Birmingham and Solihull Mental Health NHS Foundation Trust

Consent to Treatment

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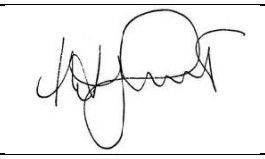
Exec Sign off Signature (electronic)		
Disclosable under Freedom of Information Act 2000	**Yes**	

POLICY CONTEXT

This is a Trust wide policy for Sections 58, 58A and s62 Part 4 of the Mental Health Act 1983 (as amended by the Mental Health Act 2007) (MHA).

These sections apply to the administration of medication for mental disorder to detained patients after three months have passed since medication was first administered (for mental disorder), requiring consent and/or a second opinion by an independent medical practitioner appointed by the Care Quality Commission (CQC)

This policy does not cover Covert medication. Please read in conjunction with the Covert Administration of Medicines Policy.

POLICY REQUIREMENT (see Section 2)

At the end of the first three months of detention (from the first dose of medication for mental disorder / start of detention), the RC must ensure there is legal authorisation in place to continue to treat a patient. The RC must personally seek consent from the patient by assessing capacity to consent to treatment using the BSMHFT approved forms devised for this purpose.

Compliance with the procedures in section 3 of this policy are monitored via Clinical teams and Local Clinical Governance Committees and the Mental Health Legislation Committee, Board Committee

CONTENTS

1 INTRODUCTION

1.1 Rationale (Why)

This policy is required to ensure that service users detained under the Mental Health Act (MHA) who require treatment, are dealt with consistently. To do this, it is necessary that BSMHFT staff operate within the confines of the MHA and its Code of Practice (CoP).

1.2 This policy should be read in conjunction with the Pharmacy Covert Administration of Medicines Policy. This policy does not apply to the prison services

1.3 Scope (Where, When, Who)

1.3.1 This is a Trust wide policy which applies to circumstances where authorisation for planned treatment for mental disorder under the MHA is required.

1.3.2 Detained and CTO (Community Treatment Order) patients recalled to hospital are referred to throughout this document as detained patients.

1.3.3 Section 58 applies after the first three months of continued detention from the first dose of medication for mental disorder (commonly referred to as the 'three month rule').

1.3.4 In BSMHFT the three months is calculated from the *start of detention* to ensure reminders are timely.

1.3.5 Section 58A applies to Electro Convulsive Therapy (ECT) at any time during a period of detention under a relevant section of the MHA as well as to patients recalled to hospital. This section also applies to all patients aged under 18 (whether or not they are detained).

1.3.6 Sections 62, 64B, 64C and 64E apply in urgent cases where treatment is immediately necessary (section 62). Similarly, a part 4A certificate is not required in urgent cases where the treatment is immediately necessary (sections 64B, 64C and 64E).

1.3.7 Part 4A of the MHA sets out rules for treatment of CTO patients who have not been recalled to hospital by their Responsible Clinician (RC). This includes CTO patients in hospital without having been recalled (e.g. admitted voluntarily).

1.3.8 CTO patients not recalled to hospital with capacity to consent to treatment may not be given treatment unless they consent

1.3.9 This policy is appropriate for all clinical staff involved in prescribing and administering medication for mental disorder to patients detained under the MHA**.**

1.3.10 These procedures do not relate to those detained under section 4 emergency admission for assessment; section 5 holding powers; section 35 patients remanded to hospital for a report; sections 135 & 136 places of safety; section 37(4) or 45A temporarily detained in hospital as a place of safety; and restricted patients who have been conditionally discharged (unless recalled to hospital); Qualifying patients within the meaning of section 22 who have remained in custody for six months or longer in total.

1.4 Principles (Beliefs)

The underlying principles of this policy are the 5 principles of the Mental Health Act 1983 as amended:

1. **Least restrictive option and maximising independence**

Where it is possible to treat a patient safely and lawfully without detaining them under the Act, the patient should not be detained. Wherever possible a patient's independence should be encouraged and supported with a focus on promoting recovery wherever possible.

2. **Empowerment and involvement**

   Patients should be fully involved in decisions about care, support and treatment. The views of families, carers and others, if appropriate, should be fully considered when taking decisions. Where decisions are taken which are contradictory to views expressed, professionals should explain the reasons for this**.**

3. **Respect and dignity**

   Patients, their families and carers should be treated with respect and dignity and listened to by professionals.

4. **Purpose and effectiveness**

   Decisions about care and treatment should be appropriate to the patient, with clear therapeutic aims, promote recovery and should be performed to current national guidelines and/or current, available best practice guidelines.

5. **Efficiency & equity**

   Providers, commissioners and other relevant organisations should work together to ensure that the quality of commissioning and provision of mental healthcare services are of high quality and are given equal priority to physical health and social care services. All relevant services should work together to facilitate timely, safe and supportive discharge from detention.

The Trust positively supports individuals with learning disabilities and ensures that no-one is prevented from accessing the full range of mental health services available. Staff will work collaboratively with colleagues from learning disabilities services and other organisations, in order to ensure that service users and carers have a positive episode of care whilst in our services. Information is shared appropriately in order to support this.

2 POLICY (What)

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

2.2 Where reasonably practicable, treatment should be based on a strong evidence base. Professionals should ensure that any treatment is compliant with the current guidelines and standards about what is appropriate treatment. Examples include National Institute for Health and Care Excellence (NICE) / Social Care Institute for Excellence (SCIE) guidelines, NICE quality standards and Department of Health Care Programme Approach (CPA) guidance. In the case of medications that are used to treat mental disorder, particular care is required when prescribing medications that are outside licenced indication, or dose, or where high doses of antipsychotic (HDAT) are used to treat patients.

2.3 The GMC provides prescribing guidance for unlicensed medicines which can be found on this link **http://www.gmc-uk.org/guidance/ethical_guidance/14327.asp**

2.4 The term 'unlicensed medicine' is used to describe medicines that are used outside the terms of their UK licence or which have no licence for use in the UK. Unlicensed medicines are commonly used in some areas of medicine such as psychiatry.

2.5 You should usually prescribe licensed medicines in accordance with the terms of their licence. However, you may prescribe unlicensed medicines where, on the basis of an assessment of the individual patient, you conclude, for medical reasons, that it is necessary to do so to meet the specific needs of the patient

2.6 You must give patients (or their parents or carers) sufficient information about the medicines you propose to prescribe to allow them to make an informed decision. If you intend to prescribe unlicensed medicines where that is not routine or if there are suitably licensed alternatives available, you should explain this to the patient, and your reasons for doing so

2.7 To give time to develop a treatment programme suitable for the patient's needs, the Act allows treatment to be given in the initial three month period starting the day on which any form of medication for mental disorder was first administered to the patient during the current period in which the patient is liable to be detained under the Act. This is governed by section 63.

2.8 At the end of this period, detained patients may not be given any form of treatment to which s58 and s58A applies, other than urgent treatment, (as defined in the MHA under s62), unless there is valid authorisation in place (T2 Consent to Treatment certificate or T3 Second Opinion certificate) and the procedures in part 3 of this policy have been followed.

2.9 The relevant Mental Health Legislation Administrator (MHLA) will write to the Approved Clinician (AC) in charge of the treatment (in BSMHFT this will be the RC) reminding them of the need to authorise the treatment plan one month before it is due.

2.10 At the end of the first three months the RC must personally seek consent from the patient to continue medication beyond the 3 month period.

2.11 This must be done by assessing capacity to consent to treatment and document the same on the RIO electronic record keeping system.

2.12 If the patient lacks capacity to consent or is refusing treatment, the RC must request a SOAD (Second Opinion Appointed Doctor) from the Care Quality Commission (CQC) to certify the treatment plan is appropriate, using the online request form via link provided in the RIO record keeping system to the CQC online form. The MHLA will be included in the correspondence.

2.13 The SOAD will arrange an appropriate date and time to see the patient and liaise directly with the nurse in charge of the ward (care co-ordinator if the patient is in the community) and the MHLA.

2.14 There would be a real time (at least monthly) audit of the clinical records documenting the above process, reporting and being reviewed by the clinical team caring for the patient and the local Clinical Governance Committee reporting to the trust Clinical Governance Committee (CGC) and then for assurance to the trust Mental Health Legislation Committee (MHLC).

3 PROCEDURE

3.1 Obtaining Consent to Treatment (CTT) authority – In-Patients

3.2 At the end of the three months, the RC must assess the patient's capacity to consent to treatment

3.3 If the outcome of the assessment is that the patient **has capacity and is consenting** to treatment, the RC must complete the RIO T2 certificate with the capacity to consent documented in the form. For Guidance on completing a T2 certificate in line with the BNF please see the guidance in Appendix 2.

3.4 If the outcome of the capacity assessment is that the patient is not capable of understanding the nature, purpose and likely effects of the treatment i.e. **lacks capacity or does not consent** this will be documented via form 3 of the CTT forms in the RIO electronic record keeping system and the RC must request a SOAD.

3.5 This is done by accessing the online SOAD request form via the Link on RIO electronic record keeping system under Consent to Treatment.

3.6 The local MHLA will be named on the form as the individual to receive the confirmation of the request.

3.7 If the SOAD agrees with the treatment plan and certifies it as appropriate, they will complete a T3.

3.8 A copy of the T2 / T3 certificate must be kept with the prescription card (ePMA) and the original sent to the MHL Office.

3.9 Urgent cases where certificates are not required (sections 62, 64B, 64C and 64E)

3.10 Sections 57, 58 and 58A do not apply in urgent cases where treatment is immediately necessary (section 62). Similarly, a part 4A certificate is not required in urgent cases where the treatment is immediately necessary (sections 64B, 64C and 64E).

3.11 This applies only if the treatment in question 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 patients 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.

3.12 If the treatment is ECT (or medication administered as part of ECT) only the first two categories above apply.

3.13 It is for the RC who for the time being is in charge of the treatment, to determine whether the criteria set out are satisfied. This determination can be done over the telephone (s62(1)).

3.14 These are strict tests. It is not enough for there to be an urgent need for treatment or that the clinicians involved believe the treatment is necessary or beneficial.

3.15 Urgent treatment under these sections can continue only for as long as it remains immediately necessary. If it is no longer immediately necessary, the normal requirements for certificates apply.

3.16 Although statutory certificates are not required where treatment is immediately necessary (s62), the other requirements of parts 4 and 4A of the Act still apply. The treatment is not necessarily allowed just because no certificate is required.

3.17 The Trust has a standard s62 certificate and the RC must record the above on the s62 certificate on RiO.

3.18 A copy of this certificate should be printed and attached to the medication card (accompany ePMA).

3.19 Treatment of CTO patients not recalled to hospital (Part 4A)

3.20 Patients on a CTO also require authorisation for treatment at the end of the three months or at the end of the first month of the CTO – whichever is later.

3.21 There are different rules for treatment of CTO patients who have not been recalled to hospital by their RC. This includes such patients who are in hospital without having been recalled (e.g. if they have been admitted to hospital voluntarily). These rules apply to medication and ECT.

3.22 The rules for CTO patients who have not been recalled to hospital differ depending on whether or not they have the capacity to consent to the treatment in question.

3.23 CTO patients who have not been recalled to hospital who have the capacity to consent to treatment may not be given that treatment unless they consent. There are no exceptions to this rule, even in emergencies. The effect is that treatment can be given without their consent only if they are recalled to hospital.

3.24 At the end of the three months (or first month of the CTO, whichever is later), the RC must assess the patient's capacity to consent to treatment using Form A, Assessment of Capacity to Consent to Treatment – CTO patients on RiO

3.25 If the outcome of the capacity assessment is that the patient has **capacity and is consenting**, then the RC must complete a CTO12 certificate to authorise treatment.

3.26 A copy of the CTO12 certificate must be kept with the prescription (ePMA) and the original sent to the MHL Office

3.27 If the patient has **capacity and is refusing treatment**, then treatment may not be administered.

3.28 If the patient lacks capacity then the RC should request a SOAD in the same way as for a detained inpatient (point 3.5 above)

3.29 If the SOAD certifies the treatment plan, they will complete a CTO11 certificate.

3.30 A copy of the CTO11 certificate must be kept with the prescription (ePMA) and the original sent to the MHL Office.

3.31 Before leaving hospital the care co-ordinator will discuss with the patient a suitable place for the patient to be seen by the SOAD. This may be at an outpatient clinic or somewhere that the patient visits regularly.

3.32 Arrangements must also be made to ensure the SOAD has access to the patient's notes at the time they see the patient and that it is practicable for the SOAD to speak to the RC, statutory consultees and attorney or deputy if applicable.

3.33 The letter to the RC from the MHL Office confirming the start of the CTO includes a reminder of the treatment authorisation requirement and a copy of the CTO12. The Form A, Capacity to Consent to Treatment (CTO) can be accessed via RiO.

3.34 It is not necessary to meet the certificate requirement before treatment can be given in an emergency to a CTO patient where the patient consents to treatment or, for patients who lack capacity, where an attorney, deputy or the Court of Protection consents to it on the patient's behalf.

3.35 Where the patient lacks capacity, the RC must complete the 64G Certificate of Emergency Treatment for Community Patients Lacking capacity or Refusing Treatment. This must be followed by a SOAD request (as per guidance in 3.5 above)

3.36 CTO patients recalled to hospital

3.37 In general, CTO patients recalled to hospital are subject to s58 and s58A in the same way as other detained patients. However, there are 3 exceptions:

1. A Part 4A certificate (statutory forms CTO12 and CTO11) under s58 is not needed for medication if less than one month has passed since the patient was discharged from hospital and became a CTO patient.

2. A certificate is not needed under either s58 or s58A if the treatment is already explicitly authorised for administration on recall on the patient's Part 4A certificate.

3. Treatment that was already 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 RC considers that discontinuing it would cause the patient serious suffering. But it may only be continued pending compliance with s58 or s58A (as applicable) – in other words while steps are taken to obtain a new certificate.

3.38 It is not good practice to use a certificate that was issued to a patient when detained and who has since been discharged onto CTO to authorise treatment if the patient is then recalled to hospital, even if the certificate remains technically valid. A new certificate should be obtained as necessary

3.39 Detained Patients with capacity and consenting to ECT

3.40 Patients who have the capacity to consent may not be given treatment under s58A unless they do in fact consent.

3.41 No patient under 18 (whether detained or not) can be given ECT unless a SOAD has certified that the treatment is appropriate.

3.42 There is no initial 3 month period during which a certificate is not needed as there is with medication.

3.43 The RC must personally seek consent from the patient to administer ECT.

3.44 A record of the assessment of capacity to consent to the treatment must be made by the RC on Form 3 on RiO.

3.45 Where the patient is 18 years or over and has capacity and gives their valid consent the RC must complete the appropriate statutory form (Certificate of Consent to Treatment - ECT) form T4 s58A (3).

3.46 If the patient is under 18 years, only a SOAD may complete the certificate certifying that the treatment is appropriate. (Certificate of Consent to Treatment and Second Opinion - form T5).

3.47 A copy of the T4 / T5 (whichever is applicable) must be kept in the patient's care record. The original must be sent to the MHL Office.

3.48 The MHL Administrator will scan this certificate on to the electronic care record.

3.49 Detained patients lacking capacity requiring ECT

3.50 The RC must assess capacity to consent to the treatment using MCA Form 3 on RiO

3.51 A patient who lacks capacity to consent may not be given treatment under s58A unless a SOAD certifies that the patient lacks capacity to consent and that:

- The treatment is appropriate;
- No valid and applicable advance decision has been made by the patient under the Mental Capacity Act 2005 (MCA) refusing treatment;
- No suitably authorised attorney or deputy objects to the treatment on the patient's behalf; and
- The treatment would not conflict with a decision of the Court of Protection which prevents the treatment being given.

3.52 The SOAD must indicate on the certificate (form T6) the maximum number of administrations of ECT which is approved.

3.53 The RC is responsible for ensuring that a request for a SOAD is made following the same procedures as previously outlined in paragraph 3.5 above.

3.54 Once received from the SOAD 1 copy of the form T6 must be made, and filed in the patient's care record. The original form must be sent to the MHL Office.

3.55 The MHLA will scan the T6 onto the electronic care record

3.56 For Patients Aged Under 16, Capacity Means the Competence to Consent
(See CoP Chapter 19 and the full Gillick Operational Procedures, SOLAR in Appendix 3)

3.57 The test for assessing whether a child under 16 can give valid consent differs from that of a young person aged 16 or 17.

3.58 The capacity of a young person aged 16 or 17 to consent is assessed in accordance with the MCA or MHA, while the test for children under 16 is determined by considering whether they are 'Gillick competent'.

3.59 This is because in the case of Gillick, the court held that children under 16 who have sufficient understanding and intelligence to enable them to understand fully what is involved in a proposed intervention will also have the competence to consent to that intervention.

3.60 In such cases, the child is sometimes described as being 'Gillick competent'.

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

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

3.63 There is a separate Form G for assessing competence of an under 16 year old (Appendix3).

3.64 Second Opinion Appointed Doctors (SOADs) and Responsible Clinicians(RCs)

3.65 The doctor in charge of the proposed treatment (RC) will need to be available to speak to the SOAD.

3.66 RCs should ensure that SOADs are informed if the hospital knows that the patient has an attorney or deputy who is authorised under the MCA to make decisions about medical treatment on the patient's behalf by ensuring the form MCA1 in the RIO electronic record keeping system is completed. Details of any relevant advance decisions, or advance statements of views, wishes or feelings, should already be recorded in the patient's care record in the above form.

3.67 The SOAD's role is to provide an additional safeguard to protect the patient's rights, primarily by deciding whether the proposed treatment plan is appropriate and issuing certificates accordingly.

3.68 SOADs must provide written reasons in support of their decisions to approve treatment. SOADs do not have to give an exhaustive explanation, but should provide their reasons for what they consider to be the substantive points on which they made their clinical judgement.

These reasons can be recorded on the certificate itself or can be provided to the RC separately as soon as possible afterwards.

3.69 A certificate may be acted on even though the SOAD's reasons have yet to be received. However, if there is no pressing need for treatment to begin immediately, it is preferable to wait until the reasons are received, especially if the patient is likely to be unhappy with the decision.

3.70 The SOAD should indicate whether, in their view, disclosure of the reasons to the patient would be likely to cause serious harm to the patient's physical or mental health or to that of any other person.

3.71 It is the personal responsibility of the RC to communicate the results of the SOAD visit to the patient. This need not wait until any separate statement of reasons has been received from the SOAD.

3.72 The RC must record this discussion on the RC SOAD feedback form (Appendix 5)

3.73 When the statement of reasons is received the patient should be given the opportunity to see it as soon as possible, unless the RC (or SOAD) thinks that it would be likely to cause serious harm to the patient's physical or mental health or to that of any other person.

3.74 When the written reasons are received from the SOAD they must be sent to the MHL Office who will scan them onto the electronic care record.

3.75 Statutory Consultees

3.76 SOADs are required to consult two people (known as Statutory Consultees) before issuing certificates approving treatment. One of the statutory consultees must be a qualified nurse who knows the patient; the other must not be either a nurse or a doctor.

3.77 Where a SOAD is considering giving a part 4A certificate, at least one of the statutory consultees must not be a medical doctor (but need not be a nurse), and neither may be the clinician in charge of the proposed treatment or the responsible clinician

3.78 Both must be professionally concerned with the patient's medical treatment and neither may be the clinician in charge of the proposed treatment or the RC.

3.79 The none nurse for example may be an Occupational Therapist, Social Worker, or mental health pharmacist (for medication decisions)

3.80 The Statutory Consultees must have knowledge of the patient and their treatment to help the SOAD decide whether the proposed treatment is appropriate.

3.81 It is a CoP requirement that SOADs should make a record of their consultation with statutory consultees, which will become part of the patient notes.

3.82 Statutory Consultee Guidance can be found in Appendix 6 of this policy and forms a module in the Mandatory MHA Training for Qualified Nurses

3.83 Review of Treatment

3.84 Although the MHA does not require the validity of certificates to be reviewed after any particular period, it is good practice for the RC to review them at regular intervals.

3.85 Section 61 provides that where a patient is given treatment in accordance with Section 57(2) or Section 58(3)(b), 58A (4) or (5) or 62A (i.e. where a treatment plan has been authorised by

a doctor appointed by CQC), the RC must give CQC a report on the treatment and the patient's condition:

a. on the next and subsequent occasions that the authority for the patient's detention is renewed under Section 20(3), 20A(4) or 21B(2);

b. at any other time if so required by CQC, and

c. in the case of patients subject to a restriction order, at the end of the first six months, if treatment began during this period, and subsequently on each occasion that the responsible clinician is statutorily required to report to the Secretary of State.

3.86 Unless the treatment was initially authorised on Form T3, T5 and T6, a report is not required when the treatment has been given after the RC has certified on Form T2 that the patient is capable of understanding the nature, purpose and likely effects of the treatment and has consented to it.

3.87 When a report has been given to CQC, as required by Section 61, permission to continue treatment as authorised may be assumed to be given unless CQC gives notice of the withdrawal of the statutory form in use at the time. If such notice is given, a further certificate will be required before treatment may be continued, except for urgent treatment given under the provisions of Section 62 or 64

3.88 It is worth noting that although not a legal requirement, the CQC requires a s61 review of treatment for T2 certificates that are authorising treatment originally authorised by a T3 certificate.

3.89 S61 reports are not ordinarily required for CTO patients and treatment. There is only one circumstance when a report would be required and that is if:

- the patient was recalled to hospital in the period of the CTO; and
- the patient received treatment during the recall; and
- the treatment was certified by a SOAD on a Form CTO11 as appropriate to be given following any recall; and
- the patient is subsequently placed back onto the CTO after the recall.

3.90 In the above circumstances a s61 report should be submitted when the CTO is next renewed.

3.91 Once completed the s61 form must be returned to the MHL Office who will send it to the CQC with the appropriate certificate.

3.92 The MHLA will remind the RC of this responsibility in the section renewal reminder letter and include a copy of the form.

3.93 There are circumstances when certificates cease to be effective (CoP 25.83) and a new statutory form would be required. These are detailed in Table 1 below:

3.94 Table 1. Circumstances in which certificates cease to authorise treatment, even though they have not been withdrawn

Type of certificate	Circumstances in which the certificate ceases to authorise treatment
Certificate issued by approved clinician under section 58 or 58A	The patient no longer consents to the treatment. The patient no longer has capacity to consent to the treatment. The patient stops (even if only temporarily) being either a detained patient (as defined in chapter 24) or a community

Type of certificate	Circumstances in which the certificate ceases to authorise treatment
	patient who is not recalled to hospital. The clinician concerned stops being the approved clinician in charge of the treatment.
SOAD certificate under section 57	The patient no longer consents to the treatment. The patient no longer has capacity to consent to the treatment. The SOAD specified a time limit on the approval of treatment, and the time limit has expired
SOAD certificate under section 58 or 58A	The patient stops (even if only temporarily) being either a detained patient (as defined in chapter 24 or a community patient who is not recalled to hospital – except in the case of section 58A certificates for patients aged under 18. The SOAD specified a time limit on the approval of a course of treatment, and the time limit has expired. The certificate was given on the basis that the patient consented, but the patient no longer consents or has lost the capacity to consent. The certificate was given on the basis that the patient lacked capacity to consent, but the patient now has that capacity. Section 58 only: The certificate was given on the basis that the patient had capacity to consent but was refusing, and the patient is now either consenting or has lost the capacity to consent. Section 58A only: The certificate was given on the understanding that the treatment would not conflict with an advance decision to refuse treatment, but the person giving the treatment has since become aware that there is such a conflict. Section 58A only: The certificate was given on the understanding that the treatment would not conflict with a decision of an attorney, deputy or the Court of Protection, but the person giving the treatment has since become aware that there is such a conflict, or an attorney, deputy or the Court of Protection makes a new decision that the treatment should not be given.
Part 4A certificate	The patient stops (even if only temporarily) being either a detained patient (as defined in chapter 24) or patient on a CTO. (But note that a part 4A certificate authorises section 58 type treatment for a patient whose CTO has been revoked only pending compliance with section 58 itself.) The certificate was given on the basis that the patient lacked capacity to consent to or refuse the treatment, but the patient now has that capacity and consents to the treatment. The SOAD specified a time limit on the approval of a course of treatment, and the time limit has expired.
Part 4A consent certificate	The patient stops (even if only temporarily) being either a detained patient (as defined in chapter 24) or patient on a CTO. (But note that a part 4A consent certificate authorises section 58 type treatment for a patient whose CTO has been revoked only pending compliance with section 58 itself.) There is a permanent change in the approved clinician in charge of the patient's treatment. The certificate was given on the basis that the patient consented, but the patient no longer consents or has lost

Type of certificate	Circumstances in which the certificate ceases to authorise treatment
	the capacity to consent.

3.95 In all of the circumstances listed above, treatment cannot be continued while a new certificate is obtained, unless no certificate is needed because the treatment is immediately necessary (see paragraphs 25.37 – 25.42) and, in respect of CTO patients not recalled to hospital, the treatment is given under section 64G).

3.96 If a patient is transferred to or is on leave to one of our hospitals from an external hospital and there is a new RC, then a new T2 would be required. If the patient has a T3, the certificate remains valid, but the RC would need to demonstrate that the reasons for the T3 still apply (assessment of capacity)

3.97 All out of date T3 forms must be crossed through and removed from the medication folder and replaced with the valid form authorising the treatment.

3.98 All capacity assessment forms and checklist are available on the electronic care record and in paper format.

4 RESPONSIBILITIES

Post(s)	Responsibilities	Ref
All Staff	Must ensure they know their legal responsibilities under the MHA Qualified Nurses – complete the Mandatory MHA Training Doctors – meet training requirements	
Service, Clinical and Corporate Directors	Familiarise themselves with the policy; the reporting requirements; the legal requirements; and potential risks	
Policy Lead	Communicate the policy to all relevant staff Keep the policy up to date between formal review dates in line with any legislation changes; CQC reporting requirements; results / recommendations of incidents or audits	
Executive Director	Ensure the policy is accurate and up to date	
MHL Administrators	Familiarise themselves with the policy and their responsibilities Send timely consent to treatment reminders to RCs Report areas of non-compliance to the Head of Mental Health Legislation	

5 DEVELOPMENT AND CONSULTATION PROCESS

Consultation summary	
Date policy issued for consultation	August 2020

Number of versions produced for consultation		1
Committees or meetings where this policy was formally discussed		
Mental Health Legislation Committee		
Mental Health Legislation Business meeting		July
Where received	**Summary of feedback**	**Actions / Response**
PDMG		

6 REFERENCE DOCUMENTS

The Mental Health Act 1983 (as amended).
The MHA Code of Practice 2015
The Mental Capacity Act 2005
https://www.cqc.org.uk/guidance-providers/registration-notifications/mental-health-notifications

7 Bibliography:

MHA Manual 22nd Edition, Richard Jones
MHL14 MCA Policy
MHL01 MHA Policy

8 GLOSSARY:

Capacity	The ability to make a decision about a particular matter at the time the decision needs to be made. Some people may lack capacity to make a particular decision (e.g. to consent to treatment) because they cannot understand, retain, use or weigh the information relevant to the decision. A legal definition of lack of capacity for people aged 16 or over is set out in Section 2 of the Mental Capacity Act 2005.
Care programme approach (CPA)	A system of care and support for individuals with complex needs which includes an assessment, a care plan and a care coordinator. It is used mainly for adults in England who receive specialist mental healthcare and in some CAMHS services. There are similar systems for supporting other groups of individuals including, children and young people (children's assessment framework), older adults (single assessment process) and people with learning disabilities (person centred planning)
Consent	Agreeing to allow someone else to do something to or for you, particularly consent to treatment. Valid consent requires that the patient has capacity to make the decision and that they are given the information they need to make the decision and that they are not under any duress or inappropriate pressure.
CQC	Care Quality Commission
CTO	Community Treatment Order
ECT	Electro Convulsive Therapy is a form of medical treatment for mental disorder in which seizures are induced by passing electricity through the brain of an anaesthetised patient; generally used as a treatment for severe depression.
Guiding principles	The five principles set out in chapter 1 which have to be considered when decisions are made under the Act
MCA	The Mental Capacity Act 2005 is an Act of Parliament that governs decision making on behalf of people who lack capacity.
MHA	Mental Health Act
MHLA	Mental Health Legislation Administrator – administers the statutory functions of the MHA as delegated by Trust Board and any relevant MCA functions.

Part 4	The part of the MHA which deals mainly with the medical treatment for mental disorder of detained patients (including CTO patients who have been recalled to hospital)
Part 4A	The Part of the MHA which deals with the medical treatment for mental disorder of CTO patients when they have not been recalled to hospital. Treatment is certified on a Part 4A certificate by a SOAD
RC	Responsible Clinician - The Approved Clinician (AC) with overall responsibility for a patient's case.
SOAD	Second Opinion Appointed Doctor – An independent doctor appointed by the CQC who gives a second opinion on whether certain types of medical treatment for mental disorder should be given without the patient's consent

9 AUDIT AND ASSURANCE:

Element to be monitored	Lead	Tool	Freq	Reporting Committee
Compliance with Procedures outlined in Part 3 of the policy	**Head of Mental Health Legislation**	MHA / MCA Monitoring Tool	Monthly	**MHLC Board Committee**
A specific element of Consent to Treatment is identified each year and included in the MHLC Annual Audit Priority Plan	Deputy Director of Pharmacy	Trustwide Annual Audit	Annual	**MHLC Board Committee**

10 APPENDICES consisting of:

APPENDIX 1 Equality Assessment
APPENDIX 2 Guidance for completion of T2 and T3 certificates in relation to the BNF
APPENDIX 3 Gillick Procedures
APPENDIX 4 Children and Young People - Capacity and Consent to Treatment Form G
APPENDIX 5 RC SOAD Feedback Form
APPENDIX 6 Guidelines For Acting as a Statutory Consultee
APPENDIX 7 Email Template for Annual T2 Review for Restricted Patients
APPENDIX 8 12 months Review of Certificate of Consent to Treatment for Restricted Patients

Equality Analysis Screening Form

A word version of this document can be found on the HR support pages on Connect
http://connect/corporate/humanresources/managementsupport/Pages/default.aspx

Title of Proposal	**MHL10 CONSENT TO TREATMENT POLICY**		
Person Completing this proposal	**LOUISE MCLANACHAN**	**Role or title**	**HEAD OF MENTAL HEALTH LEGISLATION**
Division	**CORPORATE**	**Service Area**	**MEDICAL**
Date Started	**AUGUST 2020**	**Date completed**	**October 2020**

Main purpose and aims of the proposal and how it fits in with the wider strategic aims and objectives of the organisation.

To ensure compliance with sections 58, 62 and 64 of the Mental Health Act 1983 in relation to the provision of treatment for mental disorder

Who will benefit from the proposal?

Patients, clinical staff and MH Legislation staff

Impacts on different Personal Protected Characteristics – *Helpful Questions:*

Does this proposal promote equality of opportunity *Eliminate discrimination*	*Promote involvement and consultation* *Protect and promote human rights*

Please click in the relevant impact box or leave blank if you feel there is no particular impact.

Personal Protected Characteristic	**No/Minimum Impact**	**Negative Impact**	**Positive Impact**	**Please list details or evidence of why there might be a positive, negative or no impact on protected characteristics.**
Age	x			
Including children and people over 65 Is it easy for someone of any age to find out about your service or access your proposal? Are you able to justify the legal or lawful reasons when your service excludes certain age groups				
Disability	x			
Including those with physical or sensory impairments, those with learning disabilities and those with mental health issues Do you currently monitor who has a disability so that you know how well your service is being used by people with a disability?				

Are you making reasonable adjustment to meet the needs of the staff, service users, carers and families?				
Gender	x			
This can include male and female or someone who has completed the gender reassignment process from one sex to another Do you have flexible working arrangements for either sex? Is it easier for either men or women to access your proposal?				
Marriage or Civil Partnerships	x			
People who are in a Civil Partnerships must be treated equally to married couples on a wide range of legal matters Are the documents and information provided for your service reflecting the appropriate terminology for marriage and civil partnerships?				
Pregnancy or Maternity	x			
This includes women having a baby and women just after they have had a baby Does your service accommodate the needs of expectant and post natal mothers both as staff and service users? Can your service treat staff and patients with dignity and respect relation in to pregnancy and maternity?				
Race or Ethnicity	x			
Including Gypsy or Roma people, Irish people, those of mixed heritage, asylum seekers and refugees What training does staff have to respond to the cultural needs of different ethnic groups? What arrangements are in place to communicate with people who do not have English as a first language?				
Religion or Belief	x			
Including humanists and non-believers Is there easy access to a prayer or quiet room to your service delivery area? When organising events – Do you take necessary steps to make sure that spiritual requirements are met?				
Sexual Orientation	x			
Including gay men, lesbians and bisexual people Does your service use visual images that could be people from any background or are the images mainly heterosexual couples? Does staff in your workplace feel comfortable about being 'out' or would office culture make them feel this might not be a good idea?				
Transgender or Gender Reassignment	x			
This will include people who are in the process of or in a care pathway changing from one gender to another				

Have you considered the possible needs of transgender staff and service users in the development of your proposal or service?				
Human Rights			x	
Affecting someone's right to Life, Dignity and Respect? Caring for other people or protecting them from danger? The detention of an individual inadvertently or placing someone in a humiliating situation or position?				
If a negative or disproportionate impact has been identified in any of the key areas would this difference be illegal / unlawful? I.e. Would it be discriminatory under anti-discrimination legislation. (The Equality Act 2010, Human Rights Act 1998)				

	Yes	**No**		
What do you consider the level of negative impact to be?	**High Impact**	**Medium Impact**	**Low Impact**	**No Impact**

If the impact could be discriminatory in law, please contact the **Equality and Diversity Lead** immediately to determine the next course of action. If the negative impact is high a Full Equality Analysis will be required.

If you are unsure how to answer the above questions, or if you have assessed the impact as medium, please seek further guidance from the **Equality and Diversity Lead** before proceeding.

If the proposal does not have a negative impact or the impact is considered low, reasonable or justifiable, then please complete the rest of the form below with any required redial actions, and forward to the **Equality and Diversity Lead.**

Action Planning:
How could you minimise or remove any negative impact identified even if this is of low significance?
How will any impact or planned actions be monitored and reviewed?
How will you promote equal opportunity and advance equality by sharing good practice to have a positive impact other people as a result of their personal protected characteristic.

Please save and keep one copy and then send a copy with a copy of the proposal to the Senior Equality and Diversity Lead at **bsmhft.hr@nhs.net** . The results will then be published on the Trust's website. Please ensure that any resulting actions are incorporated into Divisional or Service planning and monitored on a regular basis.

Guidance for completion of T2 and T3 certificates in relation to the BNF

T2 and T3 certificates should:

1. record the **class of drug**; and **route of administration**

But rather than noting particular **sections of the BNF**, should either:

- state that the **dose** (when calculated together with frequency) is **within BNF guidelines** as to advisory **maximum dose limits** for that route;
- or **state a maximum dose limit** referenced to BNF guidelines such as, for example, 50% or 120%;

Example extracts from a T2 or T3 certificate might therefore read as follows:

One oral antidepressant drug within BNF advisory maximum dose limits

Or

2. record a **named drug** and its **route & maximum dose**

Example extracts from a T2 or T3 certificate might therefore read as follows

Olanzapine, oral antipsychotic, maximum 15mg daily

Practice Guidance: Assessing Competence and Making Decisions for Children under the age of 16

Consent

Consent should be sought by staff for each aspect of the child's admission, care and treatment as it arises. Where a child gives valid consent it will be sufficient authority for any care or treatment for their mental health and additional consent by a person with parental responsibility will not be required.

The refusal by a competent child with capacity under the age of 18 may be overridden by the Mental Health Act or in certain circumstances a court.

In order to give valid consent a child must have sufficient information about the decision, not be under any undue pressure or influence to make the decision and have the competence to make the decision.

Blanket consent forms (i.e. forms that purport to give consent to any proposed treatment) are not acceptable and should not be used. Please see Trust Consent to Treatment Policy for further information

Gillick Competence

The test for assessing whether a child under 16 can give valid consent differs from that of a young person aged 16 or 17.

The capacity of a young person aged 16 or 17 to consent is assessed in accordance with the MCA, while the test for children under 16 is determined by considering whether they are 'Gillick competent'.

This is because in the case of Gillick, the court held that children under 16 who have sufficient understanding and intelligence to enable them to understand fully what is involved in a proposed intervention will also have the competence to consent to that intervention.

In such cases, the child is sometimes described as being 'Gillick competent'.
A child may be Gillick competent to consent to admission to hospital, medical treatment, research, or any other activity that requires their consent.

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

Supporting Decisions

- Staff should take practical steps to enable the child to make the decision for themselves.

- Staff should also ensure that the child has been given the relevant information in an appropriate manner (such as age appropriate language).

- The kind of support that might help the decision-making will vary, depending on the child's circumstances. Examples include:

  - steps to help the child feel at ease;
  - ensuring that those with parental responsibility are available to support the child (if that is what the child would like);
  - giving the child time to absorb information at their own pace;
  - considering whether the child has any specific communication needs (and if so, adapting accordingly).
  - Involve an independent advocate where appropriate

Assessing Competence

Practitioners with expertise in working with children and young people should be consulted in relation to competence assessments. In general a competence decision should be made by the member of staff who is proposing the particular intervention/treatment that a decision needs to be based upon.

When considering whether a child has the competence to decide about the proposed intervention, practitioners should consider the following questions.

1. **Does the child understand the information that is relevant to the decision that needs to be made?**
2. **Can the child hold the information in their mind long enough so that they can use it to make the decision?**
3. **Is the child able to weigh up that information and use it to arrive at a decision?**
4. **Is the child able to communicate their decision (by talking, using sign language or any other means)?**

Staff should also consider if a child has developed the necessary intelligence and understanding to make that particular decision or if their mental disorder adversely affects their ability to make the decision.

Assessments of competence should be clearly recorded in the child's clinical record and reviewed at key stages of their intervention / treatment. Staff should also document information they have given the child, the reasons / nature of the treatment, the child's views / feedback and the alternatives, disadvantages, advantages of the treatment / intervention offered (Form G)

A detailed review will not be required if there has been no substantial change in the competence of the child to make a decision about a particular intervention / treatment. However, evidence that a review has taken place must be documented. (Form G)

Making decisions for children

Where staff have made a decision that a child lacks the competence to make a decision for themselves they need to consider if the particular intervention can be undertaken on the basis of parental consent in the light of the particular circumstances of the case.

Practitioners will need to consider if:

1) **This is a decision that someone with parental responsibility should reasonably be expected to make? (Scope of Parental Responsibility)** - Considering the type and invasiveness of the proposed intervention, the age, maturity and understanding of the child, the past and present wishes of the child and their resistance to the treatment.
2) **Are there any factors that might undermine the validity of parental consent?** For example, the person with parental responsibility is not able to make the relevant decision because they lack capacity to make it, they are not acting in the best interests of the child or there is significant conflict between the person with parental responsibility and the child, or there is disagreement between individuals with parental responsibility.

If the decision is not one that a parent would reasonably be expected to make, or there are concerns about the validity of the consent of the person with parental responsibility, it will not be appropriate to rely on parental consent.

In cases where the proposed intervention relates to the assessment and/or treatment of the child or young person's mental disorder, they could be admitted and treated under the Mental Health Act if the criteria are met.

If the MHA is not applicable, legal advice should be sought on the need to seek authorisation from a court before further action is taken.

Where there are safeguarding concerns staff must liaise with the Local Authority regarding possible options under The Children Act.

Staff should also consider guidance set out in the Mental Capacity Act Code of Practice for general guidance around best interest decisions and the GMC Guidance in relation to children.

Where a child is not Gillick competent and someone with parental responsibility is consenting to treatment on their behalf, the person(s) with parental responsibility must be given information about the nature and purpose of treatment and this must be documented within the child's record.

Emergency situations

If a person with parental responsibility is not available to give consent, the child's best interests must be considered and treatment limited to what is reasonably required to deal with the particular emergency.
Justification should be clearly recorded in the child's clinical record and reviewed at key stages of their intervention / treatment. Staff should also document information they have given the child, the reasons / nature of the treatment, the child's views / feedback and the alternatives, disadvantages, advantages of the treatment / intervention offered (Form G)

Complex cases

For more complex cases, such as those involving disagreements about treatment, there should be evidence of discussion with colleagues and the offer of a second opinion (this should be proportionate to the circumstances of the case). Where issues cannot be resolved, seeking legal advice is recommended.

Deprivation of Liberty

Where a child under the age of 16 is not competent to make a decision about their deprivation of liberty in hospital, as long as there are no factors that undermine the validity of parental consent, someone with parental responsibility can agree to the admission as outlined in the recent case - Trust A and X[2015] EWHC 922 (Fam).

If staff require any additional information they should consider the guidance below or contact the Trust Solicitor or Head of Mental Health Legislation for advice or legal guidance

Further Reading

CQC (2015) Brief guide: capacity and competence in under 18s – October 2015 https://www.cqc.org.uk/sites/default/files/20151008%20Brief%20guide%20-%20Capacity%20and%20consent%20in%20under%2018s%20FINAL.pdf

Department for Constitutional Affairs. *Mental Capacity Act 2005 Code of Practice*. London: The Stationery Office, 2007 https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/497253/Mental-capacity-act-code-of-practice.pdf

Department of Health. *The Code of Practice to the Mental Health Act 1983 – Chapter* 19 p168 – 196 http://connect/corporate/governance/mental-health-act/Documents/MHA%20Code%20of%20Practice%202015.pdf

General Medical Council. *0-18 Guidance for all doctors*. GMC, 2007. http://www.gmc-uk.org/guidance/ethical_guidance/children_guidance_index.asp

Department of Health (2001) - Seeking Consent: Working with Children http://webarchive.nationalarchives.gov.uk/20130107105354/http:/www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4067204.pdf

Working together to safeguard children 2015

Appendix 4

Capacity and Consent to Treatment: Form G

Young people aged 16 and 17 are presumed to have sufficient capacity to decide on their own treatment, unless there is significant evidence to suggest otherwise.

Children under the age of 16 can consent to their own treatment if they are believed to have enough understanding, intelligence and competence to fully appreciate what is involved in their treatment. This is known as being 'Gillick competent'.

The health professional leading your initial appointment will determine your capacity and competence using the Gillick framework. This will entail the health care professional asking you a number of questions to determine your understanding about your care and treatment plan.

The health care professional will provide you with any additional support or information that you may require to help you in making a decision

Do you understand the proposed intervention / treatment in terms of:		
What the treatment is and its purpose	YES	NO
Why the intervention/treatment is being proposed	YES	NO
You can weigh up the risks and benefits of treatment	YES	NO
You can retain the information about the treatment long enough to make a decision	YES	NO
You can communicate your decision about treatment to the health care professional	YES	NO

Following your assessment has Gillick competence/capacity been determined?	YES	NO

It is Important to understand that if the health care professional determines that you do not have capacity following the above assessment you will be encouraged to involve your parents / guardians in your care and your parent or guardian can consent on your behalf.

Responsible Health Professional

Name: …… Job title: ……

Signature: …….. Date:……

Child / Young Person's consent

I confirm that the health professional has discussed with me all aspects of the proposed intervention/treatment I am satisfied with the discussion and I give my consent for the intervention/treatment. I understand that I can withdraw this consent at any time.

Name of patient: ……**Patient signature**: ……

Date: ……

Parental consent

I confirm that the health professional has discussed with me all aspects of the proposed intervention/treatment I am satisfied with the discussion and I give my consent for the intervention/treatment. I understand that I can withdraw this consent at any time.

Name of person with parental responsibility ……

Parent signature: …… **Date**: ……

Parental Consent

I confirm that the health professional has discussed with me all aspects of the proposed intervention/treatment I am satisfied with the discussion and I give my consent for the intervention/treatment. I understand that I can withdraw this consent at any time.
Name of person with parental responsibility: ……
Parent signature: …… **Date**: ……..……

Appendix 5

RC SOAD FEEDBACK FORM

Name of the patient
The treatment plan agreed by the Second Opinion Appointed Doctor (SOAD) and the written statement of reasons given by the SOAD for his/her decision (when certifying under section 58 of the Mental Health Act 1983 that a detained patient should be given medication against his/her will or because he/she lacks capacity to consent),
*(Delete as appropriate***)**
1. Have been disclosed to the patient.
2. Have not been disclosed to the patient because such disclosure would be likely to cause serious harm to the physical or mental health of the patient or any other person as detailed below
RC Name:
Signature
Date:

Appendix 6

GUIDELINES FOR ACTING AS A STATUTORY CONSULTEE

1. Statutory consultees are the people who SOADS (Second Opinion Appointed Doctors) consult when they come to review a patient's treatment plan.

2. One MUST be a nurse and one MUST be a non-nurse / non medic (usually an OT, psychologist, pharmacist for example)

3. The requirements for the role of statutory consultee (in other words what makes you eligible) are:

- You must know the patient
- Be involved professionally with their care
- Make yourself available for a private discussion with the SOAD (face to face is preferable, but over the phone is acceptable)

4. Prior to the meeting with the SOAD, you will need to ensure you are prepared and are aware of the following:

- the proposed treatment and the patient's ability to consent to it;
- their understanding of the past and present views and wishes of the patient;
- other treatment options and the way in which the decision on the treatment proposal was arrived at
- the patient's progress and the views of the patient's carers; 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

5. The SOAD will formally record the discussion, but it may be helpful to make a note of your discussion in the patient's progress notes

Appendix 7

Email template for MHAAs requesting T2 Annual Review

Dear Dr ……

Please be reminded that Consent to Treatment for PATIENT NAME is due to be reviewed as good practice and policy requirement by …….. (12 month review)

Currently a T2 is in placed dated……..., if you are happy for this to remain in place please complete the attached review form.

If any change to treatment or capacity please find relevant forms attached.

Kind Regards

Appendix 8

Form T2 - 12 months Review of Certificate of Consent to Treatment (Capacity & Consenting)

I (PRINT full name and address)

The approved clinician in charge of the treatment described on T2 dated | | certify that

(PRINT full name and address of patient)

is capable of understanding the nature, purpose and likely effects of treatment and also has consented to that treatment.

I have therefore reviewed the Consent to Treatment on | |

and the T2 stated above will continue.

Signed | Date
