Act given the patients circumstances.

It has been confirmed that all MHRTs going forward will be held over Microsoft Teams and it has also confirmed that as of 01/03/2023 hearings will go back face to face. Its not clear on the finer details regarding this- for instance preliminary examinations/ whether choice will be given to the patient regarding face to face or virtual hearings etc. One lead IMHA has highlighted that patients, from her knowledge, would prefer to have face to face preliminary examinations as they feel they can express themselves better and feel they have a more independent examination. The new Senior Operations Manager at the MHRT is very keen to get back to a model more similar to pre-covid as soon as possible.

Action – MHA Manager to confirm finer details on hearings/pre-hearing examinations

Training is continuing to be rolled out and encouraged throughout the clinical board and wider health board. Auditing wards and in particular consent to treatment documents has started again fairly recently and it envisaged that by the next meeting some statistics regarding this can be put together.

It was also noted that the health board has purchased new software that aims to make auditing more consistent across the board (AMaT software). The hope is that it links systems together so its important the MHA department progresses this.

Action- investigate AMaT software

5 Matters Arising

Matters arising are being turned into an action log to hopefully progress matters more quickly.

Additional local secure transport is still being investigated by the Deputy Director of Nursing.

A decision has been made that at present the health board doesn't have the capacity to ask clinicians to further scrutinise consent to treatment documents. Neither the pharmacy department or ward managers are able to take this task on and it was acknowledged that as no particular problems have arisen that have triggered this that it wouldn't be prudent to further burden staff. The Code of Practice does not stipulate that these extra checks must be made and it was also discussed that nurses should already be reconciling CO forms and drug charts when dispensing medication. The responsibility still lies with the doctors to ensure drug charts are

correct. If any incidents occur this can be looked at again. It was suggested that MHA office attendance at ward rounds may be beneficial to see how these are being checked in reality. A template is being made for inpatient reviews as part of the Clinical Boards return to stability programme. The MHA Manager will be provided with a copy of this with the aim of ensuring both the requirements under Section 132 (rights) and Part 4 (consent to treatment) are included in this template.

Action- Ensure inpatient template includes necessary MHA prompts- MHA Manager to liaise with Senior Locality Nurses.

There is no update regarding the shortage of Section 12 doctors but it is acknowledged that this is still an issue.

Voluntary assessments and the monitoring of them has already been discussed earlier in the meeting.

Work is still needed regarding the design of a Section 136 flow chart.

Action- progress the completion of the S136 flow chart.

There has been some movement regarding the health boards position with Section 140 of the MHA. The Lead Nurse for MHSOP shared with us a piece of work she had completed in conjunction with the lead AMHP for MHSOP. A number of discrepancies were picked up within the flow chart but it was noted that it is very encouraging that this is finally being looked into. The two lead AMHPS for Cardiff and the Vale have also been doing some work in relation to the LA's stance on S140 and it was suggested that once the LA leads had completed their work that this could then be shared with the health board to ensure the processes link up smoothly. It was acknowledged that there are times when no bed can be found and the complications of how to maintain a patient's safety whilst decisions are being made need to be discussed between both agencies. Out of area patients and what to do with patients who meet the criteria to be detained but do not reside within our patch also needs to be discussed and agreed. One of the LA leads has found a useful document produced in England that may work as a guide for us. This agenda item is very complicated and involves many different agencies and working arrangements that all need to be discussed and agreed upon so is likely to take a substantial amount of work to resolve.

Action – Lead Nurse from Adult/MHSOP to discuss s140 with Cardiff/Vale LA

The length of time that CAMHs patients spend in Hafan Y Coed is being looked into by the Chair with help from Senior Locality Nurses but is complicated by the fact that patients can remain in Hafan Y Coed informally after having been detained.

Action – Chair to look into data received from Senior Locality Nurses

Unfortunately, there still appears to be a gap in the knowledge of some LA children's services staff who don't always understand their obligations under Section 117 of the MHA. The CAMHs representative informed the group that more of the CAMHs patients eligible for S117 do not have a social worker as the LA believe health alone can fulfil the requirements of aftercare. Training does need to be formulated

regarding this as we need to engage the correct members of staff to overcome this. The LA lead in Cardiff will escalate this to her manager with the aim of having something more definite to discuss by the time of the next meeting, if not before.

Action- Ensure Section 117 training is offered to relevant younger persons team members.

6 Feedback on operational issues and incidents:

Covid 19 continues to have some impact on the functions of the Act- most notably hearings and the fact they are still virtual. Guidance on face masks may well change over the coming months as we head into winter.

There is no update regarding digital signatures.

A subsequent meeting regarding the locked doors in Hafan Y Coed is coming up in the very near future. Some of the agenda items in this are the result of serious incidents that will have been investigated and there may well be discussion regarding the use of the MHA for patients who are de facto deprived of their liberty when in hospital behind two locked doors. Discussions may also be had surrounding the Liberty Protections Safeguards and the impact this will have on decision making. The lead AMHP has offered to share some recent training she has had in relation to informal admissions.

Unfortunately, there is no progress with recording and notifying clinicians of repeat S136 presentations. This is currently with the Digital Lead for the Clinical Board who can hopefully get this moved forward. During the police liaison meetings each month repeat presentations are discussed and investigated if needed.

7 Feedback

Both the Cardiff and Vale of Glamorgan AMHPs forums have fed back that the main issue for AMHPs at present is lack of beds.

There is still lack of clarity surrounding RC allocation for CAMHS patients in Hafan Y Coed. The CAMHS representative has said that ward staff in HYC are automatically allocating Dr Jane Jones as RC for all CAMHS patients which in reality is not the case. It was discussed that this is potentially an easily resolvable problem as it is likely that ward staff are naming Dr Jane Jones by default at the time of entering details into PARIS as an RC must be identified at the time of detention. The CAMHS representative asked that ward staff to check this information before identifying Dr Jones for all patients. It was acknowledged that not all younger people are allocated a consultant and this is likely to be where the confusion is arising from. The younger people's team are currently undergoing changes in their structure which may help resolve this over time.

The police representative identified two instances recently in general health where patients went missing after having been detained under a holding power. These instances were again thought to be a training issue as staff were unaware of the powers that use of the MHA gave them. These may be discussed further at the next meeting.

The advocacy manager informed the group that from an advocacy perspective relationship between patients, staff and advocates has improved since advocates have been allowed back onto the wards. The Advocacy Manager gave his praise to staff who he felt have ensured patients understand their right to an advocate. It was felt that there is good rapport and communication between professionals and advocates at present.

8 Power of Discharge Group comments, compliments and feedback

The Power of Discharge Group had the same concerns as at the previous meeting regarding CTPs and risk assessments and the quality of them. They have also started to note a rise in the number of patients without an identified nearest relative and a lack of movement by the LA to get one allocated or at least investigate further. The Power of Discharge Group would also like training regarding the use of the WARRN risk assessment once this is fully operational.

9 External reviews

There have been no external reviews of mental health services by HIW since the last meeting but it was acknowledged that the recently published report into services at accident and emergency did contain some reference to the Mental Health provision there.

10 Interface MHA/MCA/DOLS

The first meeting of the LPS implementation board is due to be held imminently. This meeting should give more clarity on when these changes are likely to come into force and how the health board plans to move forward with this. The lower age range of the LPS also needs to be considered and how this will impact on the women's and children's clinical board.

11 Quality indicators and audit activities

The chair of the meeting confirmed that himself and the MHA Manager have had discussions surrounding what qualitative data could be collated going forward. It is hoped that the AMaT system might facilitate this. One nurse mentioned the use of the Tendable system in Mental Health and queried how this may connect into the AMaT system. There is concern that at present there isn't a unified voice regarding auditing and this needs to be looked into further.

12 Any other business

The group were unaware of how quickly the Draft Bill to amend the MHA may be pushed through Parliament as it was considered that Government may be seeing other matters as more pressing. A report on the Draft Bill will hopefully be published in December this year.

The Chair of the group did wish to highlight the race and ethnic inequalities report which was seen at the last meeting. It was felt that the driver for the MHA reform is partly at least based on this in England and that we in Cardiff and Vale do need to do

some work on ensuring our use of the MHA on different ethnic groups is recorded more vigorously. The Chair of the group would appreciate feedback on this report.

The stagnation of progress regarding Section 117 eligible people that aren't currently open to a CMHT was discussed. It was agreed that this would be escalated to more senior members of both the LA and health board and then potentially a single point of contact would be allocated to ensuring this task is completed.

Action- Deputy MHA Manager to ensure this task is escalated as agreed.

It was also agreed that the list of Section 135 warrant applications that is currently being compiled in the MHA office will be sent to LA leads to ensure the agreed process is being followed.

Action- Deputy MHA Manager to ensure aforementioned list is circulated as agreed.

Date of future meetings

12 January 2023

06 April 2023

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Mental Health Legislation & Governance Group Action Log

Key:	Red: Outstanding	Amber: In progress	Green: Completed
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ACTIONS FROM PREVIOUS MEETINGS

STATUS	SUBJECT	AGREED ACTION	ACTION BY
<u>To be removed</u>	MHA Training and how to promote with Senior Nurse for EQ&S	MHA Manager met with Senior Nurse for EQ&S and it was agreed the MHA Manager would send info on available MHA training, to be included in the quarterly Sentinel's bulletin that gets sent out	DS
<u>Carried over from 2021</u>	How to record repeat section 136 admissions on PARIS	Digital Lead to look into how repeat 136 presentations can be recorded in PARIS	SM
<u>Revised below</u>	To escalate the s140 discussion	Chair to escalate the s140 discussion by e-mailing the Director of Nursing and Director of Operations	RK
<u>To be removed</u>	Outstanding rights on all wards.	MHA Manager has agreed to e-mail outstanding rights to Locality Senior Nurses on a fortnightly basis to help chase ward/deputy ward managers	DS
<u>Carried over from 2021</u>	Using digital/electronic signatures on MHA documentation	Digital Lead will look into the use of digital/electronic signatures	SM
<u>Revised below</u>	Discuss whether consent to treatment certificates should be scrutinised	MHA Manager met with Senior Nurses and it was felt that it was the responsibility of the doctor to check that the consent to treatment certificate had been updated if the drug chart was changed	DS
<u>Revised below</u>	How to best monitor voluntary assessments	Deputy MHA Manager met with SWP and the Crisis Teams and agreed voluntary assessment data would be shared by the Crisis Team monthly to ensure all assessments are being recorded accurately	BS-L
<u>Carried over from 2022</u>	Create an easy to follow flow chart for the 136 process	MHA Manager to arrange to meet with SWP to discuss and create flow chart	DS, C-LT
<u>Revised below</u>	Length of time CAMHS patients are in HYC	Chair to gather data from ActionPoint in order to investigate how long CAMHS patients are in HYC	RK

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Revised below	117 knowledge gaps in CAMHS teams	Chair to investigate the knowledge gaps for 117 specifically in CAMHS teams	RK
	Shortage of s12 doctors	Chair to discuss the shortage of s12 doctors with relevant colleagues and escalate as appropriate	RK
Revised below	RC responsibility for CAMHS patients in HYC	Consultant Rep clarified that Jane Jones will be RC unless patient is known to the CITT team and Callista Hettiarachchi would be the RC	ML
Revised below	Tribunal pre-hearing examinations returning	MHA Manager spoke to Senior Operations Manager at Tribunals and is waiting an update from the Tribunal President—update that face to face hearings are starting from 01/03/23	DS
To be removed	Easy and accessible LPS updates	Chair to create an LPS Teams channel and invite appropriate colleagues	RK
	DATIX forms	Ensure completion of DATIX forms for transportation/conveyancing problems in order to monitor the situation	RK

ACTIONS FROM THIS MEETING – 6TH OCTOBER 2022

STATUS	SUBJECT	AGREED ACTION	ACTION BY
	Process of DATIX forms	MHA Manager to investigate the DATIX hierarchy system.	DS
	Secure transport	Deputy Director of Nursing is looking into alternative secure transport. Colleagues are encouraged to complete DATIX forms for transportation/conveyancing problems in order to monitor the situation	TR
	S140 discussion	Cardiff/Vale LA to share their work on s140 with Lead Nurse Adult/MHSOP and to discuss further together.	MS/KL/LW
	Scrutinising consent to treatment certificates	MHA Manager to attend ward rounds to ensure certificates are being checked and to see how the inpatient review forms are being used in reality.	DS
	Length of time CAMHS patients are in HYC	Chair to investigate the data received from SW Senior Locality Nurse on how long CAMHS patients are in HYC and if informal patients are included	RK
	117 knowledge gaps in CAMHS teams	CAMHS rep to raise the issue again with her seniors and the Lead AMHP for Cardiff will also raise the issue with her seniors to try and progress the issue	CH/KL/RK
	RC responsibility for CAMHS patients in HYC	Ward staff are to check with CAMHS who the RC is before allocating on PARIS. NW Senior Locality Nurse to inform wards	PB
	Tribunal face to face hearings	MHA Manager to speak to Senior Operations Manager at the Tribunal to get finer details for returning to face to face	DS

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Report Title:	Policies Review of Detention & Community Treatment Order Policy & Procedure. Patient Rights Information to Detained & Community patients' Policy & Procedure Application for Admission under Part II of the Mental Health Act Policy & Procedure			Agenda Item no.	12.1
Meeting:	Mental Health Legislation and Mental Capacity Act Committee	Public	X	Meeting Date:	25 th October 2022
Status <i>(please tick one only):</i>	Assurance	Approval	X	Information	
Lead Executive:	Mental Health Clinical Board Director of Operations				
Report Author (Title):	Mental Health Act Manager – David Seward				
Main Report Background and current situation:					
<p>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.</p> <p>The review of detention & community treatment order policy & procedure sets out the requirements and criteria of reviewing a patient's detention and community treatment order along with the process of reviewing these for practitioners and agencies involved in the application and management of patient's detained or subject to a community treatment order under the Mental Health Act 1983 (as amended by the Mental Health Act 2007).</p> <p>The patient rights information to detained & community patients' policy & procedure sets out the requirements, process and duty of staff of giving information to informal, detained and community patients and their nearest relatives regarding their detention, consent to treatment provisions, advocacy and the role of Healthcare Inspectorate Wales in a suitable format and timely way.</p> <p>The application for admission under Part II of the Mental Health Act policy & procedure sets out the requirements, purpose and process of assessing the suitability for admission and the duties of the practitioners and agencies involved in the application and management of patients admitted under the Part II of the Mental Health Act.</p> <p>These documents provide 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.</p>					
Executive Director Opinion and Key Issues to bring to the attention of the Board/Committee:					
<p>The current review of detention & community treatment order policy & procedure has been reviewed and amended accordingly:</p> <ul style="list-style-type: none"> • Removal of glossary of terms • Expanded on paragraphs throughout for easier reading and understanding 					

- Expanded on who can be consulted when renewing a detention/extending a CTO due to recent legal advice
- Added section relating to patients who are absent without leave (AWOL).

The current patient rights information to detained & community patients' policy & procedure has been reviewed and amended accordingly:

- Expanded on paragraphs throughout for easier reading and understanding
- Added section on 'Information following a CTO recall to hospital'
- Added section on 'Information about withholding correspondence'
- Added section on 'Information on seeking discharge from detention or CTO'
- Enhanced section on 'recording the reading of rights to a patient' to offer more clarity

The current application for admission under Part II of the Mental Health Act policy & procedure has been reviewed and amended accordingly:

- Removal of glossary of terms
- Enhanced section on receiving detention papers to offer more clarity
- Expanded on paragraphs throughout for easier reading and understanding

These policies and procedures will ensure that the Health Board remains compliant with their statutory duty under the Mental Health Act.

Wide consultation has taken place to ensure that the policy and procedure meets the needs of our stakeholders and the Health Board. The consultation undertaken specific to these documents were as follows: -

- The review of detention & community treatment order policy & procedure was added to the Policy Consultation pages on the intranet between 26th May 2022 and 23rd June 2022;
- The patient rights information to detained & community patients' policy & procedure was added to the Policy Consultation pages on the intranet between 12th September 2022 and 10th October 2022;
- The application for admission under Part II of the Mental Health Act policy & procedure was added to the Policy Consultation pages on the intranet between 12th September 2022 and 10th October 2022;
- The documents were shared with the Mental Health Policy Group, Adult and MHSOP Directorate Medics, Adult and MHSOP Directorates, 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 and the Principal Health Promotion Specialist.

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

The primary source for dissemination of these documents 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.

Recommendation:

The Committee is requested to:

a) **APPROVE**

- (i) the Review of Detention & Community Treatment Order Mental Health Act 1983 Policy and the Review of Detention & Community Treatment Order, Mental Health Act 1983 Procedure;

- (ii) the Patient Rights Information to Detained & Community Patients' under Mental Health Act 1983 Policy and & Patient Rights Information to Detained & Community Patients' under Mental Health Act 1983 Procedure; and
- (iii) the application for Admission to Hospital under Part II of the Mental Health Act Policy and the application for Admission to Hospital under Part II of the Mental Health Act Procedure; and
- b) **APPROVE** the full publication of the Policies and Procedures referred to under recommendation a) above, in accordance with the UHB Publication Scheme.

Link to Strategic Objectives of Shaping our Future Wellbeing:

Please tick as relevant

1. Reduce health inequalities	X	6. Have a planned care system where demand and capacity are in balance	X
2. Deliver outcomes that matter to people	X	7. Be a great place to work and learn	X
3. All take responsibility for improving our health and wellbeing	X	8. Work better together with partners to deliver care and support across care sectors, making best use of our people and technology	X
4. Offer services that deliver the population health our citizens are entitled to expect	X	9. Reduce harm, waste and variation sustainably making best use of the resources available to us	X
5. Have an unplanned (emergency) care system that provides the right care, in the right place, first time	X	10. Excel at teaching, research, innovation and improvement and provide an environment where innovation thrives	X

Five Ways of Working (Sustainable Development Principles) considered

Please tick as relevant

Prevention	X	Long term	X	Integration	X	Collaboration	X	Involvement	X
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Impact Assessment:

Please state yes or no for each category. If yes please provide further details.

Risk: Yes/No

No

Safety: Yes/No

No

Financial: Yes/No

No

Workforce: Yes/No

No

Legal: Yes/No

Yes – detail provided in the report regarding compliance with the Mental Health Act

Reputational: Yes/No

No

Socio Economic: Yes/No

No

Equality and Health: Yes/No

No

Decarbonisation: Yes/No

No

Approval/Scrutiny Route:

Committee/Group/Exec

Date:

Reference Number: TBA Version Number: 2	Date of Next Review: TBA Previous Trust/LHB Reference Number:
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REVIEW OF DETENTION AND COMMUNITY TREATMENT ORDER, MENTAL HEALTH ACT 1983 POLICY

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 carrying out a review of detention and Community Treatment Order (CTO) under the Mental Health Act 1983.

Practitioners will have due regard to the Mental Health Act Code of Practice generally and specifically when managing patients considered for renewal of detention or extension of community treatment. 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 renewal of detention or extension of community treatment 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 review of detention and community treatment orders under 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 detention or CTO.

This does not apply to restricted patients without the consent of the Secretary of State for Justice

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 Review of Detention and Community Treatment Order, Mental health Act 1983 Policy describe the following with regard to a review:

- The purpose of a review
- The process for assessing the suitability for the continued use of detention or community treatment
- The duties of the practitioners and agencies involved in the management of patients subject to detention and community treatment

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 Legislation Committee
Accountable Executive or Clinical Board Director	Mental Health Clinical Board Director of Operations

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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 12/02/2019	TBA	<i>New document</i>
2	20/10/2022		N/A

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Equality & Health Impact Assessment for

REVIEW OF DETENTION AND COMMUNITY TREATMENT ORDER, MENTAL HEALTH ACT 1983 POLICY

1.	For service change, provide the title of the Project Outline Document or Business Case and Reference Number	REVIEW OF DETENTION AND COMMUNITY TREATMENT ORDER, MENTAL HEALTH ACT 1983 POLICY
2.	Name of Clinical Board / Corporate Directorate and title of lead member of staff, including contact details	Mental Health Clinical Board David Seward, Mental Health Act Manager 029 21824746 David.Seward@wales.nhs.uk
3.	Objectives of strategy/ policy/ plan/ procedure/ service	<p>The aim of this policy is to ensure staff are aware of their individual and collective responsibilities when carrying out a review to consider renewal of detention or extension of community treatment.</p> <p>Provide clear guidance to staff in relation to their legal responsibilities under the Mental Health Act 1983 as amended by the MHA 2007.</p> <p>Ensure that statutory requirements under the Mental Health Act 1983 are met.</p> <p>Practitioners should have due regard to the Mental Health Act Code of Practice generally and specifically to the Guiding Principles when they carrying out a review to consider renewal of detention or extension of community treatment. This would ensure that considerations are given as to whether the objectives can be met in a less restrictive way.</p>

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<p>4.</p>	<p>Evidence and background information considered. For example</p> <ul style="list-style-type: none"> • 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 <p>Population pyramids are available from Public Health Wales Observatory¹ and the UHB's 'Shaping Our Future Wellbeing' Strategy provides an overview of health need².</p>	<p>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</p> <p>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.</p> <p>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)</p> <p>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).</p> <p>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</p>
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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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		<p>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.</p> <p>Results of Welsh Health Survey 2015 – reported in Mental Health Foundation Fundamental Facts 2016:-</p> <p>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, 1 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.</p> <p>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.</p> <p>The Mental Health Act relates to all patients suffering from a mental disorder who meet the criteria for detention, irrespective of age.</p> <p>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)</p>
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		<p>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</p> <p>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.</p> <p>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:-</p> <p>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.</p>
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		<p>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.</p> <p>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.</p> <p>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.</p> <p>This policy will apply regardless of gender.</p> <p>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.</p> <p>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</p>
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		<p>relating to lesbian, gay, bisexual and trans (LGBT) people, which is resulting in unfair treatment of both LGBT patients and colleagues.</p> <p>The NHS Centre for Equality and Human Rights (CEHR) has published a new guide for all staff in NHS Wales. <i>“It’s Just Good Care – A guide for health staff caring for people who are trans*”</i> 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</p> <p>Human Rights - The proposed policy promotes human rights in ensuring that all patients are detained lawfully.</p> <p>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</p> <p>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</p>
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		<p>Health, in the UK, 20% of women are affected by mental health problems during the perinatal period.¹¹ In Wales, 70% of people have no access to specialist perinatal mental health services; a figure significantly higher than the UK average of 40%.</p> <p>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.</p> <p>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.</p> <p>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 <u>admissions</u> 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.</p> <p>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</p>
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		<p>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”)</p> <p>The proposed policy will apply regardless of the race / ethnicity of patients or staff.</p> <p>Health inequalities are further linked to unequal access to healthcare. Some BAME groups face considerable barriers to healthcare.</p> <p>In 2009 the Department for Communities and Local Government <u>noted</u> 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.</p> <p>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 <u>included</u> poor continuity of care and the experience of not having the same doctor in the practice.</p> <p>A Cultural Competency Toolkit, was developed by Diverse Cymru, with</p>
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		<p>assistance from UHB staff. Its aim is to help staff better interact with clients with mental ill health who are from different cultures</p> <p>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.</p> <p>Within the explanation of rights this now details if the information has been given in the patients preferred language and will be reported on.</p> <p>Access to an interpreter is available and translation of written information can be obtained as and when required.</p> <p>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”).</p> <p>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),</p>
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		<p>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.</p> <p>The proposed policy will apply regardless of the religion or belief of patients or staff.</p> <p>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”).</p> <p>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.</p> <p>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.</p> <p>This report also provides hard evidence that gay and bisexual men nationwide are more likely to attempt suicide, self-harm and have</p>
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		<p>depression than their straight peers.</p> <p>The proposed policy will apply regardless of the sexual orientation of the patients or staff.</p> <p>Welsh Language - No evidence of disproportional representation to date, but a proportion of service users may be Welsh speakers</p> <p>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.</p> <p>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.</p>
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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).

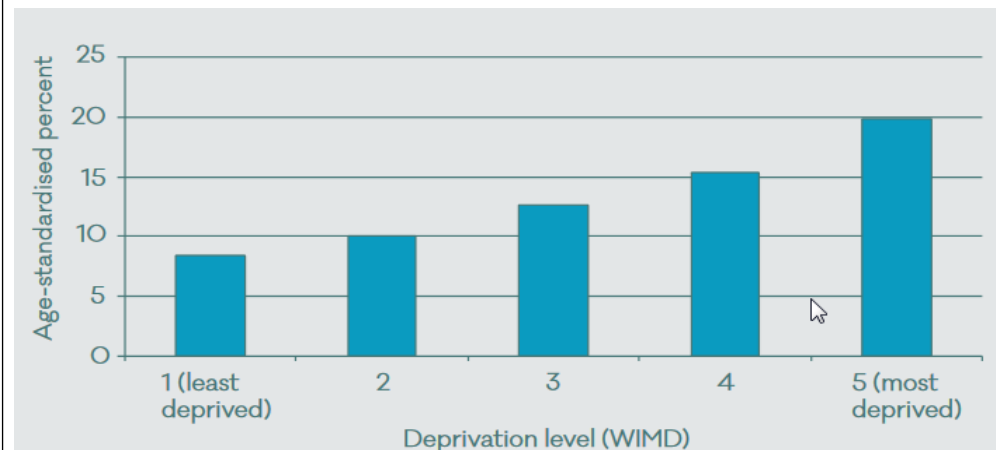
Between 30% and 50% of people with schizophrenia are capable of work but only between 10% and 20% are in employment (Marwaha and Johnson, 2004; Schneider, 1998). Although some are in managerial or senior official positions, most are in 'elementary' jobs, for example cleaning and labouring, or are in 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 et al., 1992; Johnstone et al., 1986). For people with Schizophrenia,

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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 range of outcomes for individuals and communities. These include

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		<p>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.</p> <p>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 <i>distribution</i> 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</p>
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		<p>poverty.</p> <p>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.</p> <p>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' <i>a/so</i> 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).</p> <p>This policy will apply regardless of where a person lives.</p> <p>(From: http://www.euro.who.int/_data/assets/pdf_file/0012/100821/E92227.pdf</p>
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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_asylum_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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		<p>26% of women and 16% of men said they had received treatment for a mental health problem in the year before custody.</p> <p>Personality disorders are particularly prevalent among people in prison. 62% of male and 57% of female sentenced prisoners have a personality disorder.</p> <p>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.</p> <p>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.</p> <p>http://www.prisonreformtrust.org.uk/ProjectsResearch/Mentalhealth</p> <p>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 there are higher incidences of mental health issues among certain protected groups.</p> <p>Mind's report "Our Communities, Our Mental Health" identified the following contributory risk factors:-</p> <p>Trauma and stressful events, poverty, unemployment and housing insecurity, social isolation and loneliness, discrimination and inequality.</p>
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		<p>These risk factors may be present in any protected group.</p> <p>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'.</p> <p>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.</p> <p>Community treatment orders are not a good thing -Simon Lawton-Smith / John Dawson and Tom Burns)</p> <p>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,</p>
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		<p>increased medication compliance and feelings of empowerment. The negative feedback included feelings of being coerced and the stigma associated with it.</p> <p>(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)</p> <p>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.</p> <p>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.</p>
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		<p>(A Question of Numbers – Potential Impact of Community Based Treatment Orders in England and Wales” Simon Lawton Smith for the Kings Fund Sept 2005)</p> <p>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.</p>
5.	Who will be affected by the strategy/ policy/ plan/ procedure/ service	<p>Mental health issues affect the whole population, though some protected groups are disproportionately represented among service users.</p> <p>The policy addresses administrative issues and responsibilities in relation to direct care and treatment of patients.</p> <p>The Review of detention and Community Treatment 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.</p>

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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: <ul style="list-style-type: none"> • 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.	
<p>6.3 People of different genders: Consider men, women, people undergoing gender reassignment</p> <p>NB Gender-reassignment is anyone who proposes to, starts, is going through or</p>	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.	<i>"It's Just Good Care – A guide for health staff caring for people who are trans**" is made available to staff</i>	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.	<i>"It's Just Good Care – A guide for health staff caring for people who are trans*" is made available to staff.</i>	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	<p>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.</p>	<p>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</p>	<p>Under Policy Statement</p> <p>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.</p>

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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: <ul style="list-style-type: none"> • 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.		
<p>6.9 People who communicate using the Welsh language in terms of correspondence, information leaflets, or service plans and design</p> <p>Well-being Goal – A Wales of vibrant culture and thriving Welsh language</p>	<p>There is the potential for a negative impact. However staff have to take into account the diverse needs of the individual patient.</p>	<p>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</p>	<p>Under Policy Statement</p> <p>Staff are made aware of the translation and interpretation policy.</p>

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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	<p>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.</p> <p>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.</p>	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
<p>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</p> <p>Well-being Goal - A more equal Wales</p>	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
<p>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</p>	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
<p>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</p> <p>Well-being Goal – A healthier Wales</p>			
<p>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</p>	<p>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.</p>	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			
<p>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</p> <p>Well-being Goal – A resilient Wales</p>	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
<p>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</p> <p>Well-being Goal – A Wales of cohesive communities</p>	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
<p>7.6 People in terms of macro-economic, environmental and sustainability factors: Consider the impact of</p>	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
<p>government policies; gross domestic product; economic development; biological diversity; climate</p> <p>Well-being Goal – A globally responsible Wales</p>	<p>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.</p>		

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

<p>8.1 Please summarise the potential positive and/or negative impacts of the strategy, policy, plan or service</p>	<p>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.</p> <p>.</p> <p>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</p> <p>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.</p>
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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
<p>8.4 What are the next steps?</p> <p>Some suggestions:-</p> <ul style="list-style-type: none"> • Decide whether the strategy, policy, plan, procedure and/or service proposal: <ul style="list-style-type: none"> ○ 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 	<p>No significant negative Impact.</p> <p>The policy will be submitted to the Health Systems Management Board for consideration and the Mental Health and Capacity Legislation Committee for approval.</p> <p>Once the policy has been approved the documentation will be placed on the intranet and internet.</p> <p>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.</p>	N/A	N/A	<p>N/A</p> <p>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.</p> <p>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.</p>

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Version Number: 2	Previous Trust/LHB Reference Number: N/A
REVIEW OF DETENTION AND COMMUNITY TREATMENT ORDER, MENTAL HEALTH ACT 1983 PROCEDURE	
Introduction and Aim	
<p>This document supports the Review of Detention and Community Treatment Order, Mental Health Act 1983 Policy.</p> <p>To ensure staff are aware of their individual and collective responsibilities when reviewing detention and community treatment order's (CTO) under the Act.</p> <p>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.</p> <p>To Ensure that statutory requirements under the Mental Health Act 1983 are met.</p>	
Objectives	
<p>This Procedure describes the following with regard to renewing detention and extending a community treatment order:</p> <ul style="list-style-type: none"> • The purpose of reviewing detention and CTO • The process for reviewing detention CTO • The duties of the practitioners and agencies involved in the management of reviewing detention and CTO <p>Practitioners must have due regard to the Mental Health Act Code of Practice generally and specifically to the Guiding Principles when they are reviewing detention or CTO. This will ensure that considerations are given as to whether the objectives can be met in a less restrictive way.</p>	
Scope	
<p>This procedure applies to all of our staff in any inpatient or community setting where a person is liable to be detained or who is subject to a CTO and the Associate Mental Health Act Managers who have delegated responsibility from the Board.</p>	

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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	<ul style="list-style-type: none"> • 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 <p>All Cardiff and Vale policies on the Mental Health Act 1983 as appropriate including:</p> <p>Review of detention and Community Treatment Order Policy Community Treatment Order Policy Community Treatment Order Procedure Hospital Managers' Scheme of Delegation Policy Hospital Managers' Scheme of Delegation Procedure 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</p>
Approved by	Mental Health and Capacity Legislation Committee

Accountable Executive or Clinical Board Director	<i>Mental Health Clinical Board Director of Operations</i>
Author(s)	<i>Mental Health Act Manager</i>

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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	12/02/2019	14/02/2019	<i>New document</i>
2	20/10/2022		<i>Removal of glossary</i> <i>Expanded on paragraphs throughout for easier reading</i> <i>Expanded on who can be consulted when renewing a detention/extending a CTO</i> <i>Added section relating to patients who are absent without leave (AWOL)</i>

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1. INTRODUCTION

The Mental Health Act gives the Hospital Managers the power to renew detention and extend a CTO. These persons are known as Associate Hospital Managers or the Power of Discharge Group. Some functions of the Hospital Managers are also delegated to the Mental Health Act Department, such as

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accepting reports that have been furnished to the Hospital Managers. This does not apply to restricted patients without the consent of the Secretary of State for Justice (Ministry of Justice). This procedure is to ensure that the Health Board meets its responsibilities in relation to renewing detention and extending CTO.

2. PROCEDURE STATEMENT

This procedure has been developed to guide staff on the management of patients considered for renewal of detention or extension of CTO. This guidance has been developed in line with the Mental Health Act 1983 Code of Practice for Wales (Revised 2016).

It provides guidance on the role and responsibilities of the Responsible Clinician (RC), other professionals involved and the role of the patient's nearest relative. Due consideration should be given to the use of the option with the least possible restrictions.

3. SCOPE

This procedure applies to all staff working in Cardiff and Vale University Local Health Board whose role involves the care and treatment of patients/service users covered under the Mental Health Act and the Associate Mental Health Act Managers who have delegated responsibility from the Board.

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.

4. DETENTION: RENEWAL, DISCHARGE OR CTO

Before a patient's detention or CTO expires, the RC must decide whether the patient's current period of detention should be renewed or CTO extended. The RC must examine the patient and decide within the two months leading up to the expiry of the patient's detention or CTO whether the criteria for renewing detention under section 20 of the Act or extending the CTO under section 20A are met, or whether discharge is appropriate.

The RC should discuss their decision to renew/extend with the patient and must consult one or more other people who have been professionally concerned with the patient's medical treatment. The RC should also consult the wider multi-disciplinary team (MDT). Where appropriate, this should include the nearest relative, the independent mental health advocate (IMHA) and/or other

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representatives, and any other key service providers.

The Mental Health Act Department will advise the RC via e-mail and they will also receive the PARIS daily report confirming that the detention or CTO is due to expire within 2 months and that the patient needs to be examined in order to renew the detention or extend the CTO.

The Mental Health Act Department will arrange a hearing date for the Hospital Managers (Power of Discharge Group) to sit and review the patients' case. They will either support the renewal of detention/extension of CTO or they will exercise their power of discharge. Please see 18 below for further information.

5. EXAMINATION OF THE PATIENT

If a patient refuses to be examined or is assessed as being either too ill or too disturbed to be examined, the RC's examination of the patient could comprise of:

- Their observations of the patient
- A consideration of the patient's medical history and prognosis
- An evaluation of the patient's current condition in an MDT case conference

The examination could take place on an out-patient basis if the patient is on section 17 leave.

A mandatory condition of a CTO is that a patient must make themselves available for examination under Section 20A, as requested.

The patient's compliance with the conditions will be a key indicator of how a CTO is working in practice. If the patient is not complying, the reasons for this should be properly investigated. Appropriate action will be needed, which may indicate a need to consider recall to hospital.

6. RENEWAL OF DETENTION (SECTION 20)

In order to renew detention, the patients RC must submit Form HO15 to the Hospital Managers (Mental Health Act Department) confirming that the following conditions are satisfied:

- The patient is suffering from mental disorder of a nature or degree which makes it appropriate for him to receive medical treatment in a hospital; and
- It is necessary for the health or safety of the patient or for the protection of other persons that he should receive such treatment and that it

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- cannot be provide unless he continues to be detained; and
- Appropriate medical treatment is available to him

Where the RC is satisfied that the criteria for renewing the patient's detention are met, they must complete part 1 of the statutory renewal report (Form HO15), which includes naming a person who the RC has consulted with and which can be different to the person who signs part 2. Part 1 must be completed before part 2 below.

7. SECOND PROFESSIONAL

Before the RC can submit the statutory renewal of detention report, they are required to consult with one or more other persons and obtain the written agreement of another person that the criteria are met. The other person must be professionally concerned with the patient's treatment and must not belong to the same profession as the RC.

The involvement of a second professional is intended to provide an additional safeguard for patients by ensuring:

- Renewal is formally agreed by at least two suitably qualified and competent professionals who are familiar with the patient's case
- Those two professionals are different disciplines, and so bring different complementary, professional perspectives to bear
- The two professionals are able to reach their own decisions independently of one another

The second professional should:

- Have sufficient experience and expertise to decide whether the patients continued detention is necessary and lawful
- Have been actively involved in the planning, management or delivery of the patients care and treatment
- Have had sufficient recent contact with the patient to be able to make an informed judgement about the patient's case.

Second professionals should satisfy themselves, they have sufficient information on which to make the decision or whether they need to meet separately with the patient. RC's should ensure the second professional is given enough notice to be able to interview or examine the patient if appropriate.

If the second professional is in agreement with the RC they must complete part 2 of the statutory renewal report (Form HO15). The person who signs part

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2 can be a different person to the one named in part 1. The RC is now able to complete part 3 of the form and furnish to the Hospital Managers (Mental Health Act Department).

It is submitted that in the event of the second professional deciding that the grounds for renewal are not satisfied, the agreement of another second professional could be sought even if there are no “exceptional circumstances”.

8. EXTENDING A CTO (SECTION 20A)

In order to extend a CTO, the patients RC must submit Form CP3 to the Hospital Managers (Mental Health Act Department) confirming that the following conditions are satisfied:

- The patient is suffering from mental disorder of a nature or degree which makes it appropriate for him to receive medical treatment;
- It is necessary for his health or safety or for the protection of other persons that he should receive such treatment;
- Subject to his continuing to be liable to recalled, such treatment can be provided without his being detained in hospital;
- It is necessary that the RC should continue to be able to exercise the power under section 17E(1) above to recall the patient to hospital; and
- Appropriate medical treatment is available for him

They must also consult with one or more other people who have been professional concerned with the patient’s medical treatment.

Where the RC is satisfied that the criteria for extending the patient’s CTO are met, they must complete part 1 of the statutory report (Form CP3) before part 2 below can be completed.

9. APPROVED MENTAL HEALTH PROFESSIONAL (AMHP)

Before the RC can submit the report (Form CP3), they must obtain the written agreement of an AMHP. The RC should ensure the AMHP is given enough notice to be able to interview the patient if appropriate, however, this isn’t a requirement.

The AMHP does not have to be the same AMHP who originally agreed the patient should become a CTO patient. It may (but need not) be an AMHP who is already involved in the patient’s care and treatment. It can be AMHP acting on behalf of any willing local authority. If no other local authority is willing, responsibility for ensuring that an AMHP considers the case should lie with

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the local authority which is responsible under section 117 for the patient's after-care.

If the AMHP is in agreement with the RC they must complete part 2 of the statutory report (Form CP3). The RC is now able to complete part 3 of the form by naming a person they have consulted with, which must be a different person to the AMHP named in part 2 unless they have been professionally concerned with the patient's treatment. The report is then furnished to the Hospital Managers (Mental Health Act Department) (see 12 below furnishing the report to the Hospital Managers)

10. PATIENTS WHO ARE AWOL AND RETURN WITHIN 28 DAYS (SECTION 21A)

If a patient is AWOL (absent without leave) during the week before the detention expires and returns to hospital within 28 days, section 21A applies for the purpose of renewal. The detention is extended for up to 1 week (under section 21) after the patient's return to hospital to enable the RC to examine the patient and a renewal report under section 20 (Form HO15) as above completed, if appropriate. The renewal has effect from the date when the authority for detention would have expired if it had not been extended.

11. PATIENTS WHO ARE AWOL AND RETURN MORE THAN 28 DAYS (SECTION 21B)

In order to renew the detention of a patient who has been AWOL (absent without leave) for more than 28 days, section 21B applies for the purpose of renewal and requires an examination to take place by the RC. This must be done within 1 week (under section 21) of the patient's return and the statutory renewal report (Form HO16) must be completed.

Where the RC is satisfied that the criteria for renewing the patient's detention are met, they must complete part 1 of the statutory renewal report (Form HO16), which includes naming an AMHP and another person who the RC has consulted with. The RC is now able to furnish the form to the Hospital Managers (Mental Health Act Department) (see 12 below).

A failure by the RC to complete the statutory renewal report (Form HO16) within that week will result in the automatic expiry of that detention.

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12. FURNISHING THE REPORT TO THE HOSPITAL MANAGERS

A report is furnished to the Hospital Managers (Mental Health Act Department) when it is committed to the internal mailing system or alternatively handed to a person authorised by the Hospital Managers to receive it, for the purposes of renewal of detention or extending a CTO, authorised persons are the Mental Health Act Department only (see Hospital Managers Scheme of Delegation Policy).

If the report is being furnished through the internal mailing system it must first be either faxed to the Mental Health Act Department (029 21824740) or scanned and emailed to the generic account (Mentalhealthact.Team.CAV@wales.nhs.uk).

The furnishing of the RC's report gives authority for continued detention/extension of CTO of the patient. If the authorised period of detention expires without there being a report duly furnished, any detention after the expiry date will plainly be unlawful and renders the Hospital Managers at risk of successful challenge.

13. NOT HOLDING A REVIEW BEFORE DETENTION/CTO EXPIRES

If authority for detention is not renewed and the patient continues to be kept in circumstances which amount to a deprivation of liberty this will be a breach of the patients' rights under Article 5 of the European Court of Human Rights (ECHR).

The RC should notify the Hospital Managers immediately by contacting the Mental Health Act Manager. The Hospital Managers should report the breach to Healthcare Inspectorate Wales (HIW) as a serious incident and the patient informed.

The patient must be informed and either immediately discharged or there must be lawful authority to continue to detain the patient, for example, in exercise of the holding powers in the Act. If necessary a new application for admission or assessment should then be made. The Hospital Managers should ensure a review is undertaken within one month to determine why this has happened and what actions have been taken to resolve this and to ensure that it won't happen again in the future.

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14. RESPONSIBLE CLINICIANS POWER OF DISCHARGE

Section 23 of the Act allows RC's to discharge Part 2 patients, unrestricted Part 3 patients and all CTO patients by giving a discharge order in writing. As RC's have the power to discharge patients, they must keep under review the appropriateness of using that power. If, at any time, a RC concludes that the criteria which would justify renewing a patient's detention or extending the patient's CTO are not met, they should exercise their power of discharge by completing Form HO17 for inpatients or a CP8 for a patient on a CTO and posting to the Mental Health Act Department, but it must first be either faxed (029 21824740) or scanned and emailed to the generic account (Mentalhealthact.Team.CAV@wales.nhs.uk). The RC should not wait until the patient's detention or CTO is due to expire to discharge.

15. NEAREST RELATIVE'S POWER OF DISCHARGE

A patient detained for assessment or treatment under Part 2 of the Act may also be discharged by their nearest relative. The Hospital Managers (Mental Health Act Department) and/or detaining AMHP should ensure the nearest relative is aware of the power and how to use it.

Before giving a notice or discharge order, the nearest relative must give the Hospital Managers (Mental Health Act Department) at least 72 hours' notice in writing, specifying that as the nearest relative, they are using their powers of discharge of their intention to discharge the patient. A discharge order given without prior notice should be treated as being both a notice and order of intention to discharge the patient after 72 hours.

The 72-hour period starts to run from the date/time when the notice is received by an authorised person on behalf of the Hospital Managers, which is either the shift coordinator or Mental Health Act Department.

During that period the patient's RC can block the discharge by issuing a 'barring report' (Form NR1) stating that, if discharged, the patient is likely to act in a manner dangerous to themselves or others.

The barring report should also detail the likelihood and nature of such dangerous acts, such as causing serious physical injury or lasting psychological harm and, not merely the patient's and others general need for safety and protection. If a RC wishes to block a patient's discharge by issuing a barring report, a copy should be given to the patient and to the nearest relative.

It will only be in the most exceptional circumstances that a copy would not be given, e.g. details in the report contain the patient's stated intention to harm the

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nearest relative.

The Mental Health Act Department will liaise with the RC to ensure the patient is examined within the 72 hours and a decision is made as to whether a barring notice will be issued by the RC.

If a barring order is issued the Mental Health Act Department will make arrangements for a Hospital Manager's hearing to be held within four weeks of the barring order being issued.

16. DISCHARGE BY THE HOSPITAL MANAGERS AND THE MENTAL HEALTH REVIEW TRIBUNAL FOR WALES

Patients may also be discharged by the Hospital Managers (Power of Discharge Group) or by the Mental Health Review Tribunal for Wales. See Power of Discharge Hospital Managers Hearing Protocol and the Mental Health Review Tribunal Procedure.

17. HOSPITAL MANAGERS' DISCHARGE POWER

Hospital Managers (Mental Health Act Department) should ensure all relevant parties, nearest relatives and, if different, their carer's are aware that patients have the right to seek discharge by the Hospital Managers (Power of Discharge Group). They also need to understand the distinction between this right and the right to apply to the Mental Health Review Tribunal for Wales.

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 RC submits a report to them under section 20 of the Act for renewing detention or under section 20A extending the CTO.
- Should consider holding a review when they receive request from the patient. Such a request may be supported by a carer, their independent mental health advocate (IMHA), independent mental capacity advocate, by their attorney or deputy.
- Must consider holding a review when the RC makes a report to them under section 25(1) barring an order by the nearest relative to discharge a patient.

In the last two cases, when deciding whether to consider the case, Hospital Managers should take into account whether the MHRT for Wales has recently

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considered the patient's case or is due to do so in the near future. The decision reached should be recorded in writing. If the decision is not to consider the case the reasons why not should be documented. This will be facilitated by the Mental Health Act Department.

In these cases, the patient, or the nearest relative, will be actively seeking discharge. Where the RC submits a report renewing detention or extending a CTO, the Hospital Managers must consider the renewal or extension even if the patient does not object to it.

A restricted patient is entitled to ask the Hospital Managers to consider whether they should conduct a review of his or her detention, although the Hospital Managers may not discharge the patient following any such review without the consent of the Secretary of State for Justice (Ministry of Justice).

18. HOSPITAL MANAGERS HEARING

When a hearing is due to be arranged, the Mental Health Act Department will request a date from the RC and social worker/lead, that has already been confirmed by both, and send report requests to the professionals. Reports are required from the RC, allocated social worker or CPN and primary ward nurse or care coordinator 2 weeks before the hearing. These reports get sent to the Hospital Managers panel in advance of the hearing along with the advocate (if they have one) and the nearest relative (if the patient consents to it). With these reports, there must be an up to date risk assessment and care and treatment plan provided.

The patient's RC, allocated social worker or CPN and primary ward nurse or care coordinator must attend the hearing to represent their report. If they are unavailable due to sickness then a professional who knows the patient can attend on their behalf. They must be familiar with the patient's case and have met the patient prior to the hearing. The patient's nearest relative will be informed of the review and invited to attend, provided that the patient consents.

19. 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 Department or looking on the Mental Health Act intranet page via CaV web.

20. 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.

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21. RESPONSIBILITIES

21.1 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.

21.2 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.

21.3 Designated Individuals

This procedure applies to all professionals who have defined responsibilities under the provisions of the Act.

22. 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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Patient Rights Information to Detained/Community Patients under , Mental Health Act, 1983 Policy

Policy Statement

Section 132/132A of the Mental Health Act 1983 (the Act) places a responsibility upon the hospital managers to take practicable steps to ensure that all detained patients and those subject to Community Treatment Orders (CTO) are given information about their rights regularly. Section 130D places a responsibility upon the responsible person to ensure that qualifying patients are given information about Independent mental Health Advocates. Section 133 places a duty on the hospital managers to inform the nearest relative of a detained patient that the patient is about to be discharged from detention (including being discharged subject to a community treatment order) or discharged from a community treatment order (other than a discharge ordered by the patient’s nearest relative). The policy aims to standardise practices and processes of providing information and clarify and provide guidance to staff responsible for delivering the information.

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 giving information to detained patients and community patients.

Staff will have due regard to the Mental Health Act Code of Practice generally and specifically to the Guiding Principles when they are delivering this information .

Those with responsibility for the care and treatment of patients must be fully aware of the diverse needs of the patient and the most effective way to communicate with each individual, their family, carers and relevant others. It is important that 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. Staff have a duty to check that the information they have communicated has been understood.

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Policy Commitment

We will set out the requirements for provision of giving information to detained/community patients under section 132,132A, 130D and 133 of the Mental Health Act 1983 (as amended by the Mental Health Act 2007) to those with responsibility for the care and treatment of patients.

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 Information to Detained /Community Patients (Patient's Rights) under Mental Health Act, 1983 Procedure describe the following with regard to the duties of hospital managers:

- The purpose of giving information to detained /community patients.
- The process for delivering information to detained/community patients.
- The duties of staff to inform patients subject to the MHA of their legal position.

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 who are involved in the care and treatment of patients detained under the Act and those in the community involved in the care of patients subject to a Community treatment Order.

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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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 Head of Operations
<p><u>Disclaimer</u> 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.</p>	

Summary of reviews/amendments			
Version Number	Date Review Approved	Date Published	Summary of Amendments
1	Date approved by Board/Committee/Sub Committee 12/02/2019	TBA <i>[To be inserted by the Gov. Dept]</i>	<i>New document</i>
2	20/10/2022		N/A

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Equality & Health Impact Assessment for

INFORMATION TO DETAINED/COMMUNITY PATIENTS (PATIENTS RIGHTS) UNDER, MENTAL HEALTH ACT 1983 POLICY

1.	For service change, provide the title of the Project Outline Document or Business Case and Reference Number	Information to Detained Patients and Community Patients (Patient's Rights) under, Mental Health Act, 1983 Policy
2.	Name of Clinical Board / Corporate Directorate and title of lead member of staff, including contact details	Mental Health Clinical Board David Seward, Mental Health Act Manager 029 21824746 David.Seward@wales.nhs.uk
3.	Objectives of strategy/ policy/ plan/ procedure/ service	<p>The aim of this policy is to ensure staff are aware of their individual and collective responsibilities when giving information to detained/ community patients.</p> <p>Provide clear guidance to staff in relation to their legal responsibilities under the Mental Health Act 1983 as amended by the MHA 2007.</p> <p>Ensure that statutory requirements under the Mental Health Act 1983 are met.</p> <p>Staff should have due regard to the Mental Health Act Code of Practice generally and specifically to the Guiding Principles when they are delivering this information.</p>

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<p>4.</p>	<p>Evidence and background information considered. For example</p> <ul style="list-style-type: none"> • 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 <p>Population pyramids are available from Public Health Wales Observatory¹ and the UHB's 'Shaping Our Future Wellbeing' Strategy provides an overview of health need².</p>	<p>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</p> <p>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.</p> <p>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)</p> <p>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).</p> <p>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</p>
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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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		<p>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.</p> <p>Results of Welsh Health Survey 2015 – reported in Mental Health Foundation Fundamental Facts 2016:-</p> <p>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.</p> <p>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.</p> <p>The Mental Health Act relates to all patients suffering from a mental disorder who meet the criteria for detention, irrespective of age.</p> <p>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)</p>
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		<p>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</p> <p>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.</p> <p>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:-</p> <p>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.</p>
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		<p>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.</p> <p>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.</p> <p>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.</p> <p>This policy will apply regardless of gender.</p> <p>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.</p> <p>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</p>
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		<p>relating to lesbian, gay, bisexual and trans (LGBT) people, which is resulting in unfair treatment of both LGBT patients and colleagues.</p> <p>The NHS Centre for Equality and Human Rights (CEHR) has published a new guide for all staff in NHS Wales. <i>“It’s Just Good Care – A guide for health staff caring for people who are trans*”</i> 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</p> <p>Human Rights - The proposed policy promotes human rights in ensuring that all patients are detained lawfully.</p> <p>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</p> <p>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</p>
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		<p>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%.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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</p>
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		<p>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”)</p> <p>The proposed policy will apply regardless of the race / ethnicity of patients or staff.</p> <p>Health inequalities are further linked to unequal access to healthcare. Some BAME groups face considerable barriers to healthcare.</p> <p>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.</p> <p>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.</p> <p>A Cultural Competency Toolkit, was developed by Diverse Cymru, with</p>
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		<p>assistance from UHB staff. Its aim is to help staff better interact with clients with mental ill health who are from different cultures</p> <p>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.</p> <p>Within the explanation of rights this now details if the information has been given in the patients preferred language and will be reported on.</p> <p>Access to an interpreter is available and translation of written information can be obtained as and when required.</p> <p>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”).</p> <p>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),</p>
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		<p>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.</p> <p>The proposed policy will apply regardless of the religion or belief of patients or staff.</p> <p>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”).</p> <p>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.</p> <p>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.</p>
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		<p>The proposed policy will apply regardless of the sexual orientation of the patients or staff.</p> <p>Welsh Language - No evidence of disproportional representation to date, but a proportion of service users may be Welsh speakers</p> <p>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.</p> <p>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.</p>
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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).

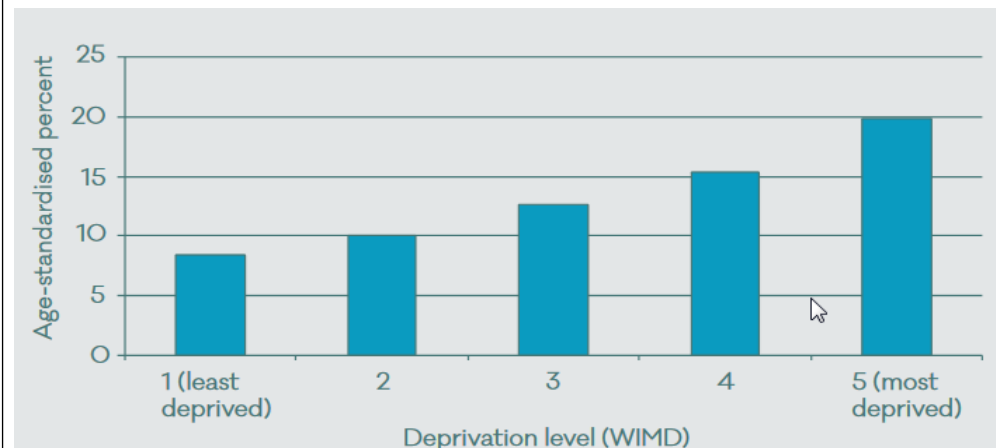
Between 30% and 50% of people with schizophrenia are capable of work but only between 10% and 20% are in employment (Marwaha and Johnson, 2004; Schneider, 1998). Although some are in managerial or senior official positions, most are in 'elementary' jobs, for example cleaning and labouring, or are in 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 et al., 1992; Johnstone et al., 1986). For people with Schizophrenia, premorbid social and occupational history are associated with

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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 range of outcomes for individuals and communities. These include healthier lifestyles; better physical health; improved recovery from

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		<p>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.</p> <p>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 <i>distribution</i> 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.</p>
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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' *a/so* 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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		<p>Homeless</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>It is a fundamental fact that single homeless people are much more</p>
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		<p>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</p> <p>This policy will apply regardless of where a person lives.</p> <p>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_asylum_seeker_health.pdf</p> <p>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%.</p> <p>26% of women and 16% of men said they had received treatment for a</p>
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		<p>mental health problem in the year before custody.</p> <p>Personality disorders are particularly prevalent among people in prison. 62% of male and 57% of female sentenced prisoners have a personality disorder.</p> <p>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.</p> <p>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.</p> <p>http://www.prisonreformtrust.org.uk/ProjectsResearch/Mentalhealth</p> <p>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.</p> <p>Mind’s report “Our Communities, Our Mental Health” identified the following contributory risk factors:-</p> <p>Trauma and stressful events, poverty, unemployment and housing insecurity, social isolation and loneliness, discrimination and inequality.</p> <p>These risk factors may be present in any protected group.</p>
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		<p>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'.</p> <p>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.</p> <p>Community treatment orders are not a good thing -Simon Lawton-Smith / John Dawson and Tom Burns)</p> <p>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, increased medication compliance and feelings of empowerment. The</p>
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		<p>negative feedback included feelings of being coerced and the stigma associated with it.</p> <p>(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)</p> <p>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.</p> <p>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.</p> <p>(A Question of Numbers – Potential Impact of Community Based</p>
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		<p>Treatment Orders in England and Wales” Simon Lawton Smith for the Kings Fund Sept 2005)</p> <p>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.</p>
5.	Who will be affected by the strategy/ policy/ plan/ procedure/ service	<p>Mental health issues affect the whole population, though some protected groups are disproportionately represented among service users.</p> <p>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.</p> <p>The Information to Detained Patients and Community Patients (Patient’s Rights) under, Mental Health Act, 1983 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.</p>

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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: <ul style="list-style-type: none"> • 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.	
<p>6.3 People of different genders: Consider men, women, people undergoing gender reassignment</p> <p>NB Gender-reassignment is anyone who proposes to, starts, is going through or</p>	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.	<i>"It's Just Good Care – A guide for health staff caring for people who are trans**" is made available to staff</i>	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.	<i>"It's Just Good Care – A guide for health staff caring for people who are trans*" is made available to staff.</i>	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.	
<p>6.7 People with a religion or belief or with no religion or belief. The term 'religion' includes a religious or philosophical belief</p>	<p>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.</p>		<p>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.</p>
<p>6.8 People who are attracted to other people of:</p> <ul style="list-style-type: none"> • the opposite sex (heterosexual); • the same sex (lesbian or gay); • both sexes (bisexual) 	<p>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</p>	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.		
<p>6.9 People who communicate using the Welsh language in terms of correspondence, information leaflets, or service plans and design</p> <p>Well-being Goal – A Wales of vibrant culture and thriving Welsh language</p>	<p>There is the potential for a negative impact. However staff have to take into account the diverse needs of the individual patient.</p>	<p>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</p>	<p>Under Policy Statement</p> <p>Staff are made aware of the translation and interpretation policy.</p>

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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	<p>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.</p> <p>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.</p>	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
<p>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</p>	<p>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.</p>	<p>N/A</p>	<p>Under Policy Statement</p>
<p>6.12 Consider any other groups and risk factors relevant to this strategy, policy, plan, procedure and/or service</p>	<p>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.</p>	<p>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</p>	<p>Under Policy Statement</p>

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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
<p>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</p> <p>Well-being Goal - A more equal Wales</p>	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
<p>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</p>	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
<p>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</p> <p>Well-being Goal – A healthier Wales</p>			
<p>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</p>	<p>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.</p>	<p>N/A</p>	<p>Under Policy Statement</p>

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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			
<p>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</p> <p>Well-being Goal – A resilient Wales</p>	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
<p>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</p> <p>Well-being Goal – A Wales of cohesive communities</p>	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
<p>7.6 People in terms of macro-economic, environmental and sustainability factors: Consider the impact of</p>	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
<p>government policies; gross domestic product; economic development; biological diversity; climate</p> <p>Well-being Goal – A globally responsible Wales</p>	<p>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.</p>		

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

<p>8.1 Please summarise the potential positive and/or negative impacts of the strategy, policy, plan or service</p>	<p>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.</p> <p>A search of similar policies elsewhere indicated a neutral or positive impact in relation to protected groups:-</p> <p>http://www.rdash.nhs.uk/wp-content/uploads/2014/04/S-132-Providing-Legal-Rights-v11-EIA2.pdf</p>
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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
<p>8.4 What are the next steps?</p> <p>Some suggestions:-</p> <ul style="list-style-type: none"> • Decide whether the strategy, policy, plan, procedure and/or service proposal: <ul style="list-style-type: none"> ○ 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 	<p>No significant negative Impact.</p> <p>The policy will be submitted to the Mental Health and Capacity Legislation Committee for approval.</p> <p>Once the policy has been approved the documentation will be placed on the intranet and internet.</p> <p>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.</p>	N/A	N/A	<p>N/A</p> <p>Whilst it is the hospital managers who have responsibilities under the Act for the provision of information to patients, carers and others, in practice it would usually be more appropriate for professionals working with the patient to provide them with the information. However in order to fulfil their statutory duties, hospital managers should have policies in place to ensure that regular checks are made to confirm the required information has been given to each patient and understood by them.</p>

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<p>Reference Number: TBA</p> <p>Version Number: 2</p>	<p>Date of Next Review: TBA</p> <p>Previous Trust/LHB Reference Number: Any reference number this document has been previously known as</p>
<p>Patient Rights Information to Detained/ Community Patients Mental Health Act, 1983 Procedure</p>	
<p>Introduction and Aim</p> <p>This document supports the Information to Detained/Community Patients (Patient's Rights) under Section 132, 132A & 130D, Mental Health Act, 1983 Policy.</p> <p>To Provide clear guidance to staff in relation to their legal responsibilities under the Mental Health Act 1983 as amended by the MHA 2007.</p> <p>To standardise practices and processes of providing information and clarify and provide guidance to staff responsible for delivering information.</p> <p>To Ensure that statutory requirements under the Mental Health Act 1983 are met.</p>	
<p>Objectives</p> <p>This procedure describes the following with regard to information to detained patients and community patients (patient's rights)</p> <ul style="list-style-type: none"> • The purpose of giving information to detained/community patients • The process for providing information to detained/community patients • The duties of staff responsible for delivering the information <p>Staff must have due regard to the Mental Health Act Code of Practice (for Wales) generally and specifically to the Guiding Principles when they giving information to detained/community patients. This will ensure that considerations are given as to whether the objectives can be met in a less restrictive way.</p>	
<p>Scope</p> <p>This policy is applicable to employees within all Mental Health inpatient settings, community settings and general hospital settings, including those with honorary contracts who are involved in the care and treatment of patients detained under the Act and those in the community involved in the care of patient's subject to a Community treatment Order.</p>	
<p>Equality and Health Impact Assessment</p>	<p>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.</p>

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Documents to read alongside this Procedure	<ul style="list-style-type: none"> • 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 • Mental Health (Wales) Measures 2010 <p>All Cardiff and Vale policies on the Mental Health Act 1983 as appropriate including:</p> <p>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 Mental Health Review Tribunal Procedure and Guidance Review of Detention and Community Treatment Order Policy Review of Detention and Community Treatment Order Procedure Section 136 Policy Section 136 Procedure Admission to Hospital under Part II of the Mental Health Act, 1983 Policy Admission to Hospital under Part II of the Mental Health Act, 1983 Procedure</p>
Approved by	Pending – Mental Health and Capacity Legislation Committee

Accountable Executive or Clinical Board Director	<i>Mental Health Clinical Board Head of Operations</i>
Author(s)	<i>Mental Health Act Manager</i>

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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	12/02/2019	TBA	<i>New document</i>
2	20/10/2022		<p><i>Additional CAV policy and procedures listed within 'documents to be read alongside this procedure'</i></p> <p><i>Expanded on paragraphs throughout for easier reading and understanding</i></p> <p><i>Added section on 'Information following a CTO recall to hospital'</i></p> <p><i>Added section on 'Information about withholding correspondence'</i></p> <p><i>Added section on 'Information on seeking discharge from detention or CTO'</i></p> <p><i>Enhanced section on 'recording the reading of rights to a patient' to offer more clarity</i></p>

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1. Introduction

Section 132 of the Mental Health Act 1983 (the Act) places a responsibility upon the hospital managers to take practicable steps to ensure that all detained patients are given information about their rights upon admission.

Section 132A places a responsibility upon the hospital managers to take practicable steps to ensure that Community Treatment Order (CTO) patients are given information about their rights. Section 130D places a responsibility

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on the responsible person to ensure that qualifying patients are given information about Independent Mental Health Advocates (IMHAs). Section 133 places a responsibility upon the hospital managers to inform the Nearest Relative of a patient's discharge from detention including being discharged from a CTO.

Although the Act does not impose any duties to give information to informal patients they should be given an explanation of their legal position and rights. It is important that they are aware that should they wish to leave the hospital they are advised to discuss this with their Doctor along with the nurse in charge of the ward, so that appropriate arrangements can be made for their safe discharge.

It must also be remembered that explaining a patient's rights to them is not a one-off event but needs to be ongoing throughout their detention as a person's level of understanding can fluctuate. This policy must be read in conjunction with Mental Health Act Code of Practice for Wales, Chapter 4.

2. Policy Statement

This policy has been developed to guide staff on the execution of their duties to inform patients subject to the Act of their rights and legal position. The policy is also applicable to their Nearest Relative.

3. Scope

The contents of this policy apply to all clinical staff working within the Health Board who are involved in the care and treatment of patients detained under the Act and those in the community involved in the care of patient's subject to Community Treatment Orders.

4. Aim

The aim of this policy is to:

- Standardise practices and processes of providing information
- Clarify and provide guidance to staff responsible for delivering the information
- Provide a framework to staff on the information that should be given to detained patients and their Nearest Relative.
- Identify who should deliver this information and the expected frequency of the delivery of information.

5. Objectives

Practitioners should have due regard to the Mental Health Act Code of Practice generally and specifically to the guiding principles when they are providing information to patients and their Nearest Relative.

There is a statutory duty to inform patients detained under specific sections of the Act of their right of access to an Independent Mental Health Advocate

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(IMHA). IMHA's are available for all patients receiving treatment for their mental disorder and can be invaluable in assisting the patient to understand the questions and information that is being presented to them and in helping patients communicate their views to staff. An IMHA should not be used as an interpreter, translator or as providers of general communication support other than in exceptional circumstances. If this is a requirement the reasons must be recorded within the patient health records (PARIS). (Chapter 6 Mental Health Act Code of Practice)

6. PROCEDURE/IMPLEMENTATION

6.1 Availability of Information

For all patients, relevant information should be given to them as soon as is practicable, following:

- Admission to Hospital;
- Commencement of a period of detention under the Act;
- Detention under another section of the Act
- Renewal of any period of detention or extension of CTO

The information must be given both verbally and in writing, and detained patients must be given a copy of the statutory information leaflet which is provided by Welsh Government. Copies of any available information should also be displayed on the ward notice boards/leaflet racks.

6.2 Information to Informal Patients

Though section 132 is specific to detained patients, information should be provided on a frequent basis to informal patients also. Information on advocacy services should also be made available. They should also be made aware of their right to leave hospital if they wish, however, if it is felt that they need to remain for a period of assessment and/or treatment, they should be informed they may be held under the Act to allow for a Mental Health Act Assessment and for possible detention under the Act. Where discussions take place staff should ensure this is documented.

6.3 Information to Detained Patients

Any detained patient must be informed as soon as practicable both verbally and in writing of the following:

- Of the provisions of the Act under which they are being detained or subject to CTO and the effect of those provisions;
- Of the rights (if any) of their Nearest Relative to discharge them (and what can happen if their Responsible Clinician does not agree with that decision);
- For community patients, of the effect of the CTO, including the conditions which they are required to keep and the circumstances in which their Responsible Clinician may recall them to hospital; and

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- That support is available to them from an IMHA, and how to obtain that support;
- The reasons for their detention or CTO;
- The maximum length of the current period of detention or CTO;
- That their detention or CTO may be ended at any time if it is no longer required or the criteria for it are no longer met;
- That they will not automatically be discharged when the current period of detention or CTO ends;
- That their detention or CTO will not automatically be renewed or extended when the current period of detention or CTO ends;
- The reasons for a CTO being revoked;
- Their rights of appeal to both the Hospital Managers and the Mental Health Review Tribunal for Wales (MHRTW). Appropriate details of address/telephone numbers should also be given along with guidance on how to make an application and a list of legal aid solicitors;
- That if they are detained on a treatment order (including a CTO) should it be extended for a further 6-month period and they do not appeal to the MHRTW in the first period of detention, then the Health Board will automatically refer their case;
- That they have the right of legal representation at the MHRTW and are given a list of legal aid solicitors who are specifically trained in mental health law;
- The nature and likely effects of any treatment which is planned;
- The role and powers of the Healthcare Inspectorate Wales (HIW) and how to make a complaint to them. The address and telephone number should also be supplied;
- Their right to receive or send correspondence and whether there are any constraints on this;
- The procedure for making a formal complaint to the Health Board;
- The patient's financial entitlements whilst in hospital and how to secure them;
- Details of the Visiting Policy for the unit and in particular any restrictions around the visiting of children;
- After care entitlement under section 117 (if applicable) and the implications of this.

6.4 Information following a CTO patient recall to hospital

Where a patient is to be recalled to hospital whilst subject to a CTO, the Responsible Clinician should give the patient, or arrange for the patient to be given, verbal reasons for the decision to recall before the recall occurs. In addition to the Nearest Relative being informed (see Chapter 5 of the Mental Health Act Code of Practice for Wales), the patient can also nominate another person whom they wish to be notified of their detention.

6.5 Information to Conditionally Discharged Patients following recall to hospital

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Where a conditionally discharged patient is to be recalled to hospital, a brief verbal explanation of the Secretary of State's reasons for recall must be provided to the patient at the time of recall unless there are exceptional reasons why this is not possible e.g. the patient is violent or too distressed. The Secretary of State's warrant will detail the reasons. The patient should also receive a full explanation of the reasons for his or her recall within 72 hours after admission, and both written and oral explanations should be provided. Conditionally discharged patients recalled to hospital, should be told that their cases will be referred automatically to the MHRTW.

6.6 Information on Consent to Treatment

All patients, regardless of their legal status, must be informed of:

- The nature, purpose and likely effects of any treatment which is planned;
- The circumstances (if any) in which they can be treated without their consent and the circumstances in which they have the right to refuse treatment;
- The role of the Second Opinion Appointed Doctors (SOADs) and the circumstances in which they may be involved; and
- (Where relevant) the rules on Electro-Convulsive Therapy (ECT) and medication administered as part of ECT.

6.7 Information on access to the Independent Mental Health Advocacy services

Access to independent advocacy services, is available in all areas of the Health Board and all patients, regardless of their legal status, should be given information about the IMHA services and how to access it.

Wards will display on their patient information boards the days and times as to when the IMHA will be on the ward.

6.8 Information about withholding of correspondence

Patients should routinely have access to any correspondence they receive and send. Their privacy must be respected. Detained patients must be told their letters for posting may be withheld if the person to whom it is addressed asks the hospital managers to do so.

6.9 Information on Rights to Vote

The Representation of the People Act 2000 makes it clear that in most circumstances, detained patients can still exercise their right to vote in general or other elections. To allow patients to exercise this right the Health Board should give information to them about their voting rights.

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6.10 Information about the role of the Healthcare Inspectorate Wales (HIW)

All patients, regardless of their legal status, should be given information about:

- The role of HIW;
- When HIW is next due to visit the service;
- Their rights to meet with HIW during a visit; and
- Their rights to make a complaint to HIW.

6.11 Information to the Nearest Relative of detained patients

On admission or as soon as practical thereafter, the patient should be made aware of the fact that their Nearest Relative, within the meaning of the Act, will be supplied with a copy of the written information of their rights, unless the patient objects.

Staff should also ascertain if the patient has an advance statement in place giving details of any other person they wish to be notified of their detention under the Act. If there is, the Mental Health Act Department is to be notified so that arrangements can be made for the necessary information to be sent.

A copy of the letter sent by the Mental Health Act Department to the patient's Nearest Relative will be held in the patient's health records. If the patient does not wish their Nearest Relative to be informed of their detention, this is to be recorded on the appropriate record of [patient's rights form](#) at the earliest convenience.

Patients should be informed of the provision of making an application to the county court to displace the Nearest Relative under Section 29 of the Act, and given help with the application if they want it. (Chapter 5 of the Mental Health Act Code of Practice for Wales)

6.12 Explaining and Understanding Patient Rights

The explaining of a patient's rights is an ongoing process throughout their stay in hospital or period of detention on a CTO and should be done both verbally and in writing.

It should be done in a suitable manner, at a suitable time, taking into account the patient's mental state and capacity to retain information. Staff should not rush through the process but give it their full attention, spending as much time as necessary with the patient in a private area free from interruption allowing time for questions to be asked. Carers and advocates should be involved where the patient wishes or if the patient lacks capacity to understand.

Consideration also needs to be given to the fact that there are some patients who have difficulties relating to their capacity to understand or the ability to retain the information given to them for any length of time. Whilst these

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patients are detained under the Act, the Mental Health Act Code of Practice for Wales advocates good practice in relation to detained patients who lack capacity or have fluctuating capacity. In these situations, staff need to comply with the principles of the Mental Capacity Act (2005) and take all reasonable steps to provide information in a suitable format, i.e. easy word version, large print version or pictorially in order to facilitate capacity to understand, if at all possible. Staff need to be aware that they may have to explain rights to some individuals on more than one occasion in the first instance and on a more frequent and ongoing basis.

The Welsh Assembly Government has produced a series of Mental Health Act patient information leaflets. These are designed to assist hospitals to meet their legal obligations under the Act to provide written information to patient's subject to detention and other compulsory measures under the Act; they can be accessed via the [Mental Health Act Homepage](#).

Once an explanation of their legal rights has been given to the patient, staff must take steps to ascertain their level of understanding. If it is identified that a patient lacks the capacity to understand even after all attempts to assist them have been undertaken, their lack of capacity should be documented in their patients records. However, staff need to be aware that in the majority of cases any lack of capacity will not be permanent and in view of this staff must continue in their attempts to facilitate the patients understanding.

6.13 Communication with patients

Section 132 places a duty on the Health Board to take all reasonable steps to facilitate the patient's understanding of their legal rights. If the patient is not fluent in English or Welsh or has a learning or sensory impairment, arrangements must be made for the explanation of their rights to be delivered in a manner which is appropriate to their needs.

Everything possible should be done to overcome barriers to effective communication. Being able to communicate in the patients' preferred language is essential to ensuring that those providing services can undertake an accurate assessment and deliver ongoing care and treatment. The Health Board should ensure people with specialist expertise e.g. in sign language or Makaton, are available as required. Staff should be aware of who to contact to ensure individuals' communication needs can be met.

Where interpretation is needed, every effort should be made to identify an interpreter who is suitable to the needs and circumstances of the patient. Arrangements are in place for staff to have access to these outside normal working hours

However, in respect of this policy, interpreters should:

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- Fully understand the terminology and conduct of a mental health interview;
- Have knowledge of the patient's cultural and religious values;
- Be able to interpret the law; and
- Be of a gender which accords with the patient's wishes.

NB: It is not desirable that relatives or friends be asked to act as interpreters and this should only be done in exceptional circumstances and at the express wish of the patient.

Mental Health Act patient information leaflets are available from the Mental Health Act Department or from the [Mental Health Act Homepage](#) in languages other than English and Welsh, and arrangements can be made for them to be provided in Braille and audio format.

6.14 Information on seeking discharge from detention or CTO

Patients must be informed of their rights to be considered for discharge and:

- that their Responsible Clinician and the Hospital Managers can discharge them (and that for restricted patients that it is subject to the agreement of the Secretary of State for Justice)
- that they have a right to ask the Hospital Managers to discharge them
- that the hospital managers must consider discharging them when their detention is renewed or their CTO is extended
- of their rights to apply to the MHRTW and of the rights, if any, of their Nearest Relative to apply to the MHRTW on their behalf, and
- how to apply to, and the role of, the MHRTW

Hospital Managers should ensure patients are supported when they request a hospital managers' hearing or to make an application to the MHRTW, and that the applications are transmitted to the MHRTW without delay. This includes patients without the capacity to make such a request.

Patients should also be told:

- how to contact a suitably qualified legal representative (and patients should be given assistance to do so if required)
- that free legal aid may be available, and how this may be accessed, and
- how to contact any other organisation which may be able to help them to make an application to the MHRTW

Patients on a CTO who may not have regular contact with people who could help them make an application to the MHRTW should be well informed and supported in this process.

6.15 Explanation of legal rights to a child/young person

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For a child:

A child aged under 16 and anyone under this age who is admitted should have their legal rights under section 132 explained to them in the presence of their parent(s) (or others with parental responsibility) who will also be given a copy of the appropriate rights form.

For a young person:

A young person is a person aged 16–17 and the usual procedure with regard to reading a person their legal rights under this procedure should apply.

However, consideration should be given to completing this in the presence of their parent(s), if the patient agrees.

6.16 Confidentiality and sharing information in relation to a child/young person:

As with adults, children and young people have a right to confidentiality. Where children are competent, and young people have the capacity to make decisions about the use and disclosure of information that they have provided in confidence, their views should be respected. (Chapter 19 Mental Health Act Code of Practice for Wales).

However, as with adults, in certain circumstances confidential information may be disclosed without the child or young person’s consent, e.g. if there is reasonable cause to believe that the child or young person is suffering, or is at risk of suffering, significant harm.

The same principles of confidentiality apply if a child who is competent or a young person who has capacity to make a decision regarding the information does not wish their parent (or others with parental responsibility) to be involved in decision making about their care and treatment. Their decision should be respected unless the disclosure can be justified, e.g. if there is cause to suspect that the child or young person is suffering or is likely to suffer serious harm. Practitioners should encourage the child or young person to involve their parents (unless it is considered to do so would not be in the best interests of the child or young person). They should also be proactive in discussing with the child or young person the consequences of their parents not being involved.

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

6.17 Recording the reading of rights to a patient

Those with responsibility for patient care should ensure patients are reminded regularly of their rights and the effects of the Act. It may be necessary to give the same information on different occasions or in different formats and to

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check the patient has fully understood it. Information given to a patient who lacks capacity may need to be repeated when their capacity improves.

An entry is to be made in the patient's health records (PARIS) to the effect that an oral and written explanation has been given with an indication of the patient's level of comprehension.

A patient rights form is to be completed and forwarded to the Mental Health Act Department indicating if the patient had the capacity to understand their legal rights or not. The outcome of this is to be recorded accordingly:

- The patient has understood the information read and has been given a copy of the information leaflet.
- The patient is currently refusing to have their rights read. Further attempts will be made.
- The patient currently lacks capacity to understand their rights. Further attempts will be made.
- The patient has no capacity to understand information

This will support in evidencing every attempt made to inform a patient of their legal rights.

Those patient on a treatment section whose rights are return to the Mental Health Act Department stipulating the patient has no capacity to understand their rights will be referred to the Independent Mental Health Advocacy Services by the Mental Health Act Department as a safeguard.

If a patient continues to lack the capacity to understand all or any of the verbal and written information regarding this detention, a record of this should be made within the patient's health records (PARIS).

The reading of rights should be undertaken to reflect the individual needs of the patient but it is recommended that, as a minimum, staff should adhere to the guidance as detailed below:

Section	Initial Frequency	Ongoing Frequency	Who by
Section 2	As soon as practicable after the patients detention begins, then twice weekly for the first two weeks of detention	Weekly for the remaining period of detention	Named nurse or other nominated clinical staff
Section 3	At the time of the section being applied then once a week for the first month of detention	Monthly for the remaining period of detention	Named nurse, Care Coordinator or other nominated clinical Staff.

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Section 37	At the time of the section being applied then once a week for the first month of detention	Monthly for the remaining period of detention	Named nurse, Care Coordinator or other nominated clinical staff
Community Treatment Order	At the time of the section being applied then once a week for the first month of detention.	Quarterly for the remaining period of their CTO	Care Coordinator or other nominated clinical staff

The patient MUST also have their legal rights explained to them if their period of detention is renewed. This is to be recorded on a [patient's rights form](#), which must then be forwarded to the Mental Health Act Department.

These minimum requirements do not prevent a member of the clinical team from using their professional judgement to decide how frequently individual patients' legal rights have to be explained to them.

For patients who have a good understanding of their rights, it may not be necessary to renew their rights at such frequent intervals.

For any subsequent explanation of legal rights under section 132, staff should document this on a [patient's rights form](#).

6.18 Discharge from Detention

When the patient is discharged from detention or if the authority for detention expires, the section's end date/time and the patient's right to leave hospital should be made known to them.

Section 133 provides a duty for the Hospital Managers to inform the Nearest Relative of discharge from detention including CTO patients and this is to be given at least seven days before the discharge if practicable. To facilitate this, it will be necessary for the patients' Responsible Clinician to inform the Mental Health Act Department of the planned discharge.

The requirement to inform the Nearest Relative does not apply if the patient requests that information is not sent. The Nearest Relative may also request that information is not sent to them regarding their relative.

7. Responsibilities

The Mental Health Legislation and Mental Capacity Act Committee is responsible for:

- Overseeing the implementation of the Act within the organisation;

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- The review and issuing of all policies and procedures which relate to the Act;
- Monitoring the Health Boards compliance with the legal requirements of the Act;
- Undertaking audit work and agreeing action plans in relation to the Act;

7.1 Hospital Managers under the Act

Whilst the Mental Health Act 1983 uses the term “Hospital Managers”, in NHS Foundation Trusts and Health Boards they are defined as the “Hospital Managers”. They have certain statutory duties they must fulfil under the Act and some of these duties including the explaining of legal rights under section 132 can be delegated by the hospital managers but in delegating this responsibility they must be satisfied that:

- The correct information is given to the patient/Nearest Relative (with the patient’s consent);
- The information is given in a suitable format and at a suitable time, and, in accordance with the law;
- The member of staff who is to give the information has received sufficient guidance and is aware of the key issues regarding the information to be given;
- A record is kept of the information given, including how, when and by whom it was given;
- A regular check is made that the information has been properly given to each detained patient and understood by him or her;
- There are processes in place to monitor the explanation to patients of their legal rights under section 132.

7.2 Independent Mental Health Advocates (IMHA)

The role of the IMHA is to help qualifying patients (those detained under the Act, conditionally discharged, subject to guardianship or a CTO) understand the legal provision to which they are subject under the Act and the rights and safeguards to which they are entitled. This could include assistance in obtaining information about any of the following:

The provisions of the legislation under which she/he qualifies for an IMHA;

- Any conditions or restrictions she/he is subject to, for example; any arrangements made for section 17 leave;
- The medical treatment being given, proposed or being discussed and the legal authority under which this would be given;
- The requirements that would apply in connection with the giving of the treatment;
- Their rights under the Act and how those rights can be exercised.

7.3 Clinical Staff

In relation to this policy all clinical staff must be aware of and comply with the contents of this procedure by providing inpatients with information about:

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- Any conditions or restrictions she/he is subject to, for example, any arrangements made for Section 17 leave;
- The medical treatment being given, proposed or being discussed and the legal authority under which this would be given;
- The requirements that would apply in connection with the giving of the treatment;
- Their rights under the Act and how those rights can be exercised;
- The rights of qualifying patients to the services of an IMHA and how to obtain one.

Clinical staff should also:

- Complete all the necessary documentation required. Click the link to access our [**Mental Health Act Homepage**](#)

7.4 Care Co-ordinators

Care Co-ordinators are responsible for ensuring patients who are on a CTO are provided with information about:

- Any conditions or restrictions she/he is subject to e.g. any specific requirements around residency;
- The medical treatment being given, proposed, or being discussed and the legal authority under which this would be given;
- The requirements that would apply in connection with the giving of the treatment;
- Their rights under the Act and how those rights can be exercised;
- The rights of qualifying patients to the services of an IMHA and how to obtain one.
- Care Co-ordinators should also complete all the necessary documentation required.

Depending on the place of residence of the patient, support workers within care homes can also undertake these functions.

7.5 Non-registered clinical staff

Any non-registered staff working within clinical services must:

- Be aware of this procedure and its contents;
- Direct any patient who has a query about their legal rights to a member of registered staff unless they are competent to address any issues raised.

7.6 Mental Health Act Department

The Mental Health Act Department are responsible for:

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- Providing clinical staff with copies of the appropriate patient information leaflets;
- Monitoring the initial and on-going explanation of their legal rights to detained patients, via the receipt of the patient's rights forms;
- Co-ordinating requests by patients for an appeal to the Hospital Managers and/or the MHRTW;
- Ensuring referrals are made to the IMHA service where necessary;
- Patient's rights forms are filed within the patient's legal correspondence file and a copy in the patient's case notes (PARIS).
- Ensuring copies of correspondence to Nearest Relative are filed within the patient's legal correspondence files (Section 133).

8. References

Jones R (2016) Mental Health Act Manual, nineteenth Edition, Sweet and Maxwell
Code of Practice for Wales (revised 2016) Welsh Government
Mental Health (Wales) Measure 2010
Mental Capacity Act Code of Practice
Human Rights Act
Data Protection Act

Appendix 1

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**Mental Health Act 1983 – Section 132/132A
Information to Detained Patients**



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WALES**

Bwrdd Iechyd Prifysgol
Caerdydd a'r Fro
Cardiff and Vale
University Health Board

Patients Name:	
Nearest Relative:	
Current Section:	Date of Section:
Ward:	Name of IMHA:
I can confirm that I have fully explained the contents of the Patients Rights Leaflet to the patient, including reasons for their detention and the patients right to an Independent Mental Health Advocate (IMHA)	
I have informed the patient how long their detention will last for, if and when they have a right of appeal against their detention to the Mental Health Review Tribunal Wales. The role of the Hospital Managers, the patients right to raise a concern and how to do so. The role of Health Care Inspectorate Wales has been explained. Information of Treatment has also been explained in full.	
Please tick one of the following boxes:	
The patient has understood the information read and has been given a copy of the information leaflet.	<input type="checkbox"/>
The patient is currently refusing to have their rights read. Further attempts will be made.	<input type="checkbox"/>
The patient currently lacks capacity to understand their rights. Further attempts will be made.	<input type="checkbox"/>
The patient has no capacity to understand information	<input type="checkbox"/>
Name of Staff Member reading rights	
Patients preferred language?	
Has the information been given to the patient in their preferred language?	YES/NO
Does the patient agree to the Nearest Relative being given information?	YES/NO
Patients Signature:	Date:

Please return this form to the Mental Health Act Office, Hafan Y Coed, Llandough Hospital, Penlan Road, Penarth, CF64 2XX.

Fax Number: 02921 824740

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**CARING FOR PEOPLE
KEEPING PEOPLE WELL**



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Bwrdd Iechyd Prifysgol
Caerdydd a'r Fro
Cardiff and Vale
University Health Board

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Admission to Hospital under Part II of the Mental Health Act, 1983 Policy

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 admission to hospital under Part II of the Mental Health Act.

Part II of the Mental Health Act relates to the following:

- Section 2 – Admission for assessment
- Section 3 – Admission for treatment
- Section 4 – Emergency admission to hospital

Practitioners will have due regard to the Mental Health Act Code of Practice generally and specifically to the Guiding Principles when they are considering admission to hospital under Part II of the Mental health Act. 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 admission to hospital under Part II of the Mental Health Act 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 admission to hospital under Part II 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 part II of the Mental Health Act.

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 Admission to Hospital under Part II of the Mental Health Act Procedure describe the following with regard to the use of part II of the Mental Health Act:

- The purpose of part II of the Mental Health Act
- The process for considering admission to hospital under part II of the Mental Health Act
- The duties of the practitioners and agencies involved in the management of patients subject to part II of the Mental Health Act

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 Legislation Committee
Accountable Executive or Clinical Board Director	Mental Health Clinical Board Director of Operations

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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 12/02/2019	TBA	<i>New document</i>
2	20/10/2022		N/A

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Equality & Health Impact Assessment for

ADMISSION TO HOSPITAL UNDER PART II OF THE MENTAL HEALTH ACT, 1983 POLICY

1.	For service change, provide the title of the Project Outline Document or Business Case and Reference Number	ADMISSION TO HOSPITAL UNDER PART II OF THE MENTAL HEALTH ACT, 1983 POLICY
2.	Name of Clinical Board / Corporate Directorate and title of lead member of staff, including contact details	Mental Health Clinical Board David Seward, Mental Health Act Manager 029 21824746 David.Seward@wales.nhs.uk
3.	Objectives of strategy/ policy/ plan/ procedure/ service	<p>The aim of this policy is to ensure professionals are aware of their individual and collective responsibilities when considering admission to hospital under Part II of the Mental Health Act 1983.</p> <p>Provide clear guidance to staff in relation to their legal responsibilities under the Mental Health Act 1983 as amended by the MHA 2007.</p> <p>Ensure that statutory requirements under the Mental Health Act 1983 are met.</p> <p>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 admission to hospital under Part II of the Mental Health Act 1983. This would ensure that considerations are given as to whether the objectives can be met in a less restrictive way.</p>

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<p>4.</p>	<p>Evidence and background information considered. For example</p> <ul style="list-style-type: none"> • 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 <p>Population pyramids are available from Public Health Wales Observatory¹ and the UHB's 'Shaping Our Future Wellbeing' Strategy provides an overview of health need².</p>	<p>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</p> <p>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.</p> <p>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)</p> <p>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).</p> <p>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</p>
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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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		<p>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.</p> <p>Results of Welsh Health Survey 2015 – reported in Mental Health Foundation Fundamental Facts 2016:-</p> <p>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.</p> <p>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.</p> <p>The Mental Health Act relates to all patients suffering from a mental disorder who meet the criteria for detention, irrespective of age.</p> <p>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)</p>
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		<p>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</p> <p>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.</p> <p>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:-</p> <p>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.</p>
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		<p>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.</p> <p>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.</p> <p>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.</p> <p>This policy will apply regardless of gender.</p> <p>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.</p> <p>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</p>
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		<p>relating to lesbian, gay, bisexual and trans (LGBT) people, which is resulting in unfair treatment of both LGBT patients and colleagues.</p> <p>The NHS Centre for Equality and Human Rights (CEHR) has published a new guide for all staff in NHS Wales. <i>“It’s Just Good Care – A guide for health staff caring for people who are trans*”</i> 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</p> <p>Human Rights - The proposed policy promotes human rights in ensuring that all patients are detained lawfully.</p> <p>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</p> <p>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</p>
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		<p>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%.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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</p>
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		<p>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”)</p> <p>The proposed policy will apply regardless of the race / ethnicity of patients or staff.</p> <p>Health inequalities are further linked to unequal access to healthcare. Some BAME groups face considerable barriers to healthcare.</p> <p>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.</p> <p>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.</p> <p>A Cultural Competency Toolkit, was developed by Diverse Cymru, with</p>
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		<p>assistance from UHB staff. Its aim is to help staff better interact with clients with mental ill health who are from different cultures</p> <p>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.</p> <p>Within the explanation of rights this now details if the information has been given in the patients preferred language and will be reported on.</p> <p>Access to an interpreter is available and translation of written information can be obtained as and when required.</p> <p>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”).</p> <p>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),</p>
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		<p>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.</p> <p>The proposed policy will apply regardless of the religion or belief of patients or staff.</p> <p>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”).</p> <p>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.</p> <p>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.</p> <p>This report also provides hard evidence that gay and bisexual men nationwide are more likely to attempt suicide, self-harm and have</p>
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		<p>depression than their straight peers.</p> <p>The proposed policy will apply regardless of the sexual orientation of the patients or staff.</p> <p>Welsh Language - No evidence of disproportional representation to date, but a proportion of service users may be Welsh speakers</p> <p>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.</p> <p>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.</p>
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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).

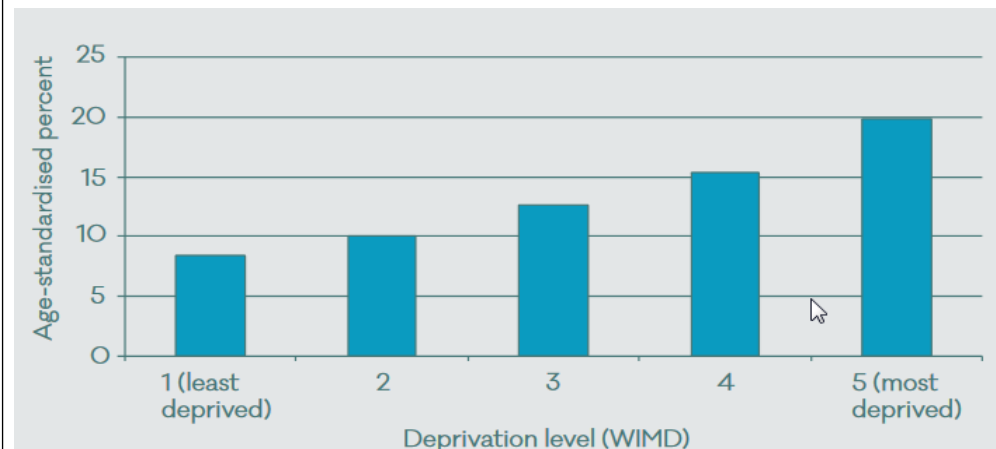
Between 30% and 50% of people with schizophrenia are capable of work but only between 10% and 20% are in employment (Marwaha and Johnson, 2004; Schneider, 1998). Although some are in managerial or senior official positions, most are in 'elementary' jobs, for example cleaning and labouring, or are in 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 et al., 1992; Johnstone et al., 1986). For people with Schizophrenia,

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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 range of outcomes for individuals and communities. These include

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		<p>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.</p> <p>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 <i>distribution</i> 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</p>
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		<p>poverty.</p> <p>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.</p> <p>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' <i>a/so</i> 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).</p> <p>This policy will apply regardless of where a person lives.</p> <p>(From: http://www.euro.who.int/_data/assets/pdf_file/0012/100821/E92227.pdf</p>
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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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		<p>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</p> <p>This policy will apply regardless of where a person lives.</p> <p>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_asylum_seeker_health.pdf</p> <p>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%.</p>
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		<p>26% of women and 16% of men said they had received treatment for a mental health problem in the year before custody.</p> <p>Personality disorders are particularly prevalent among people in prison. 62% of male and 57% of female sentenced prisoners have a personality disorder.</p> <p>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.</p> <p>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.</p> <p>http://www.prisonreformtrust.org.uk/ProjectsResearch/Mentalhealth</p> <p>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.</p> <p>Mind’s report “Our Communities, Our Mental Health” identified the following contributory risk factors:-</p> <p>Trauma and stressful events, poverty, unemployment and housing insecurity, social isolation and loneliness, discrimination and inequality.</p>
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		These risk factors may be present in any protected group.
5.	Who will be affected by the strategy/ policy/ plan/ procedure/ service	<p>Mental health issues affect the whole population, though some protected groups are disproportionately represented among service users.</p> <p>The policy addresses administrative issues and responsibilities in relation to the direct care and treatment of patients.</p> <p>The Admission to Hospital under Part II of the Mental Health Act 1983 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. 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.</p>

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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: <ul style="list-style-type: none"> • 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.	
<p>6.3 People of different genders: Consider men, women, people undergoing gender reassignment</p> <p>NB Gender-reassignment is anyone who proposes to, starts, is going through or</p>	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.	<i>"It's Just Good Care – A guide for health staff caring for people who are trans**" is made available to staff</i>	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.	<i>"It's Just Good Care – A guide for health staff caring for people who are trans*" is made available to staff.</i>	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	<p>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.</p>	<p>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</p>	<p>Under Policy Statement</p> <p>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.</p>

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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.	
<p>6.7 People with a religion or belief or with no religion or belief. The term 'religion' includes a religious or philosophical belief</p>	<p>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.</p>		<p>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.</p>
<p>6.8 People who are attracted to other people of:</p> <ul style="list-style-type: none"> • the opposite sex (heterosexual); • the same sex (lesbian or gay); • both sexes (bisexual) 	<p>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</p>	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.		
<p>6.9 People who communicate using the Welsh language in terms of correspondence, information leaflets, or service plans and design</p> <p>Well-being Goal – A Wales of vibrant culture and thriving Welsh language</p>	<p>There is the potential for a negative impact. However staff have to take into account the diverse needs of the individual patient.</p>	<p>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</p>	<p>Under Policy Statement</p> <p>Staff are made aware of the translation and interpretation policy.</p>

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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	<p>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.</p> <p>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.</p>	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
<p>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</p> <p>Well-being Goal - A more equal Wales</p>	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
<p>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</p>	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
<p>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</p> <p>Well-being Goal – A healthier Wales</p>			
<p>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</p>	<p>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.</p>	<p>N/A</p>	<p>Under Policy Statement</p>

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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			
<p>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</p> <p>Well-being Goal – A resilient Wales</p>	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
<p>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</p> <p>Well-being Goal – A Wales of cohesive communities</p>	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
<p>7.6 People in terms of macro-economic, environmental and sustainability factors: Consider the impact of</p>	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
<p>government policies; gross domestic product; economic development; biological diversity; climate</p> <p>Well-being Goal – A globally responsible Wales</p>	<p>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.</p>		

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

<p>8.1 Please summarise the potential positive and/or negative impacts of the strategy, policy, plan or service</p>	<p>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.</p> <p>A search of similar policies elsewhere indicated a neutral or positive impact in relation to protected groups:-</p> <p>http://www.cwp.nhs.uk/media/1707/mh3-admission-to-hospital-under-part-ii-of-the-mental-health-act-1983-and-mental-capacity-act-2005-deprivation-of-liberty-safeguards-issue-6.pdf</p>
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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
<p>8.4 What are the next steps?</p> <p>Some suggestions:-</p> <ul style="list-style-type: none"> • Decide whether the strategy, policy, plan, procedure and/or service proposal: <ul style="list-style-type: none"> ○ 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 	<p>No significant negative Impact.</p> <p>The policy will be submitted to the Mental Health and Capacity Legislation Committee for approval.</p> <p>Once the policy has been approved the documentation will be placed on the intranet and internet.</p> <p>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.</p>	N/A	N/A	<p>N/A</p> <p>Hospital managers should monitor the use of admission under Part II of the Mental Health Act, including:</p> <ul style="list-style-type: none"> • The use of section 4 and ensure second doctors are available to visit a patient within a reasonable time after being requested.

Monitored Sarah
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Reference Number: TBA	Date of Next Review: TBA
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Application for admission to hospital under Part II of the Mental Health Act, 1983 Procedure

Introduction and Aim

This document supports the Application for admission to hospital under Part II of the Mental Health act, 1983 Policy.

To ensure staff are aware of their individual and collective responsibilities when considering admission to hospital under Part II of the Mental Health Act.

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 admission to hospital under Part II of the Mental Health Act:

- The purpose of admission to hospital under Part II of the Mental Health Act
- The process for assessing the suitability for admission to hospital under Part II of the Mental Health Act
- The duties of the practitioners and agencies involved in the management of patient's subject to admission to hospital under Part II of the Mental Health Act

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 policy is applicable to employees within all Mental Health inpatient settings, community settings and general hospital settings, including those with honorary contracts.

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.
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Documents to read alongside this Procedure	<ul style="list-style-type: none"> • 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)
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	<ul style="list-style-type: none"> • 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 • Mental Health (Wales) Measure 2010 <p>All Cardiff and Vale policies on the Mental Health Act 1983 as appropriate including:</p> <p>Section 5(2) Doctors' Holding Power Policy 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 Receipt of Applications for Detention under the Mental Health Act Policy</p>
Approved by	Pending – Mental Health and Capacity Legislation Committee

Accountable Executive or Clinical Board Director	<i>Chief Operating Officer</i>
Author(s)	<i>Mental Health Act Manager</i>

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	12/02/2019	TBA	<i>New document</i>
2	20/10/2022		<p><i>Removal of Glossary.</i></p> <p><i>Enhanced section to clearly explain the procedure in relation to receiving detention papers on behalf of the Hospital Managers.</i></p> <p><i>Expanded on paragraphs throughout for easier reading and understanding.</i></p>

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1. INTRODUCTION

Part II of the Act deals with patients who are detained in hospital but have no criminal proceedings against them. These are referred to as civil sections.

This policy provides relevant professionals with guidance to facilitate compliance with the requirements in respect of admission to hospital under Part II of the Mental Health Act 1983.

Part II of the Mental Health Act relates to the

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following:

- Section 2 – Admission for assessment
- Section 3 – Admission for treatment
- Section 4 – Admission for assessment in cases of emergency
- Section 5 – Application in respect of patient already in hospital
- Section 6 – Effect of application for admission

2. PROCEDURE STATEMENT

This procedure has been developed to guide staff on the implementation and management of patient's subject to Part II of the Act 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).

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 professionals within all Mental Health inpatient settings and general hospital settings.

4. 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.

4.1 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 should receive equitable care and treatment and support. If the criteria for detention are met, it is appropriate to detain

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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.

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 organic mental disorders associated with prolonged abuse of drugs or alcohol remain mental disorders for the purposes of the Act.

4.2 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.

4.3 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.

4.4 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.

5. NATURE OR DEGREE

Nature refers to the particular disorder from which the patient is suffering, its chronicity, its prognosis and the patient's previous response to receiving treatment for the disorder.

Degree refers to the current manifestation of the person's mental disorder.

6. APPROPRIATE MEDICAL TREATMENT

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.

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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.

7. APPROPRIATE MEDICAL TREATMENT TEST

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 a Community Treatment Order (CTO), it refers to the treatment for mental disorder that the person will be offered while on CTO.

8. SECTION 2: ADMISSION FOR ASSESSMENT

Detention under section 2 allows for assessment and treatment of people who have, or are believed to have a mental disorder for a maximum period of up to 28 days.

The person can be given treatment for mental disorder with or without their consent (under Part 4 of the Mental Health Act 1983).

If the person absconds, they can be forcibly returned to hospital by any authorised member of hospital staff or by the police (under Section 18 Mental Health Act 1983).

Criteria:

- The person is suffering from mental disorder **and**
- It is of a nature or degree to warrant detention in hospital for assessment or assessment followed by treatment for at least a limited period **and**
- The person ought to be detained in the interests of their own health **or** safety **or** with a view to the protection of others.

Section 2 pointers:

- An assessment as an inpatient is required in order to produce a treatment plan.
- A judgement is required on whether the patient will accept treatment on a voluntary/informal basis after admission.
- A judgement has to be made on whether a proposed treatment, which can only be administered to the patient under Part 4 of the Act, is likely to be effective.

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- The condition of a patient who has already been assessed, and who has been previously admitted compulsorily under the Act, is judged to have changed since the previous admission and further assessment is required.
- The diagnosis and/or prognosis of a patient's condition is unclear.
- It has not been possible to undertake any other assessment in order to formulate a treatment plan.

Forms:

- HO1 or HO2 Application by nearest relative **or** approved mental health professional (AMHP)
and
HO3 or HO4 Joint (x1) or single medical recommendations (x2)
- HO14 Record of detention in hospital

Not renewable:

If the patient is required to stay in hospital, this would be either as an informal patient or detained for treatment under section 3, **except** it can be extended when an approved mental health professional (AMHP) wishes to make an application to further detain a patient under section 3 but the nearest relative objects to the making of the application. As the objection prevents the application being made, the AMHP can consider displacing the nearest relative under section 29 of the Mental health Act 1983 (MHA) by making an application to the County Court. If the application is lodged with the court, the section 2 can be extended under section 38 of the County Court Act 1984 whilst consideration is being given to displacing the nearest relative.

9. SECTION 3: ADMISSION FOR TREATMENT

Detention under section 3 allows for detention and treatment of people in hospital for up to six months.

The person can be given treatment for mental disorder with or without their consent (under Part 4 of the Mental Health Act 1983).

If the person absconds, they can be forcibly returned to hospital by any authorised member of hospital staff or by the police (under Section 18 Mental Health Act 1983).

Criteria:

- The person is suffering from mental disorder **and**
- It is of a nature or degree which makes it appropriate for them to receive medical treatment in hospital **and**
It is necessary for the health **or** safety of the person **or** for the protection of others that they

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receive that treatment **and**

- Treatment cannot be provided unless they are detained **and**
- Appropriate medical treatment is available for them

Learning disability – under the provisions of section 3 of the Act, learning disability is only considered to be a mental disorder if it is associated with **abnormally aggressive or seriously irresponsible conduct** on the part of the person concerned (this does **not** apply to section 2).

Section 3 pointers:

- The patient is considered to need compulsory admission for the treatment of mental disorder, which is already known to his or her clinical team, and has recently been assessed by that team.
- The patient is detained under section 2 and assessment indicates a need for compulsory treatment under the Act beyond the existing period of detention. In such circumstances an application for detention under section 3 should be made at the earliest opportunity and should not be delayed until the end of the existing period of detention.

Appropriate medical treatment must be available in all cases; the recommending doctors are required to state on the form that ‘appropriate treatment’ is available, including the name of one of more hospitals who can provide the treatment.

Forms:

- | | |
|-------------|--|
| HO 5 or HO6 | Application by nearest relative or approved mental health professional (AMHP)
and |
| HO7 or HO8 | Joint (x1) or single medical recommendations (x2) |
| HO14 | Record of detention in hospital |

Renewable:

Initial detention is for a period of up to six months, renewable for a further six months and annually thereafter.

Before a patient’s detention expires, the Responsible Clinician must decide whether or not the statutory criteria are met in order to renew the detention. They must also consult with one or more people professionally concerned with the patient’s treatment.

10. SECTION 4: ADMISSION FOR ASSESSMENT IN CASES OF EMERGENCY

Detention under section 4 allows for admission to hospital in an emergency for a maximum period of up to 72

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hours. It may be applied when section 2 would be appropriate but the team are unable to obtain the two medical recommendations required and the patient needs urgent hospital admission.

Section 4 should only be used where the patient's urgent need for assessment outweighs the alternative of waiting for a medical examination by a second doctor. The section should never be used for medical or administrative convenience, for example because it is more convenient for the second doctor to examine the patient as an inpatient rather than in the community.

An emergency arises when those involved cannot safely manage the mental state or behaviour of the patient. To be satisfied that an emergency has arisen, there must be evidence of:

- An immediate and significant risk of mental or physical harm to the patient or others
- The immediate and significant danger of serious harm to property
- The need for physical restraint of the patient

Criteria:

- The criteria for detention for assessment under section 2 are met
- The patient's detention is required as a matter of urgent necessity; and
- Obtaining a second medical recommendation would cause undesirable delay

The AMHP making the application for detention under section 4 must have personally seen the patient within the previous 24 hours. The patient must be admitted within 24 hours from when the medical recommendation was made.

Forms:

HO9 or HO10	Application by nearest relative or approved mental health professional (AMHP)
HO11	Medical recommendation for emergency admission
HO4	Required to convert to section 2
HO14	Record of detention in hospital

Not renewable:

This section may be converted to section 2 within the 72-hour period by the addition of one other medical recommendation. Upon conversion, the 28-day period begins from the date of the section 4 (which is the time/date that the patient was admitted to hospital)

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As a matter of good practice, it should be noted that section 4 should only be used if there is serious intent for the patient to be placed on section 2. Arrangements for obtaining a second medical recommendation must be initiated immediately. During office hours the MHA dept will assist nursing staff to arrange a second doctor if necessary.

If the approved clinician in charge of the patient's treatment considers that section 3 is more appropriate, two fresh recommendations and a new application must be made within the 72-hour period. The treatment order would begin from the date the section 3 is formally accepted on behalf of the Hospital Managers.

11. MEDICAL RECOMMENDATIONS

An application must be supported by written recommendations from two doctors who have personally examined the patient. Except for section 4 when only one medical recommendation is required.

Recommendations may be made separately by each doctor or as a joint recommendation signed by both.

A medical examination must involve:

- A direct personal examination of the patient and their mental state, and
- Consideration of all available relevant clinical information, including that in the possession of others, professional or non – professional
- If the risk of violence from the patient makes direct examination unsafe then an examination by observation can be undertaken, such circumstance must be fully documented.

Where practicable, at least one of the medical recommendations should be provided by a doctor who has previous acquaintance with the patient. Preferably, this should be a doctor who has personally treated the patient. It is sufficient for the doctor to have had some previous knowledge of the patient's case. A patient's GP will usually have knowledge of the patient's physical health and family circumstances, which may be helpful in any assessment.

It is preferable that a doctor who does not have previous acquaintance with the patient be approved under section 12 of the Act. The Act requires that at least one of the doctors must be so approved.

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

Where patients are subject to the short-term effects of alcohol or drugs, whether prescribed or self administered, which make interviewing them difficult, the doctors should either wait until the

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effects have abated before interviewing the patient or arrange to return later. If it is not realistic to wait, because of the patient's disturbed behaviour and the urgency of the case, the assessment will also have to be based information the doctor can obtain from reliable sources. This will also apply if the patient is not willing to speak to the doctor. This should be made clear in the doctor's recommendation.

When making recommendations for detention under section 3, doctors are required to state that appropriate medical treatment is available for the patient. It is their responsibility to take the necessary steps to secure a hospital bed; it is not the responsibility of the applicant.

Except for emergency applications under section 4, the limits are:

- The date on which the applicant last saw the patient must be within the period of 14 days ending with the date of the application.
- The dates of the medical examinations of the patients by the two doctors who gave the recommendations (not the dates of the recommendations themselves) must be not more than 5 clear days apart.
- The dates of signatures of both medical recommendations must not exceed the date of the application.
- The patient's admission to hospital (or if the patient is already in hospital the reception of the documents by a person authorised by the hospital managers to receive them) must take place within 14 days beginning with the date of the later of the two medical examinations.

When an emergency application is made under section 4 it is accompanied in the first place by only one medical recommendation. The time limits, which apply to emergency applications, are:

- The time at which the applicant last saw the patient must be within the period of 24 hours ending with the time of the application
- The patient's admission to hospital must take place within the period of 24 hours starting with the time of the medical examination.
- An emergency application is founded on a medical recommendation therefore the date/time of an application must be later/ the same as the date/time of the medical recommendation.
- The second medical recommendation must be received on behalf of the managers not more than 72 hours after the time of the patient's admission. The two medical recommendations must then comply with all the normal requirements except the requirement as to the time of the signature of the second recommendation.

2. APPLICATIONS UNDER THE ACT

An application for detention may only be made by an AMHP or the

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patients nearest relative. An AMHP is usually a more appropriate applicant than a patient's nearest relative, given their professional training and knowledge of the legislation and local resources. This also removes the risk that an application by the nearest relative might have an adverse effect on their relationship with the patient.

An application must be supported by two medical recommendations, other than an emergency application, given in accordance with the Act. Doctors who are approached directly by a nearest relative about the possibility of an application being made should advise the nearest relative of their right to require a local authority to arrange for an AMHP to consider the patient's case.

When AMHP's make an application for admission under section 2, they must take such steps as are practicable to inform the nearest relative that the application is to be (or has been) made and of the nearest relative's power to discharge the patient. The AMHP should also inform the main carer (if a different person from the nearest relative) that an application has been made.

Before making an application for admission under section 3, AMHP's must consult the nearest relative, unless it's not reasonably practicable or would involve unreasonable delay. When coming to a decision to consult the nearest relative the applicant will need to give consideration to the patient's Article 5 and Article 8 rights.

The applicant must be satisfied that detention in hospital is the most appropriate way of providing the care and medical treatment that the patient needs, and that the criteria for that particular section is met. Consideration should be given to all the circumstances of the case, including:

- The benefit to the patient of the involvement of their nearest relative, including to protect the patient's Article 5 rights
- The patient's wishes, including taking into account whether they have the capacity to decide whether they would want their nearest relative involved and any statement of their wishes they have made in advance. However, a patient's wishes will not solely determine whether it is reasonably practicable to consult the nearest relative
- Any detrimental effect that involving the nearest relative would have on the patient's health and wellbeing
- Whether there is good reason to think that the patient's objection may be intended to prevent information relevant to the assessment being discovered.

If the nearest relative is not consulted or informed, AMHP's should record their reasons. Consultation must not be avoided purely because it is thought that the nearest relative might object to the application.

If the nearest relative objects to an application being made for admission for treatment under section 3, the application cannot be made. If it is thought necessary to

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proceed with the application to ensure the patients safety or that of others and the patient continues to object, the AMHP will need to consider applying to the county court for the nearest relative's displacement under section 29 of the Act.

13. CONFLICT OF INTEREST

Conflicts of interest may arise which prevent an AMHP from making the application for a patient's detention, and a doctor from making a recommendation supporting the application.

The potential conflict of interest may arise for a number of reasons. Those reasons are the existence of a professional, financial, business or personal relationship between that person and another assessor, or between that person and with the patient or, where the application is to be made by the patients nearest relative.

Assessor's have a potential conflict if any of the following apply:	
The assessor has a financial interest in the outcome of the decision whether or not to give a recommendation or make the application	
The assessor employs	The patient, or
The assessor directs the work of	Either of the other assessors making the recommendations or application
The assessor is closely involved in the same business venture (which includes being a partner, director, other office-holder or major shareholder) as	
The assessor is the wife, ex-wife, husband, ex-husband, civil partner, ex-civil partner, mother, father, sister, brother, half-sister, half-brother, daughter, son, aunt, uncle, grandmother, grandfather, grandson, granddaughter, first cousin, nephew, niece, mother-in-law, father-in-law, daughter-in-law, son-in-law, sister-in-law, brother-in-law, grandmother-in-law, grandfather-in-law, granddaughter-in-law, grandson-in-law, (including adoptive and step-relationships) of	The patient, or Either of the doctors making the recommendations on which the application is based
The assessor is living as wife, husband or civil partner with	The applicant (whether an AMHP or the nearest relative
The assessors making the recommendations and application are members of the same team organised to work together for clinical purposes on a routine basis	
The assessors and the patient are members of the same team organised to work together for clinical purposes on a routine basis	
Both doctors are on the staff of an independent hospital to which the patient's admission is being considered	

An application which relied on a recommendation made by a doctor who

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had a potential conflict of interest would be invalid.

Among the effects of this are that:

- only one of the recommendations in support of an application for admission to an independent hospital may be made by a doctor on the staff of that hospital, and
- three professionals involved in an application may not all be in the same clinical team, as described above.

Note that 'in-law' relationships include relationships based on civil partnerships as well as marriage. They do not include relationships based on people living together as if they were married or in a civil partnership.

14. RECEIPT AND SCRUTINY OF DOCUMENTS

Once the application has been completed, the section papers must be delivered to the appropriate officer acting on behalf of the Hospital Managers.

The UHB has delegated the receipt of detention documents on behalf of the Hospital Managers to:

- Mental Health Act Office
- Shift Co-ordinator

Officers responsible for receiving detention papers should accept them as soon as possible on a statutory form HO14 (sections 2, 3 and 4 – record of detention in hospital). An administrative scrutiny checklist for receiving detention papers should be used each time and attached to the detention papers.

During office hours (9.00am to 5:00pm) detention papers must be submitted to the Mental Health Act Office in Hafan Y Coed, UHL to enable the team to undertake receipt and scrutiny. Other sites must make contact with the Mental Health Act Office to inform them that they have detention papers to be received and make arrangements to fax or scan the papers as a priority. The AMHP who completed the application must complete a receipt to confirm that the detention papers have either been given directly to the Mental Health Act Office or to a member of HB staff who will give the papers to the relevant person in the scheme of delegation who is authorised to receive them on behalf of the Hospital Managers.

Outside of office hours between 5:00pm and 8.30pm the Shift Coordinator for the appropriate area i.e. Hafan Y Coed, MHSOP or Rehab must be contacted via bleep or through the main switchboard in order to make arrangements to receive detention papers. The AMHP must e-mail or call the Mental Health Act Office with details of the patient that has been detained to ensure they are aware of the detention.

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The Night Site Manager is the delegated officer between 8.30pm and 8.30am for the purpose of receipt of detention papers and can be contacted by bleep or the main switchboard.

The ward must keep a copy of the section papers in the patients file until the final version which has been processed by the Mental Health Act Office is available via PARIS.

For further information see Receipt of applications for detention under the Mental Health Act 1983 policy UHB 340:

<http://www.cardiffandvaleuhb.wales.nhs.uk/opendoc/300573>

15. OUTCOME OF DETENTION

The Responsible Clinician's power of discharge:

Section 23 of the Act allows Responsible Clinicians to discharge Part 2 patients, by giving a discharge order in writing. As Responsible Clinicians have the power to discharge patients, they must keep under review the appropriateness of using that power. If, at any time a Responsible Clinician concludes that the criteria which would justify renewing a patient's detention are not met, they should exercise their power of discharge. They should not wait until the patient's detention is due to expire.

Section 2:

- Discharge by Responsible Clinician **Form HO17**
- Discharge by Mental Health Review Tribunal for Wales **Form HO17**
- Discharge by Hospital Managers' hearing **Form HO17**
- Discharge by the nearest relative **Form HO17**

Section 3:

- Discharge by Responsible Clinician **Form HO17**
- Discharge by Mental Health Review Tribunal for Wales **Form HO17**
- Discharge by Hospital Managers' hearing **Form HO17**
- Discharge by the nearest relative **Form HO17**
- Placed onto a community treatment order **Form CP1**

Section 4:

- Discharge by Responsible Clinician **Form HO17**

The nearest relative's power of discharge:

Section 25 of the Act allows the nearest relative to order a patient's discharge from detention under section 2 or 3.

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The nearest relative must give 72 hours notice in writing to the hospital. The 72 hours will commence as of when the notice is received by either the Mental Health Act Office or the shift coordinator on duty (whichever is the earlier). The nearest relatives order may be barred if within the 72-hour period, the Responsible Clinician provides a written report using form NR1 stating that they consider the patient, if so discharged, **would be likely to act in a manner dangerous to other persons or to himself**. This question focuses on the probability of dangerous acts, such as causing serious physical injury or lasting psychological harm, not merely on the patient's general need for safety and others general need for protection.

The barring report prevents the nearest relative from ordering discharge again at any time in the six months following the date of the report.

If the patient were detained under section 2 at the time of the discharge request the nearest relative cannot take the matter further.

If the patient were detained under section 3 at the time of the discharge request then the nearest relative may, within 28 days of the barring report being issued, apply to the Mental Health Review Tribunal for Wales for the patients discharge instead.

The Hospital Managers must consider holding a review when the Responsible Clinician makes a report to them barring an order by nearest relative to discharge a patient.

When deciding whether to consider the case, Hospital Managers should take into account whether the Mental Health Review Tribunal for Wales has recently considered the patients case or is due to do so in the near future. If the decision is not to consider the case reasons why not should be documented.

16. MONITORING

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

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

17. TRAINING

The Health Board will provide ongoing training for staff who have a delegated duty under the scheme of delegation. Details of

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training courses available can be found by contacting the Mental Health Act Office or looking on the Mental Health Act intranet page via CaV web.

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

This procedure applies to all of those who have defined responsibilities under the provisions of the Act.

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

Mental Health Act 1983, Code of Practice for Wales, Revised 2016 - <https://gov.wales/docs/dhss/publications/160920mentalacten.pdf>

Reference Guide to the Mental Health Act 1983 - https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/417412/Reference_Guide.pdf

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Report Title:	Mental Health Legislation and Governance Group Terms of Reference	Agenda Item no.	12.2
Meeting:	Mental Health Legislation and Mental Capacity Act Committee	Public	X
		Private	
Meeting Date:			25 th October 2022
Status (please tick one only):	Assurance <input type="checkbox"/>	Approval <input checked="" type="checkbox"/>	Information <input type="checkbox"/>
Lead Executive:	Chief Operating Officer		
Report Author (Title):	Mental Health Act Manager		

Main Report

Background and current situation:

In line with UHB's Standing Orders, Terms of Reference for Sub-committees of the Board should be reviewed on an annual basis.

This report provides Members of the Mental Health Legislation and Mental Capacity Act Committee (MHLMCAC) with the opportunity to approve the Terms of Reference after review by the Mental Health Legislation and Governance Group (MHLGG)

Executive Director Opinion and Key Issues to bring to the attention of the Board/Committee:

As part of the All Wales Mental Health Act Manager's Group, the terms of reference for sub-committee groups was discussed leading me to review the Terms of Reference for the MHLGG as they were last reviewed in 2018.

Recommendation:

The Committee is requested to:

(a) Approve the Terms of Reference for the Mental Health Legislation Governance Group

Link to Strategic Objectives of Shaping our Future Wellbeing:

Please tick as relevant

1. Reduce health inequalities		6. Have a planned care system where demand and capacity are in balance	
2. Deliver outcomes that matter to people	X	7. Be a great place to work and learn	
3. All take responsibility for improving our health and wellbeing		8. Work better together with partners to deliver care and support across care sectors, making best use of our people and technology	
4. Offer services that deliver the population health our citizens are entitled to expect		9. Reduce harm, waste and variation sustainably making best use of the resources available to us	X
5. Have an unplanned (emergency) care system that provides the right care, in the right place, first time		10. Excel at teaching, research, innovation and improvement and provide an environment where innovation thrives	

Five Ways of Working (Sustainable Development Principles) considered

Please tick as relevant

Prevention		Long term	X	Integration	X	Collaboration		Involvement	
Impact Assessment:									
<i>Please state yes or no for each category. If yes please provide further details.</i>									
Risk: Yes/No									
No									
Safety: Yes/No									
No									
Financial: Yes/No									
No									
Workforce: Yes/No									
No									
Legal: Yes/No									
No									
Reputational: Yes/No									
No									
Socio Economic: Yes/No									
No									
Equality and Health: Yes/No									
No									
Decarbonisation: Yes/No									
No									
Approval/Scrutiny Route:									
Committee/Group/Exec					Date:				

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MENTAL HEALTH LEGISLATION AND GOVERNANCE GROUP TERMS OF REFERENCE AND OPERATING ARRANGEMENTS

1. Purpose

1.1 The Purpose of the **Mental Health Legislation and Governance Group** (MHLGG) is to:

- Review and monitor the functioning for Cardiff and Vale UHB and associated partners in undertaking their powers under the Mental Health Act and related legislation to provide assurance that Cardiff and Vale UHB is compliant in relation to these requirements and that appropriate governance arrangements are being adhered to.
- Ensure that actions of Cardiff and Vale UHB & partners are consistent with the principles of the Human Rights Act.
- Provide an operational scrutiny of the Mental Health Act activity reports and identify themes for further consideration at Cardiff and Vale **Mental Health Act Monitoring Committee** **Mental Health Legislation & Mental Capacity Act Committee**.
- Ensure an interagency forum where best practice under the Mental Health Act is highlighted.
- Provide an interagency forum where learning from sentinel events/critical incident reviews/complaints of actions with relation to Mental Health Act are discussed and actioned.
- To escalate issues of concern, in relation to functioning under the Mental Health Act to Cardiff and Vale **Mental Health Act Monitoring Committee** **Mental Health Legislation & Mental Capacity Act Committee**.

2. Membership

2.1 The membership of the MHLGG compliance group will consist of representatives from the following areas:

- Emergency Unit
- Mental Health Act office
- Cardiff Council AMHP service
- Vale of Glamorgan Council AMHP service
- Emergency Duty Team
- **Mental Capacity Act/DoLs**
- Approved Clinicians within Cardiff and Vale UHB
- Welsh Ambulance Service
- South Wales Police
- South Wales Mental Health Advocacy
- Cardiff and Vale UHB Equality Advisor
- **Senior Nurse, Service Manager & Lead Medic for North & West Cardiff**
- **Senior Nurse, Service Manager & Lead Medic for South & East Cardiff**
- **Senior Nurse, Service Manager & Lead Medic for the Vale Locality**
- Lead Nurse for Adult & MHSOP for Mental Health
- **Nursing Education, Quality, Patient Safety & Experience**
- **Shift Coordinator**
- **Pharmacy**

- Power of Discharge Group
- CAMHS
- Liaison Psychiatry

The Group will be chaired by a nominee of the divisional triumvirate.

Secretariat support will be arranged by the chair of the group.

3. Group meetings

3.1 Meetings shall be held quarterly

4. Accountabilities

- The group will be accountable to Cardiff and Vale ~~Mental Health Act Monitoring Committee~~ Mental Health Legislation & Mental Capacity Act Committee. The group will provide a written report to Cardiff and Vale ~~Mental Health Act Monitoring Committee~~ Mental Health Legislation & Mental Capacity Act Committee in the form of a summary of issues based on the transcribed notes from the meeting.
- Ensure that appropriate arrangements are in place to alert the chair of Cardiff and Vale ~~Mental Health Act Monitoring Committee~~ Mental Health Legislation & Mental Capacity Act Committee of any urgent/critical matters that may affect the operation and/or reputation of Cardiff and Vale UHB