NHS
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STANDARD OPERATING PROCEDURE
CONSENT TO TREATMENT FOR PATIENTS DETAINED UNDER THE MHA

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VALIDITY – SOPs should be accessed via the Trust internet to ensure the current version is used

CHANGE RECORD

Version	Date	Change details
1	*Feb-21*	*New SOP. Approved MHL Steering GHroup 21 April 2021*
1.1	*Dec-21*	*Reviewed. Added responsibility for completion of consent to treatment documentation where there is a change in RC.* *Approved by MHL Steer group 16-Jan-22*
1.2	*Jan-24*	*Full review. Approved at Mental Health Legislation Steering Group (17 January 2024).*

Contents

1. INTRODUCTION

Under English common law all mentally competent adults have an absolute right to give or withhold consent to any medical treatment. This remains so even if withholding consent may seriously jeopardise the person's health or even result in their death.

In general, therefore the treatment of informal (or voluntary) patients in Mental Health Services follows the same principles as in general medicine and elsewhere and should only proceed on the basis of the informed consent of the patient.

Informed consent should be taken to mean at a minimum that:

- the person is assessed by a competent professional as being capable of understanding and decision-making in relation to the treatment in question i.e. having capacity

- the person has received and understood information about the nature of their condition, the planned effects of treatment, and the possible side effects, the risks of taking or not taking treatment

- the person has voluntarily and without undue pressure or duress, agreed to the treatment in question.

'Continuing consent' means that it should not be assumed that because a patient has once given consent they therefore continue to do so. A patient is entitled to change their mind and withdraw their consent. For any course of treatment extending over time, steps must be taken by professionals to assure themselves that the patient continues to consent. If the patient withdraws consent for any reason, the treatment cannot continue on an informal basis.

To give treatment without informed and continuing consent may constitute assault and trespass against the person (i.e. unless the special provisions of the Mental Health Act 1983 or the Mental Capacity Act 2005 apply). It may result in legal action by the patient for compensation, redress in the Criminal Courts and/or disciplinary action.

The Mental Health Act 1983 allows for treatment without consent in certain circumstances. It should always be remembered that even when dealing with detained patients, good practice requires that the doctor and other professionals involved in the patient's care should always:

- Assess whether the patient has the capacity to understand the nature of their illness and the potential effects of treatment. Capacity is presumed in over 16 year olds unless otherwise established
- Record the assessment of capacity in the patient's electronic care record

In the Act, "Medical Treatment" also includes nursing, psychological intervention, specialist mental health habilitation, rehabilitation and care.

Patients subject to the Mental Health Act have a statutory right to access the Independent Mental Health Advocacy service and they may be referred to this service if they have issues relating to treatment under the Act. Ward staff and the Mental Health Act office must ensure patients are provided with information about the Independent Mental Health Advocacy service.

2. SCOPE

This SOP applies to all Trust operational staffing, contracted agency staff and supporting agencies which access and provide care to patients subject to the MHA or liable to be detained under the MHA.

3. SOP STATEMENT

This procedure aims to ensure that staff are aware of the overall legal framework within which consent to treatment decisions must be made.

The procedure also specifically aims to ensure that staff are aware of the particular legal requirements for detained patients and that their clinical practice is informed by this.

4. DUTIES AND RESPONSIBILITIES

Hospital Managers (the Trust)
The "Hospital Managers" are responsible for ensuring compliance with the provisions of the Act. This includes ensuring statutory documentation is completed and available and that adequate arrangements are made for "Second Opinion Appointed Doctor" (Second Opinion Appointed Doctor) visits.

Approved Clinician/Responsible Clinician

- To assess the patient's capacity, discuss consent with them where possible and document this accordingly on the electronic Capacity to Consent to Treatment form (Z48) in the Mental Health Act and Legal tab in the patient's electronic care record (Lorenzo).
- To make best interest decisions about treatment where necessary.
- To authorise treatment under Part 4/4A of the Mental Health Act 1983.
- Where capacity exists seek the patient's informed consent, taking account of the patient's preferences.
- Review the treatment plan and consider alternative options if the patient refuses or withdraws consent.
- Keep the patient's capacity and consent under review.
- Seek the patient's consent where changes in treatment are proposed.

Other Clinical Staff

- To ensure consent is obtained for specific nursing and psychological interventions, specialist mental health habilitation, rehabilitation and care
- To assess capacity and contribute to assessments of capacity and willingness to consent where appropriate.
- To make or contribute to best interest decisions where necessary.
- To contribute to Second Opinion Appointed Doctors' assessments.

Nursing Staff

- To administer medication and other treatment in accordance with this procedure.
- To be alert to the possibility that the patient may withdraw their consent to treatment and to inform the Approved Clinician/ Responsible Clinician if the patient's consent has been withdrawn.
- To raise a datix where the law has been breached in relation to consent to treatment under the MHA.

Mental Health Act administrators

- To maintain records on Electronic Patient Record (EPR) and elsewhere of consent to treatment information for detained patients.
- To issue reminders to Approved Clinician/Responsible Clinicians and others as necessary about consent expiry dates.
- To give non-clinical advice to staff about consent to treatment issues.
- To inform the mental health legislation manager of any breaches

Mental Health Legislation Manager

- To monitor compliance with the Act, including consent to treatment issues through the Mental Health Act administrators.
- To organise Trust-wide guidance, information sharing, audits of consent to treatment practice and policy changes, as necessary.

Pharmacists

- To scrutinise relevant consent to treatment documentation and raise a datix where the law has been breached in relation to consent to treatment under the MHA.
- To alert Approved Clinician/Responsible Clinicians where errors are made and re-scrutinise documentation to ensure compliance.
- To inform MHL Team about all unauthorised treatment incidences under the MHA.

Medicine Safety Officer

- To inform MHL Team about all unauthorised treatment incidences under the MHA when an incident has been raised with them via datix.

Ward Technicians

- To raise a datix where the law has been breached in relation to consent to treatment under the MHA.

Second Opinion Approved Doctor (SOAD) is an independent doctor appointed by the Care Quality Commission. They must:

- Satisfy themselves that the patient's detention papers are in order
- Offer a second opinion on a patient's treatment if the patient is not consenting or if the patient lacks capacity to consent
- Issue a Second Opinion Appointed Doctor certificate approving treatment/s for the particular patient

Statutory Consultee - Second Opinion Appointed Doctors are required to consult two people before issuing certificates approving treatment. One must be a nurse the other must not be either a nurse or doctor. Both must have been professionally concerned with the patient's medical treatment and neither may be the Approved Clinician of the proposed treatment or the Responsible Clinician. In Humber Trust it is permissible for this person to be a Pharmacy Technician who has good knowledge of the patient's treatment plan.

5. PROCEDURES

5.1. Treatment without Consent

The Mental Health Act 1983 (The Act) gives legal authority for the treatment of mental disorder without the patient's consent, this is governed by Part 4/4A of the Act which applies to the majority of detained patients; Section 2, Section 3, Section 37, Section 37/41, Section 38, Section 36, Section 45A, Section 47, Section 48, Section 47/49 Section 48/49 and Section 17A patients who have been recalled. This includes patients who have been granted leave using Section 17.

Patients specifically excluded from Part 4 provisions are:

- Patients detained under Section 4, 5(2), 5(4), 35, 37(4), 135, and 136.
- Patients on Section 7 (Guardianship) or Community Treatment Orders who are not 'liable to be detained in hospital'.
- Patients conditionally discharged from a Hospital Order, but subject to restriction in the community under Section 41 or Section 49.

These patients can only be treated without their consent in accordance with the Mental Capacity Act 2005 or in exceptional circumstances under common law. Patients subject to Community Treatment Orders with capacity cannot be given treatment without consent in the community.

Section 58 of the Act applies specifically to treatment for mental disorder. Treatment for physical disorders is outside the remit of the Act and can only be given in the absence of consent if it can be justified under the Mental Capacity Act 2005 as being in the person's best interests.

5.2. The Three Month Period

If a patient is detained under a section included in the list provided in 4.1, then for the first three months they may be given medication for mental disorder under the authority of their Responsible Clinician without the need for consent or the authorisation of a Second Opinion Appointed Doctor. The Code of Practice states that the patient's consent should still be sought before any medication is administered, wherever practicable. The patient's consent, refusal to consent, or a lack of capacity to give consent should be recorded by the Responsible Clinician on the Capacity to Consent to Treatment form (Z48).

If a person has capacity to consent but such consent is not forthcoming or is withdrawn during this period, the clinician in charge of the treatment must consider carefully whether to proceed in the absence of consent or give alternative treatment or stop treatment. These decisions must be recorded in the person's electronic care record.

Clinicians authorising or administering treatment without consent under the Act are performing a function of a public nature and must therefore comply with the 1998 Human Rights Act which gives effect to certain rights and freedoms guaranteed under the European Convention on Human Rights. In particular the following should be noted:

> Compulsory administration of treatment which would otherwise require consent is invariably an infringement of Article 8 of the European Convention on Human Rights, however it may be justified where it is in accordance with law (in this case the procedures of the Act) and where it is proportionate to a legitimate aim i.e. the reduction of the risk posed by a person's mental disorder and the improvement of their health.
>
> Compulsory treatment is capable of being inhuman treatment contrary to Article 3 of the European Convention on Human Rights, if its effect on the person concerned reaches a sufficient level of severity. The European Convention on Human Rights has said that a measure which is convincingly shown to be a medical necessity from the point of view of an established principle of medicine cannot in principle be regarded as inhuman and degrading.

The three-month period is not affected by renewal of detention, leave or changes to or discontinuation of treatment. A fresh three-month period will only start if the section ends and a new one commences. For patients detained on Section 2 period followed by a Section 3, the date medication was started under Section 2 will be the date the three-month period starts.

Recording of capacity and consent to treatment should be completed on assessment following admission, at the three month point, renewal, change of Responsible Clinician, Community Treatment Order, or withdrawal of consent and change in mental state and on a review of treatment of restricted patients.

Mental Health Act administrators will notify the Responsible Clinician and nursing staff 6 weeks before the expiration of the three month period. This notification will include details of the requirement to comply with Section 58 if treatment is to continue. The Mental Health Act administrator will also contact the ward every 2 weeks before and on the day of expiry to remind nursing staff they cannot continue with treatment if the necessary documentation is not in place.

The three-month period does not apply to Electro Convulsive Therapy and some other special treatments.

5.3. Patients who can and do consent to treatment

Prior to the three month period ending the Responsible Clinician must personally seek the patient's consent and make a record of that discussion. The Responsible Clinician should record that decision on the electronic Capacity to Consent to Treatment (Z48) form in the Consent to Treatment tab in the patient's electronic care record.

Form T2 must be completed by the patient's Responsible Clinician to signify the patient's capacity to give consent to the treatment and must include:

- All drugs proposed (including PRN medication) either by name or by ensuring that the number of drugs authorised in each class is indicated using BNF categories.
- If drugs are specified by class, the certificate must clearly state the number of drugs authorised in each class, and whether any drugs within the class are excluded.
- Maximum dosage, and route of administration must be clearly indicated for each drug or category of drugs proposed.

If the combined dose of antipsychotic medication (by any route) exceeds BNF limits, the form must record the combined maximum dose as a percentage of BNF maximum

The patient should be given a copy of the completed Capacity to Consent to Treatment (Z48) form.

Once completed, Form T2 should be sent to the MHA Office and a copy must be:

- Available in a separate file kept in the clinic so this can be cross referred with the MAR chart on the EPR for the nurse to check before giving medication.
- Scrutinised by Pharmacy (process arranged via MHL Team)
- Uploaded onto EPR by the MHL Team once passed scrutiny

A new Form T2 must be completed:

- If a new medication is prescribed that is not included on the existing Form T2
- If there is a change of Responsible Clinician

It is good practice for a new Form T2 to be completed if a year has elapsed since the signing of the Form T2.

5.4. If the patient withholds or cannot give consent

Consent must be voluntary and based on sufficient understanding of the treatment. If a patient refuses consent or is unable to give valid consent Form T2 is not valid. Consent must also be continuing consent. If a patient withdraws consent or is no longer capable of giving valid consent, a Form T2 ceases to be valid and treatment must be renegotiated.

In the case of a patient refusing or withdrawing consent or unable to consent; treatment can only proceed on the authority of a Second Opinion Appointed Doctor (SOAD). A visit and assessment from a Second Opinion Appointed Doctor can be requested from the Care Quality Commission.

5.5. Children and Young People

Young People Age 16-17

Young persons aged 16 or 17 are presumed in law to be capable of consenting to their own medical treatment. However, a 16 or 17 year old may lack capacity because of an impairment or disturbance in the functioning of the mind or brain, just as in the same way as a person over 18. If capacity is in doubt, the 16 or 17 year old's capacity should be assessed under the Mental Capacity Act as for an adult.

The effect of section 131(4) of the Mental Health Act is that when a 16 or 17 year old has capacity and does not consent to admission to hospital for treatment of a mental disorder, they cannot be admitted informally on the basis of the consent of a person with parental responsibility.

Children Under 16

Children under the age of 16 are not automatically presumed to be legally capable of making their own decisions about their healthcare. However, under 16's may be capable of giving valid consent to a particular treatment or intervention if they have 'sufficient understanding and maturity to enable him or her to understand fully what is proposed.' This is known as being Gillick competent. There is no specific age at which a child under 16 becomes capable of consenting to a particular treatment. It depends on the child and the seriousness and complexity of the treatment proposed. Competency is assessed using the same principles considered when assessing capacity.

If a child under 16 is not 'Gillick competent' to give consent for themselves, consent should be sought from a person with parental responsibility. People with parental responsibility for a child include: the child's mother, the child's father if married to the mother at the child's conception, birth or later, the Local Authority if the child is subject to a Care Order, or a person named in a Residence Order in respect of the child. Historically, a child's refusal of treatment (including refusal by a 16 or 17 year old or a Gillick competent child), could be overruled by someone with parental responsibility. However, the modern approach (post Human Rights Act 1998) is that it is wise to seek legal advice if a competent under 18 year old is refusing consent to treatment in order to determine whether it is lawful to treat them in the face of their refusal. If detention under the Mental Health Act is not legally appropriate, an application to Court may be required.

5.6. SOAD requests and preparation

SOAD Requests are to be made through a provider portal account on the CQC website. HTFT has created a group account on the CQC website for the RCs within the trust that can be used for this purpose. RCs must contact their local MHA office to gain access details for the portal. As per Trust Information Governance requirements, the access details must be held securely and must not be shared with other parties.

The CQC will arrange for a SOAD to visit. This can often take a few weeks and Responsible Clinicians should remember that a SOAD can be requested up to one month before the end of the three-month period.

The ward team must prepare for the visit by a Second Opinion Appointed Doctor by:

- Identifying the two involved professionals (one a nurse, the other another professional i.e. excluding a nurse or doctor) whom the Second Opinion Appointed Doctor must consult with.
- Consultees may expect to have a private discussion with the Second Opinion Appointed Doctor, among the issues that consultees may be asked to comment on are; the proposed treatment and the patient's ability to consent to it, their understanding of the past and present views of the patient, other treatment options and the way in which the treatment proposal was arrived at, the patient's progress and the views of patients and carers/family and where relevant , the implications of imposing treatment on a patient who does not want it and the reasons why the patient is refusing treatment.
- Ensuring that all relevant documentation (treatment plan, section papers) is available for the Second Opinion Appointed Doctor's inspection.
- Reminding both professionals of their need to document their consultation in the patient's care record.
- Details of any relevant advance decisions to refuse treatment, advance statements, wishes or feelings should be recorded in the patient's notes, if they are not they should be drawn to the Second Opinion Appointed Doctor's attention.

If the Second Opinion Appointed Doctor feels that the treatment as prescribed by the Responsible Clinician in charge of treatment is reasonable, taking into account all the circumstances of the case, they will complete a Form T3, which provides the legal authority for treatment and should be copied and filed like a Form T2 (see 5.3 above). All T3's are now completed electronically and sent through a secure web based App to the treating Team. A copy of the form should be emailed to Mental Health Legislation Team.

Second Opinion Appointed Doctors are legally required to provide a written explanation of the reasons for their decision either to authorise or refuse to authorise treatment. The Second Opinion Appointed Doctor can document the nature of and reasons for their decision on the T3 (Mental Health Act Code of Practice 25.63).

It is the personal responsibility of the clinician in charge of the treatment to communicate the results of the SOAD visit to the patient **(there is a specific communication note for recording this in the EPR in clinical charts in the medical tab titled "record of SOAD outcomes").** This need not wait until any separate statement of reasons has been received from the SOAD. But when a separate statement is received from the SOAD, the patient should be given the opportunity to see it as soon as possible, unless the clinician in charge of the treatment (or the SOAD) thinks that it would be likely to cause serious harm to the physical or mental health of the patient or any other person (MHA Code of Practice 25.66).

5.7. MHA Section 57

Certain forms of treatment (e.g. psycho-surgery or implantation of sexual hormones) are defined in Section 57 can only be given if the patient has consented and a second opinion has been obtained.

These are rarely used in this Trust and detailed guidance on them can be found in the Code of Practice, Chapter 24.

Section 57 treatments can only be given if:-

- The patient consents to the treatment,
- A SOAD (and two other people arranged by CQC) certify that the patient has the capacity to consent and does so,
- The SOAD also certifies that it is appropriate for the treatment to be given to the patient.

Any Approved Clinician considering giving treatment under Section 57 is advised to contact the Care Quality Commission in advance to discuss how to proceed.

5.8. Changes to Treatment after the Three Month Period

Authority for treatment should be reviewed regularly and in the following circumstance:

- If the Responsible Clinician in charge of treatment needs to change the patient's medication or replace this with a different form of treatment they must discuss this with the patient and explain any possible benefits, significant or frequently occurring risks or side-effects. If the patient is consenting to the medication, a new Form T2 must be completed by the Responsible Clinician in charge of treatment. If the patient is refusing or is incapable of consenting to treatment a Second Opinion Appointed Doctor must be obtained to complete a new Form T3.
- It is good practice to review the treatment provided on Form T2 each time a section is renewed.
- If a Form T3 is in place the Responsible Clinician must complete a Section 61 review of treatment form (this will have been sent to them by the MHA administrators with the section renewal reminder) this should be completed and returned to the Mental Health Act administrator within one month of the date that it is sent to the Responsible Clinician.
- A Section 61 Review of Treatment form must also be completed when a section is restored under Section 21B following a period of absence without leave of 28 days or more
- As requested by a Second Opinion Appointed Doctor – e.g. where they have time-limited the authority for treatment or specified the requirement for periodic reports on Form T3.
- Annually when patients are under restriction orders, this coincides with the date that a report should be provided to the Ministry of Justice.

5.9. Renewal of Detention

When a section is renewed it is not a legal requirement for a Form T2 to be rewritten, but it is good practice to do so if the section is being renewed for a year and the form T2 has not recently been completed.

If there is a change in Responsible Clinician a Form T2 provides the authority to treat and only ends if the patient's consent is withdrawn or the patient becomes mentally incapable of consenting to treatment or the treatment specified in the form changes. However the Trust policy is that best practice would suggest that whenever there is a permanent change of Responsible Clinician a new form T2 should be completed as soon as possible.

Circumstances in which the certificate ceases to authorise treatment include where "there is a **permanent** change in the Approved Clinician in Charge of the patient's treatment" (Code of Practice 25.83).

It is good practice for a fresh form to be completed at the earliest opportunity where there is either a **permanent change** of AC or the AC is likely to be absent for a **considerable time** because the new or acting AC will need to review the patient's medication and completion of the form will provide evidence of the review (Jones (MHA Manual) 23rd Edition).

When a patient is transferred on a Section 19 the authority for treatment should be reviewed.

If the section is being renewed and the patient is subject to a Form T3, a section 61 review of treatment must be completed by the RC (or responsible doctor if different) and returned to the Care Quality Commission. The Section 61 review of treatment allows the Care Quality Commission to know if a patient continues to receive treatment under Form T3 and to decide whether another SOAD visit is necessary.

5.10. MHA Section 62

Section 62 allows for urgent treatment to be given to detained patients in advance of the Section 58 safeguards. A SOAD should normally have been requested before Section 62 is issued unless the treatment under Section 62 is short term use only.

To be lawful under Section 62, medication must be immediately necessary to

(a) save the patient's life or
(b) (not being irreversible) prevent a serious deterioration in their condition or
(c) alleviate serious suffering or
(d) represent the minimum interference necessary to prevent the patient from behaving violently or being a danger to themselves or others.

Treatment under Section 62 is not limited by time or to a set number of interventions.
If it is still not possible to treat under Section 58 (e.g. because the SOAD has still not assessed), the treatment can continue under Section 62 as long as the necessary conditions still apply.

Treatment under Section 62 must be documented on the appropriate Trust form (Z08, Record of Urgent Treatment under Section 62), which should be sent to the MHA office for scrutiny.

- A copy should be saved to the paper file for the nurse to check before giving medication.
- The form will be scrutinised via the medical scrutiny route (process arranged via MHL Team)
- The form will be uploaded onto EPR by the MHL Team once passed scrutiny
- RC should carry out regular reviews and record on the S62(2) form (Z?????) which has recently been devised to evidence regular review of emergency treatment whilst awaiting SOAD.

5.11. Nurses and the Administration of Medicine

Nurses need to be aware that if they administer medication without lawful authority they are themselves acting unlawfully and in breach of their professional code.

All units to have a separate file kept in the clinic with paper copies of the T2 / T3 / S62 MHA form (Z08) and Capacity to Consent to Treatment form (Z48) so this can be cross referred with the MAR chart on EPR.

Before administering medication, nurses must therefore check whether: -

- The three-month period for administering medication without consent has passed without a Form T2, Form T3 or S62 MHA form (Z08) being completed.
- Where required, a correctly completed Form T2, T3 or S62 MHA form (Z08) is available and covers all of the medication to be administered.
- Authorisation for PRN medication is included on the Form T2 or T3 if it is to be given.
- Capacity to Consent to Treatment form (Z48) has been completed by the RC which coincides with the completion of the T2/T3/ S62 MHA form (Z08).

If in doubt, medication should not be administered until the issue has been resolved with the Responsible Clinician (responsible doctor if different).

5.12. Covert Medication Administration

If the medication is being given covertly, this should have been explicitly considered in the best interests meeting. The Mental Capacity Act might be used to give authority for covert medication for physical health whether or not the patient is detained under the Mental Health Act, and may be used as authority for covert psychiatric medication for patients who are not detained under the Mental Health Act.

Please refer to Covert Administration of Medicines Guideline (G383) on Trust intranet.

5.13. Section 63 Treatment not requiring consent

Unless the special rules in Sections 57, 58 or 58A apply, detained patients may be given medical treatment for the mental disorder from which they are suffering without their consent, provided the treatment is given by or under the direction of the approved clinician in charge of the treatment in question, who need not be the patient's responsible clinician.

Section 63 allows for the treatment of medical disorder ancillary to the core treatment that the patient is receiving for their mental disorder and can include nursing and care to relieve the consequences of the disorder. Feeding by nasogastric tube of patients who refuse to eat as a form of self-harm and those suffering from anorexia nervosa or depression can also come within the scope of this section.

5.14. Section 58A Electro Convulsive Therapy

Although Electro Convulsive Therapy is a treatment for mental disorder just as is medication it is subject to a different legal position. In particular Electro Convulsive Therapy cannot be given to a capable person who is refusing it, even when that person is detained. This is as a result of the specific changes made to the Mental Health Act 1983 by the Mental Health Act 2007 amendments.

Electro Convulsive Therapy is not subject to the three month period which applies to medication. Before any course of Electro Convulsive Therapy a detained patient must:

- Either give a valid consent and have a form T4 completed by the Responsible Clinician in charge of their treatment or
- If unable to give consent (see below) have a form T6 completed by a Second Opinion Appointed Doctor or
- Meet the conditions for urgent administration of Electro Convulsive Therapy under Section 62.

These are stricter than those for medication (stated above in 5.12). Electro Convulsive Therapy must be immediately necessary to:

a) save the patient's life **or**
b) not being irreversible to prevent a serious deterioration in their condition.

Patients under 18 who are consenting to Electro Convulsive Therapy can only be given Electro Convulsive Therapy if a Second Opinion Appointed Doctor has assessed and completed a Form T5 (Code of Practice 24.19).

Where patients are incapable of consenting to Electro Convulsive Therapy but are compliant (i.e. are not physically resisting its administration) they may be given Electro Convulsive Therapy as an informal patient if it is in their best interests and in compliance with the Mental Capacity Act 2005 Section 5. A Mental Capacity Act assessment and best interest decision must be completed on the person's electronic care record.

It is also recommended that a second opinion from another doctor from within the Trust is obtained beforehand and that a referral is made to a local advocacy service. Note, however, that Electro Convulsive Therapy cannot be administered if there is one of the following:

a) Valid and applicable advance decision objecting to Electro Convulsive Therapy
or
b) A lasting power of attorney or deputy who objects to Electro Convulsive Therapy
or
c) A decision of the Court of Protection conflicting with the giving of Electro Convulsive Therapy (Code of Practice 24.21)

This position is based on guidance on Electro Convulsive Therapy issued by the Royal College of Psychiatrists in 2008.

Where the patient is incapable but not compliant (i.e. they are physically or verbally resistant to being in hospital and receiving treatment) or where their nearest or other relatives are objecting on their behalf, it is not possible to rely on the Mental Capacity Act, Section 5. As with any incapable patient needing treatment for mental disorder, but who is resistant to that treatment, consideration should be given to use of the Mental Health Act. Therefore a resisting incapable patient should only be given Electro Convulsive Therapy under a Mental Health Act section and within Section 58 safeguards. Before Electro Convulsive Therapy can be given to a refusing patient authorisation must be obtained from a Second Opinion Appointed Doctor from the Care Quality Commission by completion of a Form T6.

Note that the Second Opinion Appointed Doctor will not be able to make such authorisation if there is a:

- Valid and applicable advance decision objecting to Electro Convulsive Therapy or
- A lasting power of attorney or deputy who objects to Electro Convulsive Therapy or
- A decision of the Court of Protection conflicting with the giving of Electro Convulsive Therapy (Code of Practice 24.21)

Authorisation Forms for Electro Convulsive Therapy must always specify the upper limit for the number of time Electro Convulsive Therapy is to be given.

In addition to any necessary statutory forms it is Trust Policy that all episodes of Electro Convulsive Therapy given on the basis of the patient's consent to be accompanied by an assessment of the patient's capacity to consent to treatment which is signed by the patient

5.15. Part 4A Treatment of patients on Community Treatment Order

Patients on Community Treatment Order are subject to Medical Treatment under Part 4A of the Act.

There are different rules for Part 4A patients who have capacity to consent to specified treatments and those patients that do not. Part 4A patients that have capacity can only be given treatment in the community with their consent. There are no exceptions to this rule even in emergencies. Treatment can only be given without their consent if they are recalled to hospital, recall will not be appropriate unless the person meets the criteria of S17E.

The Part 4A rules recognise and incorporate aspects of the Mental Capacity Act 2005 including advance decisions and persons appointed to make surrogate decisions such as an attorney under a lasting power of attorney (personal welfare) or court appointed deputy. Part 4A patients who lack capacity to consent to treatment may **not** be given treatment if:

- in the case of a patient aged 18 or over, the treatment would be contrary to a valid and applicable advance decision to refuse treatment made by the patient
- in the case of a patient aged 16 or over, the treatment would be against the decision of someone with the authority under the Mental Capacity Act to refuse it on the patient's behalf (an attorney, a deputy or the Court of Protection) or
- in the case of a patient of any age force needs to be used in order to administer treatment and the patient objects to the treatment (MHA Code of Practice 24.19).

Consent is the voluntary and continuing permission of a patient to be given a particular treatment based on sufficient knowledge of the purpose, nature, likely effects and risks of the treatment, including the likelihood of its success and any alternatives to it. Permission given under any unfair or undue pressure is not consent. It is the duty of everyone seeking consent to use reasonable care and skill not only in giving information prior to seeking consent, but also in meeting the continuing obligation to provide the patient with sufficient information about the proposed treatment and alternatives to it.

It is the responsibility of the Responsible Clinician to undertake an assessment of the patient's capacity and whether they consent to treatment or not at the point of making the Community Treatment Order. This must be documented clearly on the Capacity to Consent to Treatment form (Z48) and reviewed on a regular basis, at least upon extension of the order or upon any change in treatment. A change in Responsible Clinician will also require a fresh assessment of capacity and consent.

For the initial month of a Community Treatment Order medication for mental disorder may be given to a patient without certification (provided that the patient either consents to it or, if incapacitated, does not resist taking it). In certain circumstances that 'one month period' may be extended. If a patient is discharged onto Community Treatment Order with more than one month of his or her three-month period still to run (i.e. the patient is discharged less than two months after first being treated with medication as a detained patient in hospital to whom Part 4 applies), the patient will not need to have treatment certified until the three-month period expires.

After the initial month of Community Treatment Order (or at the end of the three-month period if this is later), treatment with medication for mental disorder must be certified as appropriate. The Responsible Clinician is responsible for ensuring that the Second Opinion Appointed Doctor is arranged for patients that are incapacitous and are unable to consent to treatment. If the patient is incapable of consenting, a Second Opinion Appointed Doctor should complete Form CTO11. If the patient has capacity (or, if s/he is under 16, is competent) to consent, and does so, the Responsible Clinician should certify this on Form CTO12.

The Second Opinion Appointed Doctor cannot certify that treatment is appropriate:

- if the patient has capacity and either consents or refuses consent to it, or

- if, in the case of an incapacitated patient, that patient has refused consent through an advance decision refusing treatment, or treatment would conflict with a decision made by a deputy, donee or the Court of Protection.

A Second Opinion Appointed Doctor must interview the patient at a mutually agreed date and time, discuss the treatment plan with the Responsible Clinician in charge of the treatment, and consult two other persons who have been professionally concerned with the patient's medical treatment. At least one of these 'statutory consultees' must not be a doctor, and neither can be the patient's Responsible Clinician or the Approved Clinician in charge of the patient's treatment. The proposed treatment plan for the patient must be given to the Second Opinion Appointed Doctor before or at the time of the visit. The plan should indicate which treatments (if any) should be authorised in the case of the patient's recall (S17E) to hospital and may set conditions on such authorisation. Unless it specifies otherwise any such advance authority to treat upon recall will allow for treatment to be given by force against the patient's capacitous refusal (as well as to an incapacitated or consenting patient). If no treatment has been recorded on the CTO11 for recall emergency treatment must be considered dependant on the patient's consent status.

If a Community Treatment Order patient refuses to consent, the Care Quality Commission is asked to arrange a Second Opinion Appointed Doctor visit to consider certifying on form CTO11 that:

a) Certain treatment proposed for the patient while in the community is appropriate, even though such certification provides no authority to give the treatment where a patient refuses consent; and/or
b) Certain treatment would be appropriate (and could be given without consent) if the patient was recalled to hospital.

The Care Quality Commission accepts second opinion requests to consider issuing these certificates, but **services should be aware that certificates given in these circumstances provide no legal authority to give treatment to patients in the community if they refuse consen**t. Furthermore, a certificate issued in the circumstances described at (a) above could not be used to fulfil the certification requirement if the patient subsequently consents to treatment: in these circumstances, the patient's doctor would need to complete Form CTO12.

In the event that the patient has not been seen by a Second Opinion Appointed Doctor within the required time-frame (one month from Community Treatment Order taking effect or three months from beginning of detention whichever is the later), and the Responsible Clinician in charge of the treatment is of the opinion that the treatment is immediately necessary for a patient who has capacity to consent to it or it is emergency treatment for a patient who does not have capacity to consent to it and the criteria for its use is met, section 64 may be used to authorise treatment whilst waiting for the Second Opinion Appointed Doctor to complete form CTO11.

Where treatment has been given on the basis of a part 4A certificate Responsible Clinician's in charge of the treatment must send the Care Quality Commission a report under 64H on the treatment and the patient's condition when requested to do so by the Care Quality Commission. In addition a report must be given automatically under Section 61 if treatment is given on the basis of a part 4A certificate to a Community Treatment Order patient who has been recalled to hospital (including one whose Community Treatment Order is then revoked), in lieu of a Second Opinion Appointed Doctor certificate under Section 58 or 58A. This only applies to treatment to which the patient either did not, or could not, consent.

Where patients have capacity and they consent the Responsible Clinician should complete the CTO12 certifying that the patient has capacity to consent (or, if they are under 16, is competent to consent), and that they consent to treatment. The Care Quality Commission no longer accepts Second Opinion Appointed Doctor requests to visit consenting patients.

The CTO11 or CTO12 should be uploaded to the patients' care record and copies sent to the General Practitioner and kept with the community prescription chart. Mental health legislation will

send a copy of the CTO11 / CTO12 to the GP once scrutinised with a covering letter requesting the relevant Community mental health team be notified if the GP feels changes should be made.

If the CTO11 or CTO12 certificate is amended by Second Opinion Appointed Doctor or by the Responsible Clinician and there is a shared care arrangement with the General Practitioner to prescribe the Responsible Clinician must ensure that the General Practitioner is always kept up to date with any changes to the patient's Part 4A certificate.

5.16. Emergency Treatment (Section 64G)

In an emergency, treatment for Part 4A patients who have not been recalled and who lack capacity, can be given by anyone (it need not be an Approved Clinician or the Responsible Clinician) but only if the treatment is immediately necessary to:

- Save the patient's life;
- Prevent a serious deterioration of the patient's condition, and the treatment does not have unfavourable physical or psychological consequences which cannot be reversed
- 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
- 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.

If the treatment is Electro Convulsive Therapy (or medication administered as part of Electro Convulsive Therapy) only the first two categories apply.

In an emergency where treatment is immediately necessary as above, it may be given even if it goes against an advance decision or a decision made by a person authorised on the patient's behalf under the Mental Capacity Act. These are the only exceptional circumstances in which force can be used to treat an objecting supervised community treatment patient, who doesn't have capacity, without first recalling them to hospital.

5.17. Treatment Given to Patients Recalled to Hospital (Section 62A)

A patient recalled to hospital becomes subject to sections 58 and 58A in the same way as other detained patients but with three exceptions:

- a certificate under section 58 is not needed for medication if less than one month has passed since the patient was discharged from hospital and became subject to a Community Treatment Order;
- a certificate is not needed under section 58 or 58A if the treatment in question is already explicitly authorised for administration on recall on the patient's Part 4A certificate; and
- treatment that was being given on the basis of a Part 4A certificate may be continued, even though it is not authorised for administration on recall, if the AC in charge of treatment considers that discontinuing it would cause the patient serious suffering but it may only continue pending compliance with section 58 or 58A while steps are taken to obtain a new certificate.

Second Opinion Appointed Doctors giving Part 4A certificates need to consider what (if any) treatments to approve should the patient be recalled to hospital. The potential advantage of authorising treatments to be given on recall to hospital is that it will enable such treatments to be given quickly without the need to obtain a new certificate.

These exceptions to the requirements for certificates under section 58 and 58A continue to apply if the patient's Community Treatment Order has been revoked but only while steps are taken to comply with section 58. Responsible Clinicians should ensure that a new Second Opinion

Appointed Doctor certificate under section 58 or 58A is requested as soon as they revoke a Community Treatment Order.

5.18. Withdrawal of Part 4A Certificates (Section 64H)

The Care Quality Commission may at any time notify the Responsible Clinician that a Part 4A Certificate will cease to apply from a certain date.

Where this occurs the certificate cannot be used after the date and treatment must be stopped or suspended whilst a new certificate is sought.

However treatment may be continued temporarily if the Responsible Clinician in charge of the treatment considers that withdrawing the treatment would cause serious suffering to the patient. This also applies where the patient is recalled to hospital.

5.19. Treatment and the Mental Capacity Act 2005

Mental Capacity Act – specific guidance can be found in the Trusts policy, here it will be noted that:

- The Mental Capacity Act Section 5 may be used to give care/treatment to a patient who lacks capacity to give a valid consent to their care/treatment and the view of the Responsible Clinician or other professional is that the care/treatment is in the patient's best interests and is proportionate to the requirements of the situation. This decision should take into account the patient's previous wishes and feelings and those of others involved in their care. This may apply in non-emergency situations.
- Any use of the Mental Capacity Act to give treatment should be documented in the patient's care record and a best interest consideration completed. In some cases the Mental Capacity Act could be used to provide care and treatment for a mental health disorder (rather than a physical condition) but in cases where such care/treatment is necessary and the patient is refusing even though they may be incapable of a valid consent, consideration should be given to using the Mental Health Act (Mental Health Act Code of Practice 13.50).

Use of the Mental Capacity Act (2005) or Common Law Powers

It should be remembered that when treatment under the Mental Health Act cannot lawfully be given, treatment may sometimes be possible under the Mental Capacity Act (2005) or common law powers.

However, note that where the Mental Health Act (1983) is appropriate it must be used and common law powers cannot be used in preference to statutory powers, though they can sometimes bridge the gap until statutory powers can be put in place.

The Mental Capacity Act Section 5 may be used to give care/treatment to a patient who lacks capacity to give a valid consent to their care/treatment and the view of the responsible doctor or other professional is that the care/treatment is in the patient's best interests and is proportionate to the requirements of the situation. This may apply in non-emergency situations. Any use of the MCA 2005 to give treatment should be documented in the Clinical Notes and should be accompanied by an assessment of capacity. In some cases the MCA 2005 could be used to provide care and treatment for a mental health disorder (rather than a physical condition) but in cases where such care/treatment is necessary and the patient is refusing even though they may be incapable of a valid consent, the MHA should be used. See also the Trust's Mental Capacity Act and DoLS policy.

6. EQUALITY AND DIVERSITY

An equality impact assessment (EIA) has been completed (see appendix 5).

7. HUMAN RIGHTS ACT

The Human Rights Act came into effect in October 2000 which means that the Trust and its staff, along with its supporting agencies, are seen as a public authority and have an obligation to respect the Convention rights. This means that you must understand those rights and take them into account when carrying out the requirements of this SOP.

8. IMPLEMENTATION

This SOP will be disseminated by the method described in the Document Control Policy.

The SOP will be approved via the MHL Steering Group. It will also be discussed within Medic meetings and Pharmacy Meetings.

All other stake holders, partners and services to be made aware of the SOP via Mental Health Legislation Steering Group members and distributed via their internal systems.

9. MONITORING AND AUDIT

This SOP will be monitored via untoward incidents or PALS/complaints that arise as a result of the use of the SOP and reported to Humber NHS Foundation Trust which will then be processed at the Operation Risk Management Group and dealt with.

There are robust scrutiny processes in place with regards to consent to treatment, which involve Pharmacy, Medics and Mental Health Legislation Team. Consent to treatment is audited within the MHA audit on MyAssurance and all exceptions are reported via datix.

Incidences of unauthorised treatment are collated in a spreadsheet by MHL Team and reported via the MHL Steering Group with a clear escalation process, where required, to the MHL Committee.

10. REFERENCES/EVIDENCE/LINKS

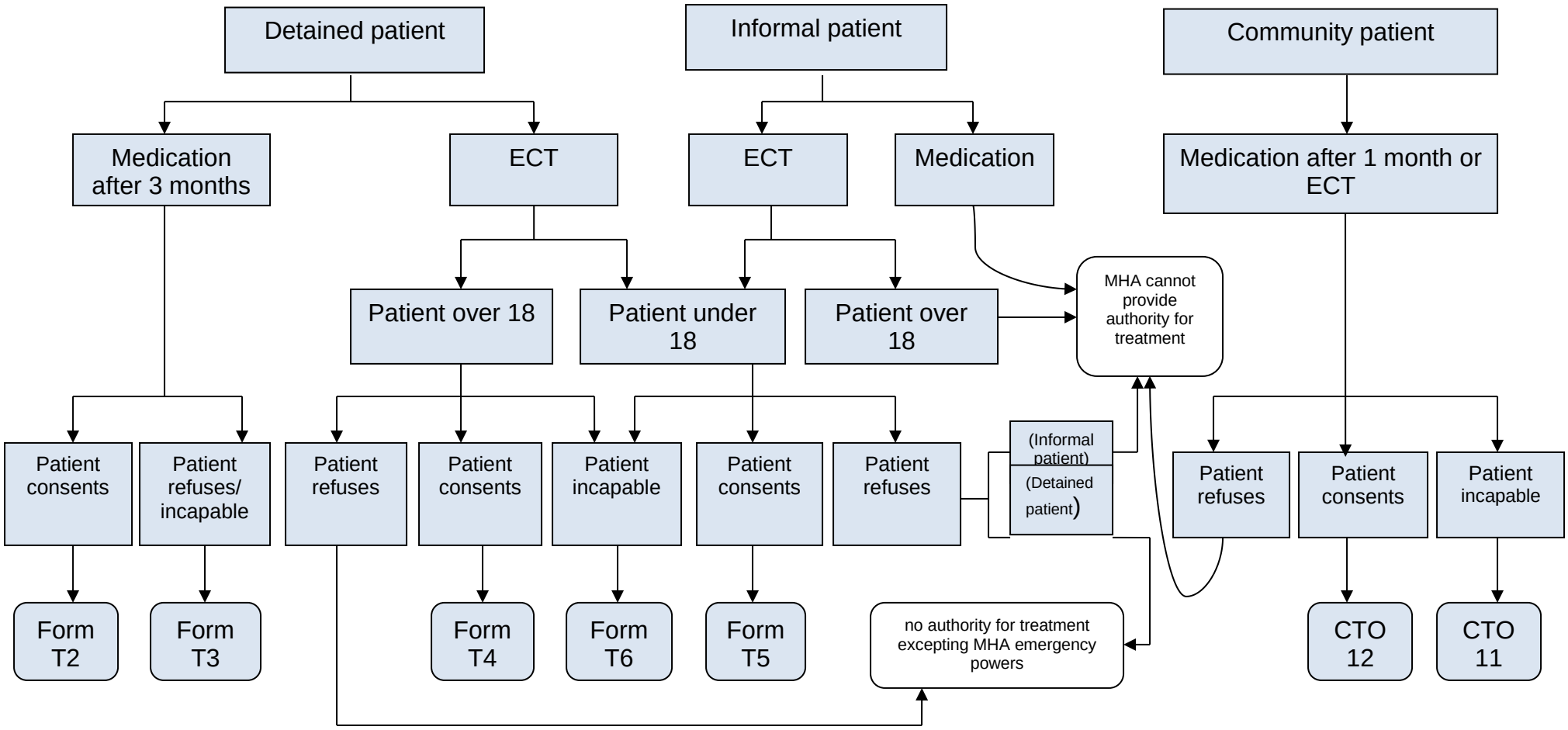
- Department of Health (2015) Mental Health Act Code of Practice. London TSO
- Greater Manchester Mental Health NHS Foundation Trust - Consent to Treatment Procedure for Detained Patients Policy
- Devon Partnership NHS Trust Consent to Treatment Procedure for Detained Patients
- Mental Health Act 1983 Statutory Forms - Mental Health Law Online
- Electronic forms for use under the Mental Health Act - GOV.UK (www.gov.uk)

11. RELEVANT HFT POLICIES/PROCEDURES/PROTOCOLS/GUIDELINES

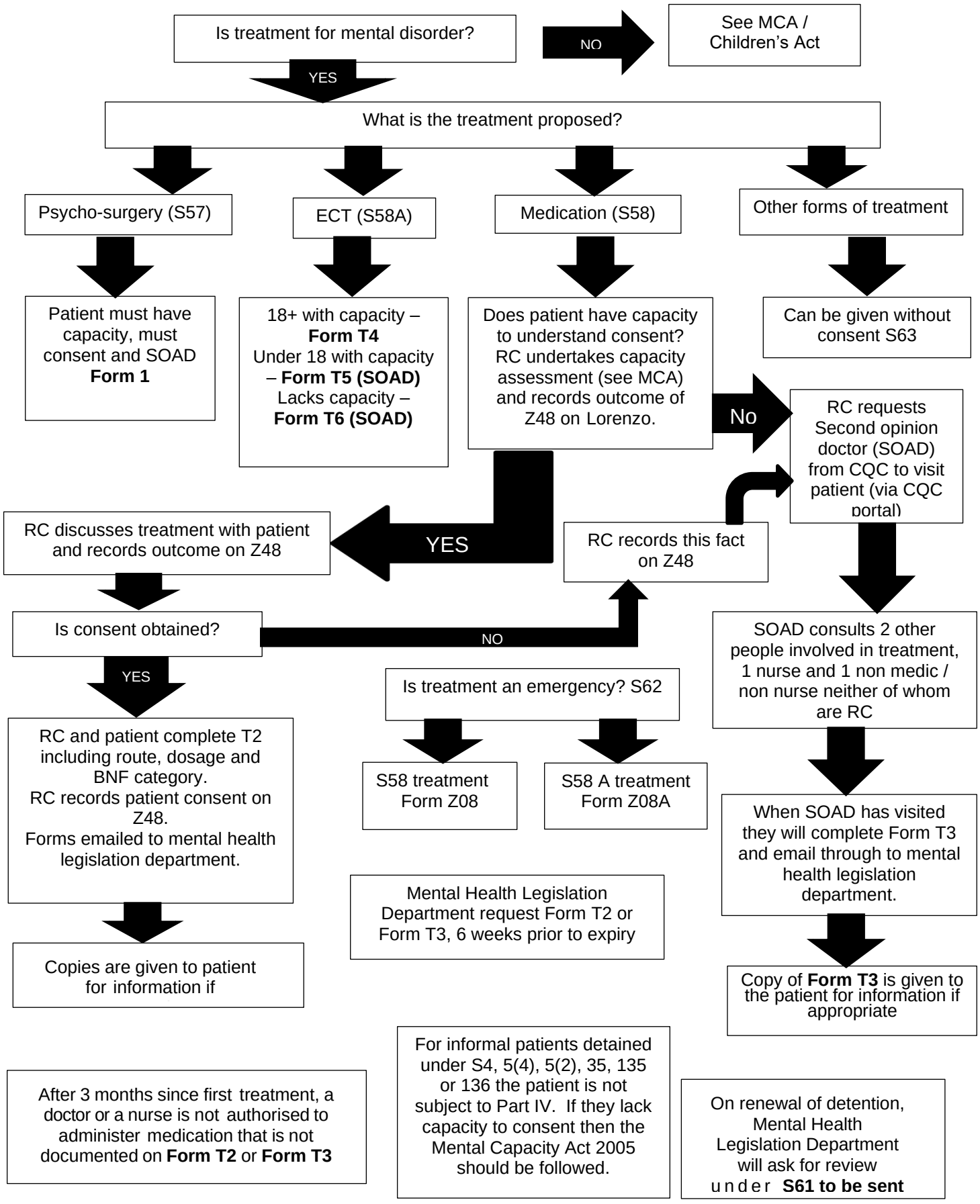
- Mental Health Act Policy
- Receipt and scrutiny SOP
- CTO Protocol
- Consent Policy

Appendix 1 - Care Quality Commission Flowchart – Treatment under the Mental Health Act

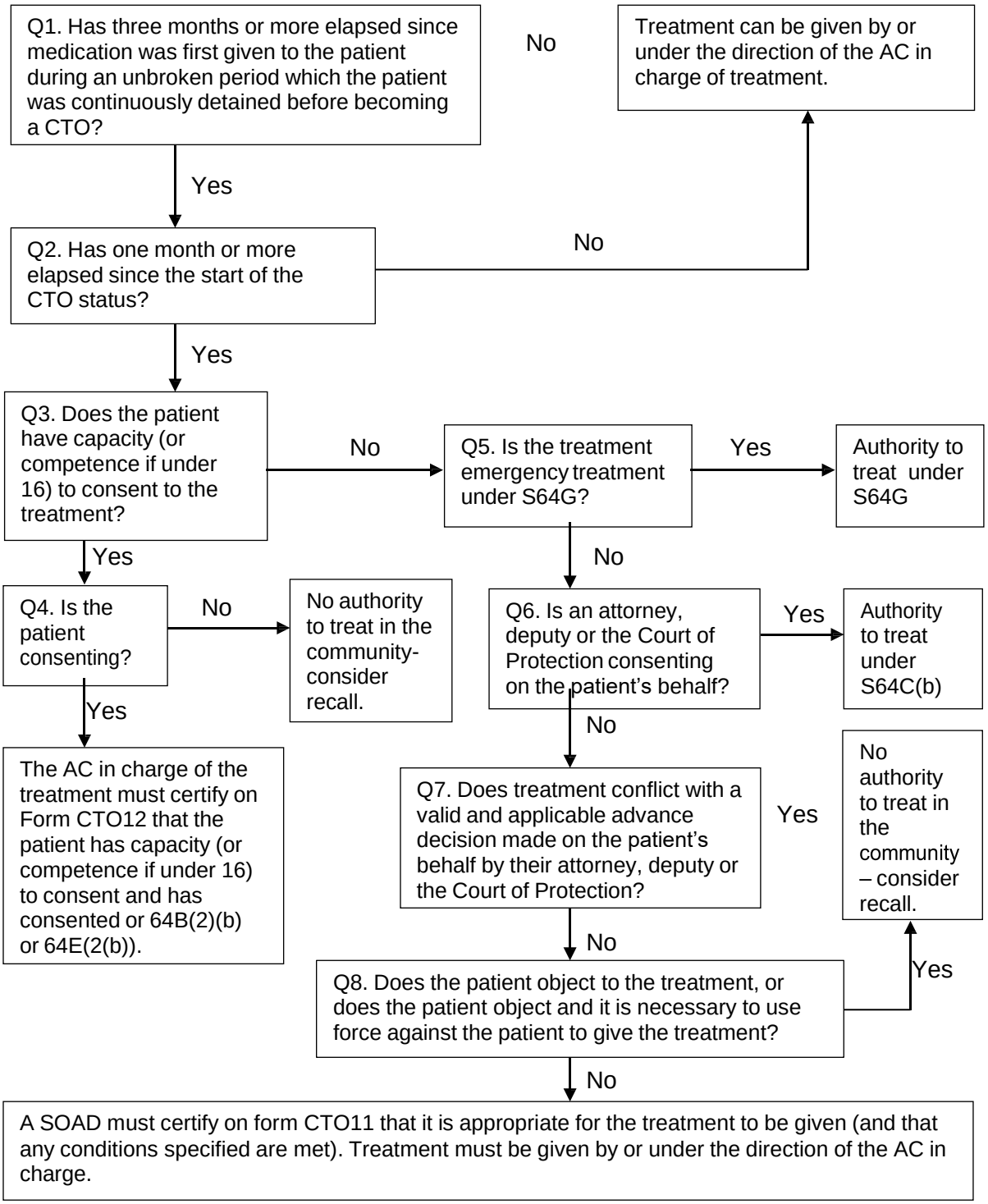
Certification of treatment under the revised Mental Health Act 1983 – all patients



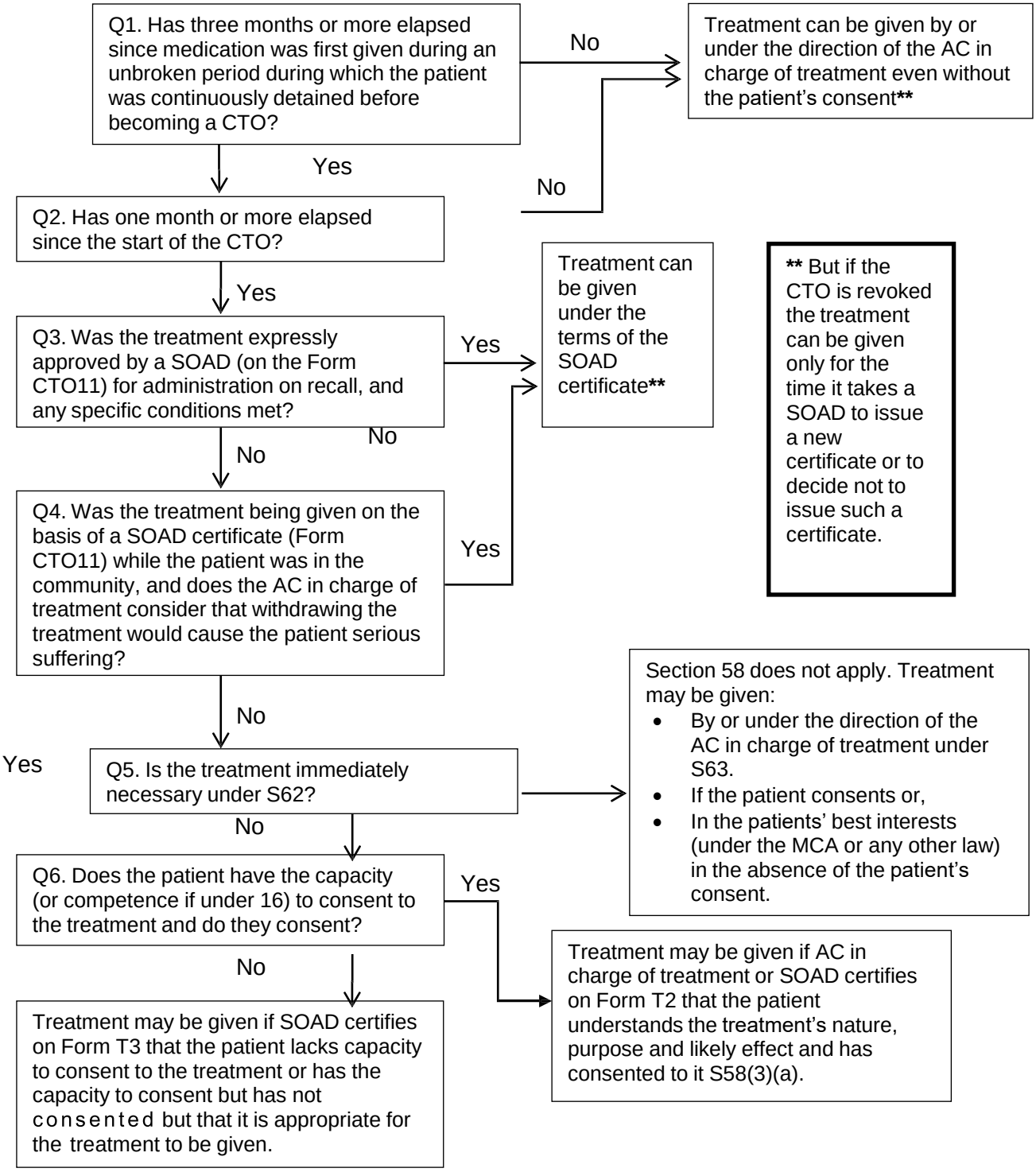
Appendix 2 - CONSENT TO TREATMENT- MHA PART IV Flow Chart
(Detained under Section 2, 3, 36, 37, 38, and 45a).



Appendix 3 - CONSENT TO TREATMENT- CTO - Patients not recalled to hospital (section 58 treatment under part 4a)



Appendix 4 - CONSENT TO TREATMENT- CTO - Patients upon recall to hospital or the revocation of the CTO



Appendix 5 – Equality Impact Assessment

For strategies, policies, procedures, processes, guidelines, protocols, tenders, services

1. Document or Process or Service Name: Consent to Treatment Under the MHA
2. EIA Reviewer (name, job title, base and contact details): Michelle Nolan, Mental Health Act Clinical Manager
3. Is it a Policy, Strategy, Procedure, Process, Tender, Service or Other? Standard Operating Procedure

Main Aims of the Document, Process or Service
This procedure aims to ensure that staff are aware of the overall legal framework within which consent to treatment decisions under the MHA must be made. The procedure also specifically aims to ensure that staff are aware of the particular legal requirements for detained patients and that their clinical practice is informed by this.
Please indicate in the table that follows whether the document or process has the potential to impact adversely, intentionally or unwittingly on the equality target groups contained in the pro forma

Equality Target Group	Is the document or process likely to have a potential or actual differential impact with regards to the equality target groups listed? Equality Impact Score Low = Little or No evidence or concern (Green) Medium = some evidence or concern(Amber) High = significant evidence or concern (Red)	How have you arrived at the equality impact score? a) who have you consulted with b) what have they said c) what information or data have you used d) where are the gaps in your analysis e) how will your document/process or service promote equality and diversity good practice
1. Age 2. Disability 3. Sex 4. Marriage/Civil Partnership 5. Pregnancy/Maternity 6. Race 7. Religion/Belief 8. Sexual Orientation 9. Gender re-assignment		

Equality Target Group	Definitions	Equality Impact Score	Evidence to support Equality Impact Score
Age	Including specific ages and age groups: Older people Young people Children Early years	Low	This SOP is consistent in its approach regardless of age.
Disability	Where the impairment has a substantial and long term adverse effect on the ability of the person to carry out their day to day activities: Sensory Physical Learning Mental health (including cancer, HIV, multiple sclerosis)	Low	This SOP is consistent in its approach regardless of disability. For patients who have a communication need or have English as their second language consideration must be given to providing information in an accessible format.
Sex	Men/Male Women/Female	Low	This SOP is consistent in its approach regardless of gender.
Marriage/Civil Partnership		Low	The SOP applies to all irrespective of relationship status.

Equality Target Group	Definitions	Equality Impact Score	Evidence to support Equality Impact Score
Pregnancy/ Maternity		Low	This SOP is consistent in its approach regardless of pregnancy/maternity status however additional consideration would be given to treatment for pregnant women.
Race	Colour Nationality Ethnic/national origins	Low	The SOP applies to all irrespective of race. Services must ensure where translator services are provided to ensure 'all practicable steps' are taken to ensure understanding in line with the five key principles of the MCA 2005.
Religion or Belief	All religions Including lack of religion or belief and where belief includes any religious or philosophical belief	Low	The SOP applies to all irrespective of religion or believes
Sexual Orientation	Lesbian Gay men Bisexual	Low	The policy applies to all irrespective of sexual orientation
Gender Reassignment	Where people are proposing to undergo, or have undergone a process (or part of a process) for the purpose of reassigning the person's sex by changing physiological or other attribute of sex	Low	This SOP is consistent in its approach regardless of the gender the individual wishes to be identified as. We recognise the gender that people choose to live in hence why the terms gender identity and gender expression ensure we are covering the full spectrum of LGBT+ and not excluding trans, gender fluid or asexual people.

Summary

Please describe the main points/actions arising from your assessment that supports your decision. This Procedure is specifically aimed at the treatment of patients subject to detention under the Mental Health Act and reflects the requirements under this legal framework. Significant attention has been paid to ensure that no groups are discriminated against either directly or indirectly.	
EIA Reviewer: Michelle Nolan	
Date completed: 03 January 2024	Signature: M Nolan