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

Associate Hospital Managers' Power of Discharge Handbook

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

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Executive Lead: *Executive Director, Public Health*

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Version Number	Date of Review Approved	Date Published	Summary of Amendments
1			Amendments made to reflect the changes made to the Mental Health Act Code of Practice, (Revised 2016). Supervised Community Treatment has been replaced with Community Treatment Order. Includes further information on types of mental disorder. Guidance included on what to do if the panel cannot reach a unanimous decision. Amendments made to reflect changes made to the Police and Crime Act 2017, in relation to section 135 and 136.
2			Removed keywords appendix as in the Mental Health Act 1983, Code of Practice, (Revised 2016). Amended to make reference to Associate Hospital Manager where appropriate. Removed the following paragraphs as not relevant to role of Associate Hospital Manager: • The Hospital Managers – Who are they? • Duties of Hospital Managers. • Powers of Hospital Managers. Information inserted about hearings being conducted via VC. Legal position on being unable to reach a unanimous decision inserted.

Associate Hospital Managers' Power of Discharge Handbook

Contents:

1. Introduction

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

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

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

2. Equality Statement

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

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

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

3. Confidentiality

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

4. The Mental Health Act 1983 (2007), 'The Act'

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

- Removal of a patient from England or Wales to Scotland.
- Removal of a patient to and from Northern Ireland.
- Removal of a patient to and from Channel Islands and Isle of Man
- Removal of alien patients.
- Return of patients absent without leave from hospitals in Northern Ireland, England and Wales and patients absent from hospitals in the Channel Islands or the Isle of Man.

The Act is the legislation that governs the formal detention, treatment and care of mentally disordered people in hospital. In particular, it provides the authority by which people

diagnosed with a mental disorder can be detained in hospital, or police custody for their disorder to be assessed or treated, or treated in the community, if necessary without their consent.

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

- The duration of detention.
- The professionals involved.
- Treatment.
- Discharge.
- Entitlement to appeal.

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

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

4.1 Protection from liability

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

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

4.2 Rights

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

4.3 Limitations

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

4.4 Age range of the Act

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

4.5 Where does the Act apply?

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

5. Key Parts of the Act

5.1 Definition of mental disorder

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

5.2 Powers to admit and treat people in hospital

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

5.3 Criminal and Court related powers

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

5.4 Community powers

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

5.5 Treatment

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

5.6 Mental Health Review Tribunal for Wales (The Tribunal)

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

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

The Tribunal’s principal powers are to:

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

There are separate Tribunals in England and Scotland.

5.7 Hospital Managers

Under the Act, the Hospital Managers represent the organisation that formally detains a person. The Hospital Managers have a number of duties under the legislation including holding appeal hearings and reviews in accordance with the rules set out in section 20, the renewal of authority to detain and section 20A when a report has been made extending the community treatment period. They also have the power to discharge patients from section following a hearing.

5.8 Independent Mental Health Advocacy

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

5.9 Healthcare Inspectorate Wales

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

5.10 Nearest Relative

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

5.11 Conflicts of interest

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

6. The Mental Health (Hospital, Guardianship, Community Treatment and Consent to Treatment) (Wales) Regulations 2008 (the Regulations)

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

7. The Mental Health Act 1983 Code of Practice for Wales, (revised 2016)

The Code provides guidance to practitioners, managers and staff of hospitals on how to proceed when undertaking duties under the Act; it also gives guidance about certain aspects of medical treatment for mental disorder. However, it does not set out to explain each and every aspect of the Act and the regulations. The Code is intended to be helpful to patients, their representatives, carers, families and friends and others who support them. It

should also be beneficial to the police and ambulance services and others in Health and Social Services (including the independent and voluntary sectors) involved in providing services to people who are or who may become subject to compulsory measures under the Act.

N.B:

This is a statutory code concerning the practical use of the Act. It represents current thinking on best practice when using the legislation.
The Act does not impose a legal duty to comply with the Code, but due regard must be paid to it by those involved in the application of the Act and reasons for any departure from it should be recorded. Departures from the Code could give rise to legal challenge. In reviewing any such departure, a court will scrutinise the reasons for doing so to ensure that there is sufficiently convincing justification under the circumstances.

7.1 The Guiding Principles

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

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

8. Human Rights Act 1998

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

8.1 Article 2 – The Right to Life

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

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

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

8.3 Article 5 - Right to Liberty and Security

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

8.4 Article 8 – Right to a Private Life

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

8.5 Article 14 – Prohibition of Discrimination

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

9 Associate Hospital Managers' Power of Discharge

The Hospital Managers do not conduct reviews of informal patients.

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

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

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

10 The Mental Health and Capacity Legislation Committee

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

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

11. 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.

11.1 Dependence on alcohol or drugs

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

Disorders or disabilities of the mind which are related to the use of alcohol or drugs e.g. withdrawal state with delirium or associated psychotic disorder, acute intoxication, or organic mental disorders associated with prolonged abuse of drugs or alcohol remain mental disorders for the purposes of the Act.

11.2 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.

11.3 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.

11.4 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.[3]

12. Assessment for Possible Admission under the Act

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

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

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

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

13. Admission to Hospital for Assessment/Treatment under the Act

Admission may either be informal or formal.

13.1 Informal Admission

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

13.2 Formal Admission

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

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

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

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

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

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

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

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

13.4 Who decides in an emergency?

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

- If in a public place, the person could be arrested by a police officer under section 136 and taken to a place of safety if that person was deemed to be suffering from mental disorder and in need of immediate care and control. In Cardiff and Vale, the designated place of safety is Hafan Y Coed.

- If the person is already in hospital, certain nurses and doctors can detain a person pending further assessment.

- If a person is in their own home and refuses to let a doctor or AMHP in to see them, a magistrate can issue a warrant under section 135(1) that enables the individual's home to be entered with the aim of removing the person to a place of safety.

13.5 Appropriate medical treatment test

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

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

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

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

13.6 What happens when the patient arrives at the hospital?

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

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

13.7 What is the role of the nearest relative?

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

13.8 Identifying the nearest relative

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

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

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

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

- **Carers**

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

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

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

13.9 Exclusions

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

The following people are excluded from being a nearest relative:

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

13.10 Nearest Relatives of detained patients who are not UK residents

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

13.11 Unrelated Nearest Relatives

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

13.12 Information for patients and nearest relatives

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

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

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

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

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

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

13.13 What power does the hospital have over the patient when they are detained?

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

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

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

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

13.14 Options available to a patient if they disagree with their detention in hospital:

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

    - The patient's diagnosis and the need for medical treatment.
    - The freedom of the individual.
    - The protection of the public: and
    - The best interests of the patient.

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

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

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

Tribunals have the power to:

- Discharge patients from hospital.
- Recommend leave of absence.
- Recommend CTO, decide on a deferred discharge, conditional discharge or transfer to another hospital: or
- Reconvene if their recommendations are not complied with – however, the hospital is not obliged to follow up recommendations of a Tribunal.

- **Hospital Managers' Review (Hearings) -** Section 23 gives the Hospital Managers the power to discharge an unrestricted detained patient from detention or CTO.

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

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

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

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

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

13.15 Section 2 – Admission for Assessment

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

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

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

13.16 Section 3 – Admission for Treatment

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

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

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

13.17 Section 37 – Hospital Order

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

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

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

13.18 Section 4 – Emergency Admission for Assessment

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

13.19 Section 5(2) – Doctor's Holding Power

This section provides the authority for a doctor or approved clinician to detain either a voluntary inpatient or a patient who lacks capacity for up to 72 hours. It is designed to provide the time required to complete an application for section 2 or section 3 if the person wishes to leave hospital before the necessary arrangements for these applications can be made.

13.20 Section 5(4) – Nurse's Holding Power

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

13.21 Section 135(1) – Warrant to search for and forcibly remove a person

Provides the power to forcibly enter a property to look for and remove a person to a place of safety (usually a hospital) for a maximum period of up to 24 hours for assessment, if it appears to a magistrate that there is reasonable cause to suspect that a person believed to be suffering from mental disorder:

- Has been ill-treated, neglected or kept otherwise than under proper control.
- Or is living alone and unable to care for themselves.

This period can be extended for a further 12 hours by the responsible medical practitioner if a Mental Health Act assessment cannot be completed within the permitted period due to the person's mental or physical condition.

13.22 Section 135(2) – Warrant to search for and remove a patient

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

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

13.23 Section 136 – Police power of arrest

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

13.24 Section 17A – Community Treatment Order (CTO)
This allows for a patient to receive the care and treatment they need for their mental disorder in the community rather than in hospital. To be eligible for CTO the patient must have been detained on one of the treatment sections when the application for the CTO was made.

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

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

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

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

13.25 Section 7 – Guardianship
For patients in the community, guardianship allows their responsible clinician and others to specify a place of residence. Guardianship is initially for a period of six months; it can be renewed for a further six months by the RC and yearly thereafter. The Local Authority would manage the guardianship rather than Cardiff and Vale UHB.

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

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

13.27 Part 4A – Treatment of a community patient (CTO)
Patients subject to a CTO (community patients) are covered by Part 4A.

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

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

- They have an attorney or deputy who can give authority for the treatment; or if the Court of Protection is asked to give authority, through an order of the court;

Or

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

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

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

13.29 Section 18 – Absent without leave (AWOL)
If a patient takes leave of absence from the hospital without a section 17 leave authorisation in place, or does not return from authorised leave, the patient is classed as AWOL.

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

13.30 Section 20 – Renewal of authority to detain
If a section is to be renewed, sections 3, 37, 17A and 47 (transfer of sentenced prisoners to hospital and treated as section 37) require the RC to complete a "renewal of authority to detain report" before expiry of the section. This allows for the section to continue for a further period of six or twelve months, dependent upon the time that the patient has already been detained.

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

13.31 Section 20A – Extending a Community Treatment Order
Once a report has been completed, the Hospital Managers (Power of Discharge panel) are obliged to consider it and whether it is appropriate to exercise their discretion of discharge before the end of the current period of community treatment ends.

13.32 Section 23 – Discharge from detention
Sections can end in a number of ways including:

- Discharge of the patient by the RC before the end of the section period.
- Discharge by the Mental Health Review Tribunal following review
- Discharge by the Hospital Managers following review
- Discharge by the nearest relative (the nearest relative may order the discharge of a patient detained under certain Part 2 sections, CTO or

guardianship, however, the RC may issue a “barring certificate” provided that sufficient grounds exist to prevent the discharge.

13.33 Section 117 – Aftercare

This section provides a legal right to aftercare services for anyone who has ever been detained under s.3, s.37, s.45A (power of higher courts to direct hospital admission), s.47 (transfer to hospital of sentenced prisoners) and s.48 (transfer to hospital prisoners who have not been sentenced).

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

14. Arrangements for Hospital Managers’ Power of Discharge Hearings

14.1 When to hold a review

Hospital Managers:

- May undertake a review of whether or not a patient should be discharged at any time, at their discretion.
- Must undertake a review if the patient’s responsible clinician submits to them a report under section 20 renewing detention or under section 20A extending CTO.
- Should consider holding a review when they receive a request from (or on behalf of) a patient.
- Should consider holding a review when the RC makes a report under section 25 barring an order by the nearest relative to discharge the patient.

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

14.2 Chairing a panel

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

14.3 Agreeing key questions

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

14.4 Location

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

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

Hearings may also be conducted via video conferencing. Separate protocols are available from the Mental Health Act Team:

- Completing a managers outcome electronically
- Completion of hearing minutes after a video conference

14.5 Uncontested Hearings

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

14.6 Contested Hearings

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

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

14.7 Potentially Complex Hearings

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

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

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

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

14.8 Mental Health Act Office Responsibilities

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

- Ensure that the patient is aware that advocacy support is available.
- Wherever possible, make suitable arrangements to accommodate those patients and/or their nearest relatives who have a physical disability or need an interpreting service.

- Identify panel members and select a chairperson in accordance with the rota in place for each role to ensure that duties are allocated fairly and skills are maintained.
- Where the patient is an inpatient, taking into account any clinical advice, identify the most appropriate venue for the hearing i.e. meeting room or ward venue or video conferencing will be identified.
- Where the patient is subject to CTO, consider the most appropriate location for the hearing i.e. community venue wherever possible. Under no circumstances will a hearing be held at a patient's or any other person's home unless using video conferencing.
- Ascertain if the patient wishes the nearest relative/others to attend the hearing; if the patient does not consent to the attendance of his/her nearest relative, the appropriate professional involved in the patient's care will obtain the views of the nearest and/or most concerned relatives and include these in their report.
- Ensure that panel members are sent relevant reports and care plans electronically; **it is expected that they will bring these reports (printed or tablet versions) with them on the day**. Panel members are also able to receive verbal evidence in the absence of a written report e.g. if it has not been possible to complete a full mental health assessment in time for a report to be completed prior to a hearing or to provide a contemporaneous written update if the report was compiled some time before the hearing.
- Ensure that all reports are circulated to the patient and others as appropriate other than in circumstances where elements of the report may be withheld.
- On the day of the hearing, check with ward staff to ascertain whether or not it is the intention of the patient to attend the hearing.

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

14.9 Conduct of proceedings

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

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

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

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

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

- The patient should be allowed to be accompanied by a representative of their own choosing to help in putting their point of view to the panel. If the patient lacks capacity to put their point of view, their deputy, attorney or other representative of their choosing should be allowed to represent them.
- The patient should also be allowed to have a relative, friend, carer, deputy, attorney or advocate attend to support them.
- The responsible clinician and other professionals should be asked to give their views on whether the patients continued detention or a CTO is justified and to explain the grounds on which those views are based.

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

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

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

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

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

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

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

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

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

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

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

Any questions should be asked of all parties in a manner that is thorough, fair and courteous.
Care should be taken not to undermine the patient's relationship with their care team or his/her family.

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

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

14.10 Questioning the clinical team (This section below seems disjointed we go from talking about the medical staff to S2, CTO etc, and then return to Nurses?)
Some essential questions which must be asked:

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

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

Section 2 patients:

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

Other detained patients:

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

CTO patients:

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

The purpose of a CTO is 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 any possible harm to the patient or others. A CTO is intended to help the patient maintain stable mental health outside hospital and to promote their recovery.

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

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

Section 25 barring order

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

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

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

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

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

14.12 Nursing staff:
When questioning the nurse or CPN the Panel should ascertain recent behaviour on the ward, compliance with medication, and details of any Section 17 leave.

14.13 Social Worker/Care Coordinator:
These professionals, usually social workers, should be asked to provide a report about the patients' social circumstances that includes:

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

14.14 The Patient
Panel members must ascertain if the patient would stay in hospital as an informal patient if the section was lifted; would they continue to comply with treatment as an outpatient (the credibility of the answers would have to be assessed in the light of past evidence).

14.15 The nearest relative
Provided the patient gives their permission the nearest relative should be given the opportunity to be heard by the panel and question professionals, if appropriate**.** Other family members may be a source of valuable information and should be heard if at all possible. If the attendance of a number of family members is potentially disruptive the chair may give consideration to hearing their views before the main hearing.

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

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

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

Whether the panel members leave the room themselves, or the other people present (which is normally the case) will depend on local circumstances and will be the decision of the panel at the time of the hearing. During a video conferencing hearing, the panel should be moved to a break-out room to make their decision before re-joining the main meeting.

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

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

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

14.18 Recording hearings and decisions

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

- Renewal of authority to detain a patient.
- Patient appeal against detention.
- Barring of discharge order by a nearest relative.

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

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

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

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

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

14.19 Adjourning/ postponing a hearing

The Code states that:

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

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

Additional information may be required if there are:

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

Other reasons for adjourning may include:

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

14.20 Unable to reach a unanimous decision

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

In the event that at the conclusion of the hearing, the Hospital Managers are unable to reach a unanimous decision whether to discharge, the legal position is:

- A split decision of a panel of three members means that the patient has not been discharged.

- There is no obligation to offer the patient a further hearing in the event of a split decision.

- The Managers have a discretion to hold a hearing at any time. However that discretion must be exercised reasonably. It would not be reasonable to hold a fresh hearing solely on the ground that there has been a split decision.

- A fresh hearing could be held if fresh information is brought to the attention of the Managers, for example, information about the patient's current mental state or psychiatric history.

14.21 Informing the patient of the Hospital Managers' decision

When the panel has reached their decision, the reasons for it should be communicated in full, both orally by the chair of the panel (unless the patient has already returned to the ward) and in writing (from the Mental Health Act office), to the patient, to the nearest relative with the patient's consent, and to the professionals concerned.

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

14.22 Recording the Decision

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

When a hearing is conducted via video conferencing the Chair will provide the panel with an electronic copy of the minutes and the reasons for their decision. Once the wording is agreed by the panel members the final minutes and reasons will be sent to panel members. Panel members are expected to confirm via the CJSM system, using the reply all function, their agreement to the minutes and decision. The Mental Health Act Office will be copied into this correspondence.

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

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

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

15. The Mental Capacity Act 2005

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

It also includes the following:

- **Reasons for doubting a person's capacity**
  There needs to be a reason for doubting a person's ability to take their own decisions. The Mental Capacity Act Code of Practice explains this further.
- **A statutory test for capacity**

The Act provides the test to be used to decide if someone can take a particular decision for themselves.

- **Identifies who has the authority to make decisions for the person**
  The Act sets out a legal framework of how to act and make decisions on behalf of people who lack capacity to make specific decisions for themselves.

- **The IMCA (Independent Mental Capacity Advocate) safeguard**
  The Act sets out when a person is entitled to the support of a statutory advocate.

- **The best interests process**
  Any decision that is made on behalf of a person who lacks capacity must follow the process set out in the Act.

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

15.1 Deprivation of Liberty Safeguards (DoLS)

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

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

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

The recent decision of the Supreme Court in the Cheshire-West case reinforced the legal test (the acid test) for a Deprivation of Liberty (DoL) and therefore, who should be subject to DoLS. The purpose of the acid test is to determine whether a person is subject to continuous supervision and control **and** is not free to leave. DoLS should therefore always be considered where the acid test is met, but the patient does not meet the criteria for

detention under the Mental Health Act. Failure to seek appropriate authorisation when a patient is deprived of their liberty is unlawful and will infringe Article 5 of the European Convention of Human Rights.