

Child and Adolescent Mental Health Services (CAMHS) Tier 4



**What are they and how do they
work?**

A Family Survival Guide

Created by Families

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Foreword

As Children's Commissioner for England, it is my role to act as the eyes and ears of children in the system, shining a light on the experiences of all children, but especially those staying away from their families in places like mental health hospitals or residential children's homes.

I am delighted to contribute a foreword to this guide. Bringing us Together do an excellent job of supporting families as they try to navigate what can be a very complicated and confusing system, with lots of jargon and professionals making decisions on a child's behalf.

My team go and visit children in inpatient hospitals on a regular basis to talk to them about their experiences. We see lots of good practice, like high quality schools and staff that are dedicated to keeping children safe. Where we see that the quality of care is not good enough, my Help at Hand (<https://www.childrenscommissioner.gov.uk/help-at-hand/about-us/>) service will support a child to raise any concerns and we will hold the NHS and local authorities to account.

When a child is admitted to hospital, they are often very unwell and in need of specialist help. Around the country, there are hundreds of dedicated staff who are working hard to keep children safe and to help them get better. Last year my office published a report shining a light on the experience of children with learning disabilities, autism or both in inpatient hospitals. While I found examples of excellent staff practice, it was also clear that the quality of care is variable and the process of admission to hospital can be bewildering and stressful for children and their families. I found that too many young people are admitted unnecessarily – a result of the failure to

provide adequate support in the community. Mums and dads have told me they can sometimes feel completely overwhelmed and powerless to change the way their children are cared for.

The NHS has set up a taskforce to improve the quality of care for children and young people with mental health needs, including those with autism and learning disabilities. I am chairing the Oversight Group to hold the taskforce to account on delivering rapid improvements to the quality of care in hospitals and in the community so that all children get the right care, in the right place, at the right time.

I know that having a child admitted into an inpatient unit is a worrying time for any parent, and I hope that this guide can provide some much needed reassurance, helps answer all your questions and gives you the information you need to get the right support and care for your child while they are in hospital.

Anne Longfield

Children's Commissioner for England

Introduction

This guide has been written to provide information and guidance based upon the legislation in place before the introduction of the Coronavirus Act on 25th March 2020, which has made some temporary changes to legislation and guidelines, including health and social care

You can find the Coronavirus Act here

<http://www.legislation.gov.uk/ukpga/2020/7/contents/enacted/data.htm>

This guide covers a range of specialist inpatient Child and Adolescent Mental Health services (CAMHS) providing assessment and treatment for children and young people with emotional, behavioural or mental health conditions.

What is this guide about?

Having a child or young person referred to a specialist assessment and treatment unit (ATU) can be a confusing and worrying time for families. This guide aims to give families the information they need to navigate the system and advocate for their loved one.

Mental Health services across the NHS are organised in four levels or Tiers, (Tier 1 to Tier 4) to reflect the nature and complexity involved. The category of provision covered in the guide is known as Tier 4 as it is the most highly specialised.

The guide covers the period following the referral of a child or young person to a CAMHS inpatient unit for assessment and treatment. Patients being accepted for CAMHS Tier 4 support are likely to have already been assessed in the community as having significant and urgent needs that require specialised help. Tier 4 services are for those with the highest or most complex needs.

Who is this guide for?

This guide has been written specifically for families with children and young people under 18, who have learning disabilities, autism or both, and behaviour that challenges others. It has been designed to help explain the way in which CAMHS inpatient services and support are provided. This is significant because the law, and NHS England policies and practice, can apply differently to this group of people.

The guide has been written by parents who have personal experience of this type of provision and have sons or daughters with this range of needs. However, it also contains information that may be useful to families who have children and young people with wider emotional, behavioural or mental health difficulties.

Please note: The process that families encounter is governed by a number of laws and codes of practice. The legal system is immensely complicated, and we have done our best to try and make this information clear, understandable and as accurate as possible, from the perspective of a child or young person, and their family.

However, the information in this guide does not represent legal advice. If you have specific legal questions, please contact a legal adviser or suitably qualified Mental Health Act advocate

How to use this guide?

We have structured the guide to follow the likely stages families will encounter if their child or young person is admitted to an inpatient mental health hospital. As this is a reference guide, we understand that readers may wish to dip in and out of the guide, as and when they need certain information, rather read the guide cover-to-cover. We have therefore made sure that the relevant important information is always included in each chapter. This means that some essential information is repeated in different sections, while non-essential information is signposted.

The final two chapters (Chapter 13: The Mental Health Act – a reference guide and Chapter 14: Mental Capacity Act - a reference guide) have been included so that readers can get more detailed information about these Acts, if they would like.

Please note: In this guide, we have used the term 'child' to refer to anyone under the age of 16 and 'young person' for those aged 16 or 17 years old. However, in relation to parents and their offspring, we use 'child' to refer to any age. This is because parents tend to say 'my child' whatever the age of their son or daughter.

About Bringing Us Together

The parents who have worked on this guide belong to an organisation called Bringing Us Together <https://bringingusstogether.org.uk/>, which is led by parents of adults, children and young people with a complex range of needs and disabilities. Bringing Us Together's main aim is to provide parents and carers with essential information to help them understand how the system works, connect them to people and resources that can provide help and advice, and give families the knowledge they need to advocate for their loved one.

If you find this guide helpful, please tell your friends and colleagues! We would also welcome any feedback - good or bad - as this will help the guide be as useful as possible.

Please contact: katie@bringingusstogether.org.uk.

1. CAMHS AND Tier 4 services

What does CAMHS stand for?

Child and Adolescent Mental Health Services (CAMHS) provide a wide range of preventive, early intervention and specialist services for children and young people up to the age of 18, who may have emotional, behavioural or mental health difficulties.

CAMHS services are commissioned by the NHS and are organised into four tiers as shown on the table below. Multidisciplinary teams work in each tier to best meet the needs of their patients.

The professionals who work in CAMHS inpatient units include: mental health practitioners, psychotherapists, psychologists, psychiatrists, nurses, health care assistants and social workers who work together to identify the cause(s) of the problem, understand what is causing it and offer helpful strategies.

CAMHS Tier	Service description
Tier 1	Universal early intervention and prevention services, which may be provided by a range of agencies (including GPs, health visitors, school nurses, teachers and social workers)
Tier 2	Targeted services, such as youth offending teams, primary mental health workers, educational psychologists and school and voluntary/third sector providers counselling (including social care and education)
Tier 3	Specialist community multidisciplinary CAMHS teams
Tier 4	Highly specialist inpatient and outpatient services
NB:	<i>The nature of the services and referral processes may vary locally</i>

What does Tier 4 mean?

As mentioned earlier, CAMHS Tier 4 services provide specialised mental health assessment and treatment services for children and young people with emotional, behavioural or mental health difficulties. Patients being accepted for CAMHS Tier 4 support should have already been assessed in the community as having significant and urgent needs that require specialised help by accessing day units, highly specialised outpatient teams or inpatient units. Tier 4 services are for those with the highest or most complex needs.

NHS England (NHSE) is the organisation responsible for commissioning all these services. NHSE publish the standards of care required to meet the needs of these patients across the range of Tier 4 CAMHS services within seven service specifications.

If you would like to know more about what you can expect from CAMHS services, you can find the *C03 Child and Adolescent Mental Health Services Specifications* here.

<https://www.england.nhs.uk/commissioning/spec-services/npc-crg/group-c/c03/>

Informal and formal admission

Tier 4 CAMHS services accept informal (or on a voluntary basis) and formal patients (who are detained in hospital under the terms of the Mental Health Act (MHA)). They may also provide specialist outreach support in the community.

Understanding informal admission

Before any treatment can be carried out, appropriate consent must be given, either by the patient (if they are able to decide for themselves), or with the help of others around them (if they need such support). If there is any doubt about this, a mental capacity assessment will be completed to decide who can make the final decision.

Mental capacity is the ability of an individual to make their own decisions. The mental capacity assessment checks that the person understands the decision-making process, and can remember and communicate the relevant information. Mental capacity assessments must be conducted for a specific

reason and at the time the decision needs to be made, as capacity can sometimes come and go.

Anyone above the age of 16 who is considered to have capacity can consent to, or refuse, informal mental health hospital admission – whether or not their parents are in agreement. Decisions about mental capacity are governed by the Mental Capacity Act 2005 (MCA).

Anyone below 16 years of age can consent or refuse informal admission if they are thought to have sufficient maturity and understanding. This is known as being 'Gillick competent'. (For further information, please see *page 70*.)

If the person lacks capacity, the *MHA Code of Practice* (chapter 20, para 30) states that:

'A person with a learning disability or autism cannot be admitted on an informal basis if they do not have capacity to consent to or refuse that admission and treatment. If this is the case, a deprivation of liberty (DoL) authorisation or a Court of Protection order must be in place to authorise the deprivation of liberty.'

Legal basis for formal admission

A formal patient is someone who has been detained in hospital, without their consent, under a Section of the MHA for assessment and treatment of a mental health condition.

The MHA is the primary legislation used to set out the legal basis for becoming a formal patient. It explains how a person can be admitted, detained and treated in hospital against their wishes. It also details the safeguards (protections) that are needed to uphold the patient's rights.

The role of parents in decision-making, if their child has been sectioned under the MHA, can be complex and confusing. Please refer to the *MHA Code of Practice* (Chapter 19, paras 38-43) for more information.

You can find out more about the MHA in Chapter 13, on *page 105* of this guide.

Other relevant legislation

Those responsible for the care of children and young people in hospital must comply with other relevant legislation, including the *Children Act* (1989 and 2004), the *Human Rights Act* and the *Equality Act*. They should also be aware of the *United Nations Convention on the Rights of the Child* (UNCRC), and keep up-to-date with relevant case law and guidance.

These laws are used to define the rights of patients undergoing assessment and treatment, and the duties and responsibilities of the professionals providing the care and support they need.

All hospitals are regularly inspected by the Care Quality Commission (CQC), which is the independent regulator of health and social care in England. The relevant standards that the CQC assess against are set out in the Health and Social Care Act 2008 (Regulated Activities) Regulations. You can find out more about these standards here <https://www.legislation.gov.uk/ukxi/2014/2936/contents/made>

What happens if my child needs a Tier 4 referral?

Each area has a local policy that governs how CAMHS Tier 4 assessment and treatment is accessed and provided. What follows is a general overview of the typical process.

Is additional community support needed?

If community services and support are failing to meet the young person's needs, the young person, their parents/carers and the relevant CAMHS team should meet to discuss additional community support (across health, education and social care) as a safe alternative to hospital admission.

Any child or young person who is at risk of admission, should be on your local area dynamic register, subject to their / your consent, as appropriate. You can find out more about Dynamic Registers on page 19.

If you are concerned your child is at risk of imminent crisis, you should request help as soon as possible from your lead health or care professional.

Is a Care Education and Treatment Review required?

If a child or young person with learning disability, autism or both is at risk of inpatient admission, their care coordinator, key worker and/or commissioner should request a Care Education and Treatment Review (CETR). This review brings everyone together (including the care professionals involved) to work out if appropriate support can be provided by community health and social care services to prevent the child or young person being admitted to an Assessment and Treatment Unit (ATU).

Anyone who is providing care or support for a person, can request a CETR, including parents. If there is not time to arrange a CETR, a Local Area Emergency Protocol may be used to carry out an emergency review.

You can find out more about CETR's here <https://www.england.nhs.uk/wp-content/uploads/2017/03/ctr-policy-v2.pdf>

Please note: Bringing Us Together have published some family survival guides on **Care and Treatment reviews** <https://bringingustogether.org.uk/wp-content/uploads/2017/08/CTR-Survival-Guide-Aug-2017-1.pdf> and on **Crisis Prevention** <https://bringingustogether.org.uk/wp-content/uploads/2019/04/Avoiding-Crisis-A-Survival-Guide.pdf>

Informal admission referral

If community services are not able to meet your child's needs, they may have to be admitted to a mental health hospital for assessment and treatment. This can be on an informal basis, if appropriate consent can be obtained and the lead CAMHS clinician can make the necessary Tier 4 referral.

An access assessment should then be undertaken, in consultation with the person/CAMHS/parents/carers, as necessary, to look at the patient's needs and to decide the best available service to meet these.

Once a service has been identified, a mental health case manager will contact the selected provider and make the necessary arrangements. The lead CAMHS professional will make contact with the identified hospital and make the necessary transfer and admission arrangements. All young people should have referral (and wherever possible, initial assessment) documentation completed prior to admission.

Please note: Finding an available bed can often be very difficult, due to the limited availability of beds across the country. Unfortunately, this means that children and young people are sometimes placed in hospitals a long way from home.

When might my child need to be sectioned?

The Mental Health Act (MHA) says that, where it is possible to treat a patient safely and lawfully without detaining them under the Act, the patient should not be detained. However, if your child is thought to have a mental disorder requiring highly specialised care, they may be referred for formal assessment and treatment under the MHA. This gives certain health or care professionals the legal authority to make a decision on the patient's behalf to detain them, if necessary, under an appropriate MHA Section.

The MHA defines 'mental disorder' as 'any disorder or disability of the mind'. The *MHA Code of Practice* (chapter 20, para 7) explains that learning disability and autism fall within the Act's definition of mental disorder, where associated with 'abnormally aggressive behaviour' or 'seriously irresponsible conduct'. The *MHA Code of Practice* can be found here <https://www.gov.uk/government/publications/code-of-practice-mental-health-act-1983>

Please note: In an emergency, certain professionals are permitted to take steps under the MHA to allow a person to be moved to a safe place/hospital for a mental health assessment, or for other arrangements to be made for their treatment or care. In this situation, consent is not required.

Avoiding inappropriate inpatient admission

The Mental Health Act (MHA) *Code of Practice* Chapter 20 explains how the MHA should be used and the special considerations required in relation to people (adults and children) with learning disability and/or autism.

It explains that, in people with learning disability, behaviour can be a communication of unmet need. It also stresses the importance of assessing its underlying causes and possible triggers.

...it is important to establish whether any abnormally aggressive or seriously irresponsible behaviour identified stems from difficulties in communication or an underlying condition or syndrome or unmet need. Challenging behaviour may be due to an unmet support need, unmet social or emotional need, or an unmet physical health need (including untreated pain), rather than to a mental disorder.

The *MHA Code of Practice* goes on to explain that:

Compulsory treatment in a hospital setting is rarely likely to be helpful for a person with autism, who may be very distressed by even minor changes in routine and is likely to find detention in hospital anxiety provoking. Sensitive, person-centred support in a familiar setting will usually be more helpful. Wherever possible, less restrictive alternative ways of providing the treatment or supporting a person should be found.

The decision to admit any person to hospital under section of the MHA should not ever be taken lightly. However, these outlined factors reveal why additional and careful consideration must be taken before a person with learning disability, autism or both is admitted to an inpatient unit under section.

You can read the *MHA Code of Practice* here. <https://www.gov.uk/government/publications/code-of-practice-mental-health-act-1983>

Dynamic Registers

It is important for local education, health and social care services to be aware of any young (or older) person with learning disability, autism or both, who may be at risk of crisis and potential admission to a mental health hospital. A Dynamic Register is used by local health and care teams to identify and prioritise their needs. The name of the register can vary from area to area (e.g. Dynamic Support Register, Best Practice Register).

If your child is at risk of crisis and potential inpatient admission, it is helpful for their details to be included in the Dynamic Register (subject to their/your consent, as appropriate). This will ensure they are known to local services and any additional support needs can be looked at and CETRs arranged as necessary.

If you are concerned that your child is at risk of crisis and is not already receiving CAMHS support speak with your child's lead professional, explain the situation and request a CETR.

If you are unsuccessful with this and you are concerned that your child is at risk of imminent crisis, as a last resort you can email your local Transforming Care Partnership (TCP) Senior Responsible Officer (SRO). You can find your child's SRO, with their contact details, here. <https://www.england.nhs.uk/learning-disabilities/tcp/> Click on your area, and scroll down to find the SRO's email address.

Care, Education and Treatment Reviews

If you are concerned that your child is at risk of crisis and potential inpatient admission, you can request a community CETR. This review looks at any additional support local services can put in place to better meet your child or young person's needs, without the need for admission to hospital.

The professionals involved should listen to what your loved one and you have to say and consider all alternatives to detention. These alternatives might include treatment from local mental health services.

Full guidance on Care, Education and Treatment Reviews can be accessed here. <https://www.england.nhs.uk/wp-content/uploads/2017/03/ctr-policy-v2.pdf>

Bringing Us Together's family survival guide to CTRs can be accessed here. <https://bringingustogether.org.uk/wp-content/uploads/2017/08/CTR-Survival-Guide-Aug-2017-1.pdf>

Local Area Emergency Protocol

If the situation deteriorates to the point where a crisis is likely without urgent intervention, and there is no time to assemble an independent panel for the CETR, an urgent meeting based on the Local Area Emergency Protocol should be arranged.

The format of the Local Area Emergency Protocol Review can be a face-to-face meeting, but given the urgent need is more likely to be a secure teleconference to allow everyone (including the person and their family) to participate if possible.

Requesting help in an emergency

If you are worried about the immediate safety of your loved one, or they are at risk of hurting themselves or others around them, take one of the following actions depending upon your circumstances.

If you have already been given a Crisis Line number from a health professional, ring them straightaway.

If your loved one has a care plan that states who to contact when you need urgent care, follow this plan.

If it is an emergency, call 999 and ask for a police and ambulance response if the person's behaviour presents a serious risk to themselves and / or others.

For further information about when to call 999 go to: <https://www.nhs.uk/using-the-nhs/nhs-services/urgent-and-emergency-care/when-to-call-999/>

Further information

A beginner's guide to Child and Adolescent Mental Health Services (CAMHS) for young people and parents

https://youngminds.org.uk/find-help/your-guide-to-support/guide-to-camhs/?gclid=EAIaIQobChMIyvyooYeH4gIVjLTtCh1bSw69EAAYASAAEgLLDvD_BwE

Your Guide to Inpatient Care

<https://youngminds.org.uk/find-help/your-guide-to-support/your-guide-to-inpatient-care/>

2. About sectioning

What is sectioning?

The term 'sectioning' refers to when a person is kept without their agreement in a mental health hospital. The Mental Health Act (MHA) defines different sections or powers to meet a range of needs. All the sections are set out in detail, with each one having its own set of rules and criteria. These are fully explained in Chapter 13 on *page 105* and in the *MHA Code of Practice*, available here. <https://www.gov.uk/government/publications/code-of-practice-mental-health-act-1983>

What happens if my child is sectioned?

If your child is sectioned, they can be kept in, or taken to, a mental health hospital for assessment and treatment, without obtaining consent in accordance with the Mental Health Act (MHA).

There are two sections most commonly used in this situation.

- **Section 2** is used for assessment and detention can last up to 28 days.
- **Section 3** allows more time for treatment, with detention lasting up to six months initially and can be renewed thereafter.

Your child's rights under the Mental Health Act depend on which section they have been detained under. All the mental health sections are covered in the *MHA Code of Practice*. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/435512/MHA_Code_of_Practice.PDF

You can also find out more about the different Mental Health Act sections here.

<https://youngminds.org.uk/media/2801/section-resource.pdf>

If it is necessary to act immediately to keep a person or those around them safe, either at home or in the community, an Approved Mental Health Practitioner (AMPH) can be requested to carry out an assessment. If

necessary, they can apply for a section 135 or 136 warrant from a magistrate to allow the person to be kept in a 'place of safety' (see below) so that an initial mental health assessment can be carried out in safety.

- **Section 135** can be used by a police officer if your child needs to be kept in or taken to a place of safety. This warrant lasts up to 24 hours, but can sometimes be extended to 36 hours. An AMHP is required to conduct an assessment before the Section 135 expires. Find out more here. <https://www.rethink.org/advice-and-information/rights-restrictions/police-courts-and-prison/section-135/>
- **Section 136** can be used by a police officer to take your child from anywhere, except a private dwelling, to a place of safety if they appear to be suffering from a mental disorder and in immediate need of care or control. This section also lasts up to 24 hours, but can sometimes be extended to 36 hours. Find out more here. <https://www.rethink.org/advice-and-information/rights-restrictions/police-courts-and-prison/section-136/>

You can find out more about police powers and places of safety provisions here. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/656025/Guidance_on_Police_Powers.PDF

What is a place of safety?

A 'place of safety' is defined in the MHA, as:

- a hospital
- an independent hospital or care home for mentally disordered people
- residential accommodation provided by a local social services authority, and
- any other suitable place (with the consent of a person managing or residing at that place).

What is an Approved Mental Health Practitioner?

An Approved Mental Health Practitioner (AMHP) is usually a social worker who has been trained and authorised to make certain legal decisions, applications and assessments the Mental Health Act (MHA). However, an AMHP can also be a nurse, occupational therapist or psychologist.

Before a child or young person can be detained under section of the MHA, they should be assessed by an AMHP and two doctors. At least one of the two medical practitioners or the AMHP should be a Child and Adolescent Mental Health Services (CAMHS) professional.

AMHPs have a range of powers and duties both in the community and in hospital. Please see *page 109* for more information.

What is a Nearest Relative?

When your child is sectioned, a 'nearest relative' will be identified using a hierarchy of relatives, defined in Section 26 of the Mental Health Act (MHA), available here. <http://www.legislation.gov.uk/ukpga/1983/20/section/26>

For children and young people, the nearest relative will usually be the eldest parent. The AMHP should explain to the nearest relative what their rights are, as well as the hospital manager's functions in support of their relative.

You can find out more about the identification of nearest relative in chapter 5 of the *MHA Code of Practice*, available here. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/435512/MHA_Code_of_Practice.PDF

Please note: Being a nearest relative is not the same as being your child's next of kin, who does not have any rights or responsibilities under the MHA.

The nearest relative has a number of rights and powers under the MHA. Hospital Managers are required to give full details of these to a person's nearest relative. As your child's nearest relative, you have an important role in making sure their rights are protected. These include:

- making applications for admission

- ordering the discharge of their relative from detention (unless certain conditions exist), and
- under specific circumstances, applying to the Mental Health Tribunal.

Nearest relatives can agree or object to a detention under section 3 of the MHA. They also have the right to be consulted and informed about their child's treatment and care. You can find out more about the role of nearest relative in Chapter 13, on *page 105*.

Important clarification

If Section 2 is being applied, the designated AMHP only has to notify the nearest relative that the application is being made. The nearest relative does not otherwise have a say in the process.

However, **if applying for Section 3 detention**, the AMHP has a legal duty to consult the nearest relative. If the nearest relative objects, the section cannot go ahead.

If the AMHP wants to continue with Section 3, they have to apply to the court for the nearest relative to be displaced on the grounds that they are acting unreasonably or if they lack mental capacity. Only if they are successful will a replacement nearest relative be appointed and the section application can then continue. If a nearest relative has been displaced, they can appeal the decision once in the first 12 months.

Further information

Nearest Relative

<https://rethink.org/advice-information/rights-restrictions/mental-health-laws/nearest-relative/>

Your Nearest Relative (Easy Read)

<https://assets.nhs.uk/prod/documents/MH-CoP-Nearest-relative.pdf>

What is a Hospital Manager?

Hospital managers have certain duties under the Mental Health Act (MHA). They are responsible for administering the use of the Act in the hospital, including making sure that:

- patients are being detained appropriately
- their treatment and care conform to the Act's requirements
- cases are referred to Mental Health Tribunals where necessary, and
- those involved are kept fully informed of their statutory rights.

A significant part of the hospital manager's role is to hear patient's applications to be discharged at a meeting called a 'Manager's Hearing'. Hospital managers have a power to discharge most detained patients and all patients who are subject to a community treatment order (CTO). To find out more about Hospital Manager's Hearings, please see chapter 5 on *page 41*.

The term 'hospital manager' used in this context can be confusing as these kinds of hospital managers do not actually work for, or manage, the hospital. They are independent lay people, specially trained and appointed by, but independent of, the NHS Trust concerned. In the case of an independently run hospital, managers are appointed by the person or persons in whose name the hospital is registered.

Further information

Hospital Managers' role and powers

MHA Code of Practice (Chapters 37 and 38)

https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/435512/MHA_Code_of_Practice.PDF

Discharge from the MHA

<https://www.rethink.org/advice-and-information/rights-restrictions/mental-health-laws/discharge-from-the-mental-health-act/>

What is a Second Opinion Appointed Doctor?

A Second Opinion Appointed Doctor (SOAD) is an independent medical professional appointed by the Care Quality Commission (CQC) to provide an additional safeguard to protect the patient's rights if they are detained under a section of the Mental Health Act (MHA). The approval of a SOAD is required before certain forms of medical treatment can be given under the MHA. For example:

- if a child or young person who is detained under the MHA refuses or lacks capacity to consent to treatment, they should be reviewed by a SOAD after the first three months to check that their treatment is appropriate; and
- a SOAD is required to certify/approve certain treatments, subject to special rules and procedures under the MHA (Section 57 available here <http://www.legislation.gov.uk/ukpga/1983/20/section/57> and section 58 (available here <http://www.legislation.gov.uk/ukpga/1983/20/section/58>, for example neurosurgery or electroconvulsive therapy.

You can also find out more about SOADs here <https://www.nhs.uk/using-the-nhs/nhs-services/mental-health-services/mental-health-act/>

3. What to expect when your child is admitted to an assessment and treatment unit?

An Assessment and Treatment Unit (ATUs) is an inpatient mental health hospital or facility in which a person's behavioural, emotional and mental health difficulties can be assessed and treated by specialist staff.

Every hospital is different, so practice will vary. However, the following chapter describes a typical admissions process to an ATU.

Arriving at the Assessment and Treatment Unit

Most Assessment and Treatment Units (ATU) provide parents/carers with a welcome pack/booklet or information leaflet when you first arrive.

An admitting nurse will welcome your child to the unit (and you, if you have travelled with your child). A doctor will then carry out a physical examination and may carry out blood tests for any relevant investigations. The doctor will also clarify any aspects of immediate medical care.

You and your child will be given a list of items that are allowed to be taken onto the ward and those that are prohibited. You will also be given the unit's welcome pack (including the unit's rules and details of the programme).

All ATUs will have a number of different types of units/wards to respond to a wide range of needs.

Your child may be admitted to an acute ward for a short period to undergo initial assessment and treatment. Once this has been completed, your child's care team will either agree their discharge or to transfer them to the unit or ward best able to meet their needs, if ongoing treatment in hospital is necessary.

For those with very high needs a ward called a Psychiatric Intensive Care Unit (PICU) may be offered for a short stay (a maximum of a couple of weeks). PICUs specialise in the assessment and treatment of people with a broad range of acute and long-term mental health needs. These will often be people who show behaviour that poses a significant risk to themselves or others. A PICU will have additional staff available to help provide sufficient support for these patients.

Your child's needs in hospital will be kept under continuous review and their care team will make sure that they continue to be treated in the right ward.

The first few weeks

A key worker should be assigned to your child as soon as possible. The key staff will risk assess, as necessary and decide how often your child will be observed. During the first few days, a personal care plan will be drawn up.

As soon as possible after admission (usually within a week), the unit may arrange a welcome meeting for you, your child's advocate (if they have one) and anyone else that is important to and for your child in order to meet the staff.

The treatment team is likely to involve a range of support staff and health professionals (e.g. nursing and education staff, consultant psychiatrist, clinical psychologist, junior doctor, speech and language therapist, occupational therapist, physiotherapist, a family therapist and dietitian), as needed.

During the first few weeks, the treatment team will focus on building a positive rapport with your child, an initial assessment of their needs and how they can best be treated and cared for. During this period, observation of your child's mood and behaviour (including interactions with peers and staff), will help staff understand your child's likes, dislikes, needs and challenges.

The actual process and the way in which treatment decisions are made will depend on the type of admission (voluntary or formally detained), the specific treatment proposed, and the age and ability of the patient to make decisions for themselves. For further information regarding this, please see the *MHA Code of Practice* (Chapter 19, para 20 - please see link below).

If your child is detained under the MHA, they will have a right to an independent mental health advocate (IMHA), regardless of age. An IMHA can help patients better understand their care and explain the choices available. They also support the person to ask questions if they are not sure what to do, and to make sure that their voice is heard. The hospital will have access to an IMHA service and can request an advocate when necessary. You can find out more about IMHAs in Chapter 6 of the *MHA Code of Practice* (link below).

Chapter 15, para 4 of the *Mental Capacity Act (MCA) Code of Practice* explains when an advocate may be useful (link below).

You and your child should be invited to participate in regular meetings and reviews where your child's care and treatment is being discussed. The key hospital meetings are summarised in Chapter 5 on *page 41*.

Further information

Mental Health Act Code of Practice

https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/435512/MHA_Code_of_Practice.PDF

Mental Capacity Act Code of Practice

https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/497253/Mental-capacity-act-code-of-practice.pdf

My family member has been sent to an inpatient unit

<https://www.challengingbehaviour.org.uk/learning-disability-files/4-My-family-member-has-been-sent-to-an-inpatient-unit---what-do-I-need-to-know.pdf>

Your Guide to Inpatient Care

<https://youngminds.org.uk/find-help/your-guide-to-support/your-guide-to-inpatient-care/>

Keeping in touch

Having a child referred to a hospital can be a very worrying time for parents (or others with parental responsibility). You are likely to want to stay as fully involved with your child and the hospital as possible. Your child may also want you to be fully involved, as they too may feel anxious and vulnerable trying to cope with an unfamiliar hospital environment and interacting with people they do not know.

There may be times, however, when your child does not want you to know everything. It is important to remember that children and young people also have a right to confidentiality. If they have the ability to make the decision themselves, they can refuse to share information about their care and treatment with you (unless they are suffering, or at risk of suffering, significant harm).

Staff involved in your child's care should encourage them to involve you, unless it is thought that doing so would not be in your child's best interests. You should also be given regular opportunities, as appropriate, to visit your child or speak to them remotely (e.g. by phone, facetime or skype), as they wish. However, as hospitals are extremely busy places and demands on staff are high, you may need to arrange your visits and calls beforehand. How this works in practice will vary, so make sure you get this information from hospital staff.

For more on confidentiality and sharing information, please see MHA Code of Practice, Chapter 19, paras 14-16, available here https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/435512/MHA_Code_of_Practice.PDF

Monitoring and communication

While your child is in hospital, you will naturally want to help them as much as you can by speaking with them routinely to find out how they are getting

on, to make sure that their care is meeting their needs and to do what you can to help staff understand how best to support them.

It can be hard to keep track of everything. It is easy to forget questions that you would like to ask or things you want to talk about with your loved one or those supporting them. Bringing Us Together has produced a Carer's Monitoring Form to help record your thoughts and experiences. The form has a list of suggested topics and questions to think about when talking to your child and their care staff. It includes sufficient space to record how things are going for your child under each heading.

You can use this information as a prompt during your conversations either in person, at reviews or during telephone conversations. Doing this will help you lead discussions, as well as serving as a permanent record of thoughts and priorities. Use a fresh form for each visit, but save the previous forms separately as comprehensive record over time.

You can download the Carer's Monitoring Form for Hospital Services here.

<https://bringingustogether.org.uk/carers-monitoring-form/>

Tip: The Carer's Monitoring Form is not intended to be shared directly with hospital services and is for personal use only. If you have any significant concerns that the hospital is unable to address, you can also share the information contained in the form with the service commissioner to help solve the problem.

4. What standards of care and treatment can you expect for your child?

The *Mental Health Act (MHA) Code of Practice* is an important document you need to be familiar with. It provides statutory guidance to doctors, approved clinicians, managers and staff of providers and approved mental health professionals (AMHPs) on the standards required when undertaking their duties under the Act. You can read the full document here

https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/435512/MHA_Code_of_Practice.PDF

Key principles of the Mental Health Act

The *MHA Code of Practice* says that all patients have a right to be treated in accordance with the law, to have their rights upheld, and their views, wishes and feelings respected. Patients have the right to be kept safe and treated as close to home as reasonably practicable, with their best interests central to all decision-making.

Patients should always be kept as fully informed as possible and receive clear and detailed information about their care and treatment, explained in a way they can understand, and in an age-appropriate format. This will also assist them in making informed decisions, where appropriate, if they are thought to have mental capacity to do so.

Children and young people should be treated with dignity and respect, and be given as much privacy and confidentiality as anyone else. Their treatment should be as least restrictive as possible. This means that it should cause the least possible restriction to the person's rights and freedoms (e.g. the amount of separation from family, carers, friends and community, or interruption of their education). You can find out more about the guiding

principles of the MHA, in Chapter 1 of the MHA Code of Practice (see above link).

The *MHA Code of Practice* states that parents (or those with parental responsibility) have a central role in decisions about the admission and treatment of their child. The relevant professionals have a responsibility to identify who has parental responsibility.

All patients have the right to keep up contact with anyone they wish either by ward visits (in private if they prefer) or by remote means (e.g. by phone or skype), subject to the terms of any legal restrictions or consent, if appropriate. This is recognised as a key part of their recovery. Every effort should be made to help parents support their child.

Protecting patient rights and autonomy

Chapters 4-12 of the *MHA Code of Practice* gives guidance on how family, friends and the professionals involved in your child's treatment and care should respect and protect their rights and autonomy.

Children and Young People

Chapter 19 of the *MHA Code of Practice* sets out the key factors regarding children and young people under the age of 18 who are informal (voluntary) or formal (detained under section of the MHA) patients. This chapter also outlines the other laws health care staff should comply with.

Particular issues arise in relation to children (under 16 years of age) and young people (16 or 17 years old). In addition to the Act, other relevant legislation includes the Children Acts 1989 and 2004, the Mental Capacity Act (MCA) 2005 and the Human Rights Act (HRA) 1998. Professionals, practitioners and others responsible for the care of children and young people should be familiar with this legislation.

You can access the *Children Act 1989* here <http://www.legislation.gov.uk/ukpga/1989/41/contents>

You can access the *Children Act 2004* here <http://www.legislation.gov.uk/ukpga/2004/31/contents>

You can access the *Mental Capacity Act 2005* here <http://www.legislation.gov.uk/ukpga/2005/9/contents>

Learning disabilities, autism or both

Chapter 20 of MHA deals with additional considerations relating to the care and treatment of people with learning disabilities or autism. We recommend you read this chapter in full as it outlines all the key issues that the medical professionals must consider. Key points include:

- *'people with learning disabilities or autism are particularly vulnerable and are likely to require a range of reasonable adjustments';*
- *'challenging behaviour may be due to an unmet support need, unmet social or emotional need, or an unmet physical health need (including untreated pain), rather than to a mental disorder';* and
- *'it is important that they [people with autism] are treated in a setting appropriate to their social and communication needs as well as being able to treat their mental condition. Practitioners working with or detaining people with autism should have relevant specialist training and experience.'*

You can read Chapter 20 of the *MHA Code of Practice* here <https://www.gov.uk/government/publications/code-of-practice-mental-health-act-1983>

Key professionals' duties and responsibilities

Responsible Clinician

The lead professional in charge of your child's assessment and treatment in hospital under the Mental Health Act (MHA) is called a responsible clinician (RC). S/he has a number of important responsibilities including:

- authorising, reviewing and ending detentions under the MHA;
- making decisions about your child's treatment; and
- a working with the multi-disciplinary care and treatment team to help shape and coordinate their recovery.

Further information

Academy of Royal Medical Colleges Guidance for Taking Responsibility (2014): Accountable Clinicians and Informed Patients

http://www.aomrc.org.uk/wp-content/uploads/2016/05/Taking_Responsibility_Accountable_Clinicians_0614.pdf

Lancashire and South Cumbria NHS Foundation Trust: What is a responsible clinician?

<https://www.lscft.nhs.uk/Responsible-Clinician>

Commissioner

NHS commissioning is the process of assessing needs, planning and prioritising, purchasing and monitoring health services. Tier 4 CAMHS and other highly specialised services are directly commissioned by NHS England Commissioners. Commissioners or their representatives should attend CETRAs and liaise with case managers and others to make sure that your child's needs are being met.

Case Manager

Case managers assess plan, facilitate and coordinate the services required to meet your child's needs. They should liaise with all those involved in your

child's education, treatment and care, including you, your child, inpatient and community services, local authorities and educational provisions. Case Managers should also produce a care management plan with clearly defined goals, objectives and priorities. They should then oversee how the plan is carried out and monitor it for as long as required.

Further information

Case Management Standards

<https://www.cmsuk.org/case-management/cmsuk-standards-of-practice>

Case management: What it is and how it can best be implemented

<https://www.kingsfund.org.uk/publications/case-management>

Local authority

Local authorities have a number of responsibilities in relation to 'Children in Need' and in the care of 'Looked After' children.

Child in Need

Under Section 17 of the Children's Act 1989, a child will be considered to be 'in need' if:

- they are unlikely to achieve or maintain, or to have the opportunity to achieve or maintain, a reasonable standard of health or development without provision of local authority services;
- their health or development is likely to be significantly impaired, or further impaired, without the provision of services from the Local Authority; and
- they have a disability.

If your child has a learning disability, autism or both, with challenging behaviour, they should be already considered 'in need' so they can access

the support needed to achieve 'a reasonable standard of health or development'.

You can find out more about 'child in need' status here <https://childlawadvice.org.uk/information-pages/child-in-need-services/>

Looked After Child

A child usually becomes 'looked after' by the local authority when they have been made the subject of a care order, under section 31 of the Children Act. The court may make an interim care order (for up to eight weeks in the first instance) to investigate a child's home circumstances.

However, a child can also be 'accommodated' as 'looked after' under Section 20 of the Child Act 1989 with the consent of parents (or whoever has parental responsibility). If the young person is 16 or 17 and they are thought to have capacity, they can consent to this themselves.

A child can become a 'looked after child' under Section 20 for a number of reasons. For example, if a parent carer becomes ill and can no longer look after their child, or if their child is in a residential educational provision or inpatient mental health unit.

If your child has 'looked after' status, the LA needs provide your child with additional support. This includes:

- an independent reviewing officer to ensure your child is listened to and their best interests are protected; and
- financial help to visit your child.

You can find out more about these duties here <https://childlawadvice.org.uk/information-pages/local-authority-duties-to-looked-after-children/>

For a useful summary of 'looked after' status, please see the *Mental Health Act Code of Practice*, Chapter 19, para 11.

Family contact

Whatever your child's status, Local Authorities have a duty to promote contact between children and young people and their families under the Children Act 1989 and the Human Rights Act. Local Authorities should

consider whether to provide financial support so that families can visit their children when they are placed in hospital for at least three months away from family in an NHS or independent hospital.

Education

Local authorities also have an obligation to ensure that children and young people admitted to hospital continue to have access to appropriate education. See a summary here. <https://www.citizensadvice.org.uk/family/looking-after-people/local-authority-services-for-children-in-need/>

Further information

The duties of local authorities in relation to children and young people in hospital can be found on Page 195 of the *Mental Health Act Code of Practice*.

https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/435512/MHA_Code_of_Practice.PDF

5. Key meetings when your child is in an assessment and treatment unit

Welcome meeting

An initial planning and welcome meeting between the multidisciplinary staff team (MDT), your child and family members may be held within one week of admission. The meeting gives you an opportunity to meet with the staff, find out more about the hospital and the range of care available, ask questions and tell them anything they need to know about your child. If this opportunity is not offered on admission, ask your child's key worker if you can meet the team.

Care Education and Treatment Reviews

While your family member is in hospital, they will receive regular independent Care Education and Treatment Reviews (CETRs) to make sure their care and treatment is meeting their needs. The first one should take place within two weeks of admission and once every three months thereafter.

The review panel will consist of the chair (appointed by NHS England), an independent clinical expert and an expert by experience. An expert by experience is someone who has lived experience of using services as someone with a learning disability and/or autism, or as the parent/carer of someone who does. They will also have experience of services for people with a mental health problem or behaviour that is seen as challenging. The independent experts' role is to make sure that the care being provided meets the standards expected of the CETR programme.

You will be invited to attend and take part in each CETR. The invitation should arrive two weeks before the meeting date.

The hospital professionals involved in your child's care and treatment will also attend the meeting, for example the responsible clinician (psychiatrist),

ward manager, key worker, psychologist, occupational therapist, speech and language therapist, education representative and social worker. Representatives from the local authority's health (e.g. Clinical Commissioning Group (CCG) Commissioner), social care (e.g your child's social worker) and Special Educational Needs (SEN) department should also attend.

The CETR panel will want to know:

- Is the person safe?
- Are they getting good care now?
- What are their care plans for the future?
- Can care and treatment be provided in the community?

You and your child will be able to speak to the independent panel members privately if you wish to explain how things are going and let them know if you have any concerns. They can help you have your voices heard at the meeting.

These reviews come in two types. A CETR is for anyone receiving education (0 to 25 years) and Care and Treatment Reviews (CTRs) are for everyone else.

If you would like to know more about these reviews, please see *Bringing Us Together's Care and Treatment Reviews: family survival guide*, which covers both types of review. You can access the guide here.

<https://bringingustogether.org.uk/wp-content/uploads/2017/08/CTR-Survival-Guide-Aug-2017-1.pdf>

NHS England's Care, Education and Treatment Review resources are also very helpful. You can access these here.

<https://www.england.nhs.uk/learning-disabilities/care/ctr/care-education-and-treatment-reviews/>

Care Programme Approach meetings

Care Programme Approach (CPA) is the national framework used to assess, plan and coordinate the care of those who have more complex needs (e.g. severe mental illness, a learning disability and/or autism with a high degree of complexity) who require ongoing and coordinated support from multiple agencies.

The ultimate aim of CPA provision is to maintain patients in the community safely and reduce the risk of them becoming mentally unwell again, possibly resulting in an admission (or readmission) to hospital.

If your child has been detained under Sections 3, 37, 45a, 47 or 48, and are discharged from hospital (including on Section 17 leave, or under a Community Treatment Order under Section 17a), they will be entitled to Section 117 aftercare, in addition to CPA. Section 117 aftercare is a free package of care to help meet their needs when they are discharged. Planning should start from admission. You can find out more about Section 117 aftercare in Chapter 13, on *page 105* of this guide.

You will be invited (with your child's consent, as appropriate) to your child's initial CPA and subsequent reviews. At the CPA meeting, you, your child, the responsible clinician and other involved clinicians discuss and make decisions about your child's care and treatment. A care coordinator should be assigned at the first meeting.

Every young person should have a CPA Care Plan that identifies activities, treatment and risk. It should also name the person(s) holding the responsibility for each different element of their care plan.

The first CPA meeting will happen within the first few weeks of admission and reviews will then be held every six months. However, if your condition changes, this could be more or less frequent.

Your CPA support will only stop if your care team determines through assessment that you no longer need the support being provided.

CPA is explained in more detail in Chapter 13, on *page 129*.

This Rethink fact sheet may also be helpful. <https://www.rethink.org/advice-and-information/living-with-mental-illness/treatment-and-support/care-programme-approach-cpa/>

Ward round meetings

A ward round meeting is generally held weekly to give members of the multidisciplinary team (MDT), your child and you (with consent, as appropriate) an opportunity to discuss your child's care and treatment, reflect on the week's events, review any issues of concern and plan for the next seven days. It can be a great opportunity for parents/carers to build constructive relationships with staff and to share your valuable lived experience.

Depending on the type of unit, the team members involved will typically include the responsible clinician (psychiatrist), psychologist, therapy, the ward manager, senior nurse and, when required, the care coordinator and education staff. The aim of the ward round is to develop your child's care plans and maintain progress towards discharge.

Ward rounds might be a difficult experience for your child and/or you. The ward team are responsible for ensuring your child's voice is heard. Your child has a right to an advocate to support them if they need one.

You can find out about Independent Mental Health Advocacy here

<https://www.seap.org.uk/services/independent-mental-health-advocacy/about-independent-mental-health-advocacy.html>

Mental Health Tribunals

A Mental Health Tribunal is a legal meeting, led by a judge, in which an independent panel reviews the restrictions in place for a patient who is being detained under the Mental Health Act (MHA), is on a Community Treatment Order (CTO), or is subject to guardianship. The Tribunal has the authority to decide whether patients should continue to be detained under section or be discharged.

The hearing can be attended by your child, their advocate, nearest relative, (and other family members) and their legal representative, the responsible

clinician, hospital manager, care coordinator, the relevant nurse or doctor. As this is a legal process, the tribunal will follow a specific agenda, led by the judge. The panel will hear evidence from those involved, and study the statements and reports presented.

The Tribunal has the authority to decide whether patients should continue to be detained under section, or be discharged. Whether or not a nearest relative is able to apply, or be referred to, the Tribunal depends on the restriction in place.

Important: The patient does not have to prove that they can be discharged. It is up to the professionals, who believe that the patient should continue to be detained or remain under a CTO, to prove their case.

Hospital managers have a duty to refer the patient to the Tribunal and take steps to ensure they understand their rights to apply for a tribunal hearing.

Further information

MHA Code of Practice (Chapter 12)

https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/435512/MHA_Code_of_Practice.PDF

Apply to the Mental Health Tribunal

<https://www.gov.uk/mental-health-tribunal>

When can I apply or be referred to the Tribunal for a hearing?

https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/716993/t130-eng.pdf

Community Treatment Orders

Find out more on *page 124* of this guide.

Nearest Relative's role

The nearest relative will be invited to attend the tribunal, subject to the consent of the person and the panel's discretion. A nearest relative can offer support, and reply to the panel's questions, for example about living arrangements or their views about discharge.

If the nearest relative does not want to attend the hearing, their views should be included in a 'Social Circumstances' report, which will be prepared for the tribunal.

Further information

Rethink Mental Illness: Nearest Relative

<https://www.rethink.org/advice-information/rights-restrictions/mental-health-laws/nearest-relative/>

Information for Nearest Relatives - Mental Health Tribunal

<https://www.gov.uk/government/publications/information-for-nearest-relatives-mental-health-tribunal-t117>

Hospital Managers' and the local authority's role

Hospital Managers and the local authority have a very important role in Tribunals and have a duty to facilitate the process. They must:

- take steps to ensure that patients understand their rights to apply for a Tribunal hearing and that the applications are sent in a timely manner;
- ensure that patients understand their rights and entitlement to the support of an independent mental health advocate, legal aid & free legal representation;
- present the Tribunal with a statement of relevant facts and certain reports; and

- provide a suitable venue for the hearing, which usually takes place in a meeting room in the hospital or unit.

Hospital managers carrying out this role do not actually work for or manage the hospital. They are independent lay people specially trained and appointed by (but independent of) the NHS Trust concerned. If the hospital is independently run, the person(s) in whose name the hospital is registered will appoint the managers.

Further information

What Is A Mental Health Tribunal Judge and Panel?

<https://youngminds.org.uk/blog/what-is-a-mental-health-tribunal-judge-and-panel/>

A Guide to Mental Health Tribunals for Young People

https://www.rcpsych.ac.uk/docs/default-source/members/faculties/child-and-adolescent-psychiatry/cap-camhs-guide-to-mental-health-tribunals-feb-2016.pdf?sfvrsn=cf42b347_2

How you can ask a mental health tribunal for a decision (Easy Read version)

<https://www.gov.uk/government/publications/how-you-can-ask-a-mental-health-tribunal-for-a-decision-easyread-version>

Discharge from detention

<https://www.rethink.org/advice-information/rights-restrictions/mental-health-laws/discharge-from-detention/>

First-tier Tribunal (Mental Health)

<https://www.gov.uk/courts-tribunals/first-tier-tribunal-mental-health>

Hospital Managers' hearing

Hospital managers must organise and conduct reviews of patients to assess whether the Mental Health Act (MHA) restrictions in place are appropriate or not. They must do so if the responsible clinician renews or extends your child's section to make sure that your child is not kept on a section for longer than necessary.

A hearing can also be held if your child or their nearest relative think they should be discharged from the hospital and the section be lifted. Your child and their nearest relative can apply for a hearing at any time. However, this is unlikely to be granted within 28 days of a previous review, or if there is a Tribunal hearing planned.

A panel of at least three Hospital Managers will carry out the review. Attendees will include your child's responsible clinician, care coordinator and nurse to answer the questions the panel may have about your child's hospital care and treatment. Your child will also be invited to attend, supported by their legal representative, advocate and/or nearest relative, as appropriate. Your child will also be allowed to have a friend or carer to support them, if they wish.

The procedure for the hearing is for the Manager's panel to decide. However, they will consider reports from your child's care team and will want to hear your child's and their nearest relative's views. If your child is thought to lack capacity or does not wish to attend, their legal representative, deputy or other appropriate supporter(s) should be allowed to represent them.

The Hospital managers have powers under Section 23 of the Mental Health Act to discharge a patient from their detention in the hospital or their supervised community treatment, provided three or more members of the panel decide to do so.

Hospital managers must ensure that your child and their nearest relative are helped to request a hospital managers' hearing. They must make sure your child has been given appropriate and accessible information (e.g. your child's care plan, information about the meeting and related reports).

Hospital Managers should also ensure that your child has an independent mental health advocate (IMHA) and/or legal representation if they need or want it.

You can find out more about Manager's Hearings in Chapters 37 and 38 if the *Mental Health Act Code of Practice* available here. <https://www.gov.uk/government/publications/code-of-practice-mental-health-act-1983>

Best interests meetings

The purpose of a best interests meeting is to make a specific decision about medical treatment or social care for someone who has been assessed as lacking mental capacity needed to make the decision for themselves. The people who know the person the best (e.g. parents/ carers/nearest relative) meet with the relevant care staff and health professionals involved in their child's care in order to make a joint decision in the best interest of the person concerned.

The term 'best interest' is not defined in the Mental Capacity Act (MCA) but the Act does say that those involved in making a 'best interest' decision must 'have regard to' the *MCA Code of Practice* in the way that people who might lack mental capacity must be cared for.

For most day-to-day actions or decisions, the decision-maker will be the carer most directly involved with the person at the time.

If making a decision in someone's best interest is complex and cannot be easily made by the decision-maker (even with the support of a health practitioner colleague in the case of medical treatment), a best interests meeting should happen.

For more information about mental capacity please see Chapter 14 on *page 135*. The *MCA Code of Practice* provides information and guidance about the best interest process and how decision making is supposed to work in practice. You can read the *MCA Code of Practice* here. <https://www.gov.uk/government/publications/mental-capacity-act-code-of-practice>

Making the decision

To assist with decision-making, the 'Best Interests Checklist' on the following page will help everyone understand what is important to the person, what they love doing or would hate to do.

A 'balance sheet' approach

For bigger decisions, such as a change to where a person lives or a serious medical procedure, The MCA recommends that decision-makers should also use a 'balance sheet' approach. This means that they should look at and evaluate all the factors involved in the decision. This could include:

- benefits of the change or procedure;
- disadvantages of the change or procedure;
- possible consequences of the decision and likelihood of these occurring; and
- striking a balance between possible benefits and disadvantages.

A change or procedure should only be viewed to be in the person's best interests if the benefits outweigh the disadvantages. Decision-makers must take into account all the relevant factors, not just those they think are important. They must also provide evidence that the process has acted in the best interest of the person concerned.

You can find out more about carrying out best interests assessments here.

<https://1f2ca7mxjow42e65q49871m1-wpengine.netdna-ssl.com/wp-content/uploads/2019/04/Mental-Capacity-Guidance-Note-Best-Interests-April-2019.pdf>

BEST INTERESTS CHECKLIST	✓
Encourage participation - Do whatever is possible (e.g. visual support, easy read information) to help and encourage the person to take part in making the decision.	
Identify all relevant circumstances - Try to identify all the things that the person would take into account if they were making the decision themselves.	
Find out the person's views - Take into account the person's past and present wishes and feelings, any beliefs and values (e.g. religious, cultural, moral or political) and any other factors that would be likely to influence the decision in question if the person were making the decision themselves.	
Avoid discrimination - Do not make assumptions about someone's best interests simply on the basis of the person's age, appearance, condition or behaviour.	
Assess whether the person might regain capacity - Consider whether the person is likely to regain capacity (e.g. after receiving medical treatment). If so, can the decision wait until then?	
If the decision concerns life-sustaining treatment - Do not be motivated in any way by a desire to bring about the person's death or make assumptions about the person's quality of life.	
<p>Consult others - Consult as many relevant people as possible, including anyone previously named by the person, close relatives, carers, friends or others for their views about the person's best interests.</p> <p>For decisions concerning major medical treatment or where the person should live, and where there is no one who fits into any of the above categories, an Independent Mental Capacity Advocate (IMCA) must be consulted.</p> <p>Be mindful of the person's right to keep their affairs private, restrict involvement to those listed above and process data in accordance with data protection law.</p>	
Avoid restricting the person's rights - Are there other options that may be less restrictive of the person's rights?	
Take all of this into account - Weigh up all of these factors in order to work out what is in the person's best interests.	
Ensure that you record your best interest decision. This is important not only to keep an accurate record but also as evidence should your decision or decision-making processes later be challenged.	

Recording how the decision was made

The decision-maker should record the process, as well as the decisions made to provide evidence that the decision-makers have acted in the best interest of the person. They will need to confirm that the panel has considered the checklist, together with anything else that the person would think important. They must also include the person's wishes and feelings and why any alternatives were rejected.

When making these important decisions, people sometimes have different views about the person's best interests. The decision-maker should also explain how any disagreements were dealt with.

You may find Young Minds' *Parents guide to mental capacity* helpful. You can read this here. : <https://youngminds.org.uk/find-help/for-parents/parents-guide-to-support-a-z/parents-guide-to-support-mental-capacity-act-2005/>

You can read more about best interest decisions in Chapter 14 on *page 141* of this guide.

6: Reasonable adjustments

What are reasonable adjustments?

The Equality Act 2010 prohibits discrimination against people with the protected characteristics specified in Section 4 of the Act. Disability is one of the specified protected characteristics.

The Equality Act says that a person has a disability if he or she has a physical or mental impairment that has a substantial and long-term adverse effect on their ability to carry out normal day-to-day activities.

The Equality Act places a duty on providers of goods, services and facilities in Great Britain to make reasonable adjustments in order to avoid a disabled person being placed at a 'substantial disadvantage' compared with non-disabled people when accessing these services and facilities. This duty not to discriminate includes all healthcare providers, and medical staff, such as consultants, doctors and nurses. It also extends to non-medical staff, like receptionists.

Duty of healthcare providers

Healthcare providers must make reasonable adjustments to the way in which they provide services to make sure that no disabled person is disadvantaged. This could include alterations to building access for wheelchair users, providing longer appointments and accessible information, or booking a person in at the start or end of the day to minimise waiting.

Under the Equality Act, healthcare providers must make reasonable adjustments for people with disabilities using their services, including people with autism and/or learning disability. Depending on the person's needs, reasonable adjustments could include making sure that enough autism and learning disability trained and experienced staff are on duty, making adaptations to the hospital ward environment to avoid sensory overload or using visual support to aid communication. Such adaptations can prevent the patient becoming distressed unnecessarily.

If you are concerned that appropriate reasonable adjustments are not being made, your child, (depending upon age and 'competence') or their nearest

relative/parents, should discuss your concerns with your child's care team. If this does not work, you can raise a formal complaint using the Hospital's complaints policy.

Should this still not result in an acceptable response, you can ask for an independent review by the Parliamentary and Health Service Ombudsman. Legal action then remains the final option if all else has failed.

Citizen's Advice has a helpful guide which you can read here: <https://www.citizensadvice.org.uk/health/nhs-and-social-care-complaints/complaining-about-the-nhs/nhs-complaints-procedure/how-to-make-a-complaint-about-nhs-services/>

You can find out more about raising concerns and making complaints in Chapter 11 on *page 96*.

Important: If you have serious concerns about your loved one's care, you can contact your home local authority's duty social work team.

Further information

The Equality Act and disabled people

<https://www.disabilityrightsuk.org/equality-act-and-disabled-people>

What are reasonable adjustments?

<https://www.equalityhumanrights.com/en/advice-and-guidance/what-are-reasonable-adjustments>

Your rights under the Equality Act 2010

<https://www.equalityhumanrights.com/en/advice-and-guidance/your-rights-under-equality-act-2010>

Reasonable adjustments for people with a learning disability in hospital

<https://www.mencap.org.uk/sites/default/files/2018-06/Treat%20me%20well%20top%2010%20reasonable%20adjustments.pdf>

Reasonable adjustments: a legal duty

<https://www.gov.uk/government/publications/reasonable-adjustments-a-legal-duty>

7. Therapeutic interventions

There are a number of different therapies that are used in mental health CAMHS services to meet a wide range of needs. This section gives an overview of the therapies that are most frequently available in specialist mental health inpatient units.

Before any intervention is chosen, a formal assessment and monitoring of your child's mental state and any necessary risk assessments will be completed. Multidisciplinary management plans will then be developed, including physical health care requirements. The choice of therapy will depend upon the results of these assessments, including the patient's age, diagnosis and their ability to be able to communicate their thoughts and feelings with others.

Medication

If your child has a learning disability and/or autism with behaviour that challenges and has been admitted to a mental health hospital because they are in crisis, it is possible that the hospital psychiatrist will prescribe psychotropic medication for them.

What is psychotropic medication?

Psychotropic drugs are medicines that affect the brain. They include:

- antipsychotic drugs (used to treat psychosis)
- sedatives (used to calm or induce sleep), and
- anxiolytics (prescribed for anxiety and agitation).

Psychotropic medications are used to treat mental health conditions, such as anxiety, depression, and psychosis. Sometimes doctors prescribe these medications to children and young people because of behaviours that challenge others.

Important: The MHA Code of Practice (chapter 26, para 55) cautions clinicians to give 'special consideration' when prescribing anti-psychotic medication to children and young people because of 'risks relating to their developing central nervous system, especially when the medication is given to children or adolescents who do not have a diagnosed psychosis.'

NICE guidelines for learning disability and challenging behaviour

Doctors should prescribe and monitor medications (and their side effects) in line with National Institute of Clinical Excellence (NICE) guidance.

When treating and providing care for a person with learning disability and behaviour that challenges, a doctor should refer to NICE Guideline NG11.

The NG11 guideline sets out recommendations for prevention and interventions for people with learning disabilities whose behaviour challenges. It says that, when prescribing psychotropic medication, a doctor should:

- identify the target behaviour;
- monitor the treatment's effectiveness, including frequency and severity of the behaviour and its impact on functioning;
- start with a low dose and use the minimum effective dose needed;
- only prescribe a single drug;
- monitor side effects as recommended in the NICE guidelines;
- review the effectiveness and any side effects of the medication after 3–4 weeks;
- stop the medication if there is no indication of a response at 6 weeks, reassess the behaviour that challenges and consider further psychological or environmental interventions;
- only prescribe PRN (as-needed) medication for as short a time as possible, and ensure that its use is recorded and reviewed; and
- review the medication if there are changes to the person's environment (for example, significant staff changes or moving to a new care setting) or their physical or mental health.

- You can read NG11 guidance here. <https://www.nice.org.uk/guidance/ng11>

NICE quality standards on autism and challenging behaviour

There are no NICE guidelines that apply to children and young people, as NICE clinical guideline on the diagnosis and management of autism (CG142) only applies to people over the age of 18. This guidance can be viewed here.

<https://www.nice.org.uk/guidance/cg142>

NICE has however published a quality standard covering health and social care services for adults, young people and children with autism (QS51). Importantly, the quality standard recognises that the causes of any behaviour that challenges for a person with autism can be multifactoral (e.g. involving physical health conditions, mental health problems, sensory and environmental factors). It also states that an assessment should take all these factors into account and consider the risk of harm to the person and others, before appropriate interventions are agreed.

Quality statement 8 of the standard says that people with autism who display behaviour that challenges should not be offered antipsychotic medication for the behaviour, unless other interventions have not worked or cannot be delivered because of the severity of the behaviour. You can read QS51 standard here <https://www.nice.org.uk/guidance/qs51>

STOMP-STAMP campaign

NHS England recognises that children and young people with a learning disability, autism or both are more likely to be given medication (including psychotropic medication) than other children and young people. It has recently launched the STOMP (**S**top **T**he **O**ver-**M**edication of children and young **P**eople with a learning disability, autism or both) STAMP (**S**upporting **T**reatment and **A**ppropriate **M**edication in **P**aediatrics) campaign to increase awareness of this. According to the STOMP-STAMP principles, children and young people should only be prescribed '*the right medication, at the right time, for the right reason*'. STOMP-STAMP sets out a number of recommendations, including that psychotropic medication should only be prescribed if other interventions (e.g. positive behaviour support (PBS)) have not been helpful.

You can find out more about STOMP-STAMP in Chapter 12 on *page 101* of this guide. You can also read NHS England's STOMP-STAMP information here.

<https://www.england.nhs.uk/learning-disabilities/improving-health/stamp/> A helpful leaflet for parents and carers is available here <https://www.england.nhs.uk/publication/stomp-stamp-pledge-resources/>

Psychological therapy

Psychologists assess and help people of all ages with mental health problems to understand their feelings, why they might act in a certain way and why some things might happen to them. Clinical psychologists assess all the factors underlying your child's mental health problems to work out how best to help them. They are different to psychiatrists in that they do not prescribe medication, but work with your child using 'talking therapies', either in groups or 1:1. This could involve helping your child with daily living skills, communication and relationships, and managing stress, anxiety and anger.

Occupational therapy

Occupational therapy (OT) aims to help children and adults to carry out the activities (or 'occupations') they need, want, or are expected to do, but are prevented from doing because of physical or mental illness, or disability. For a child, these occupations could include self-care (e.g. dressing, using a toilet, eating a meal) and participating in educational, social and leisure activities. OTs can carry out assessments, make recommendations, suggest adaptations and do direct therapy with your child (and people working with them) to help improve their fine and gross motor skills, motor-planning, self-regulation and sensory processing (which can be especially important in autism).

Speech and Language therapy

A speech and language therapist (SALT) aims to help children and adults who have difficulties with communication (speaking, understanding and using language, understanding and getting on with other people) eating, drinking and swallowing. If your child has a learning disability, autism or

both, a SALT can support your child (and people working with them) by assessing, making recommendations and doing direct therapy with your child.

Dietetic therapy

Dieticians assess a person's nutritional requirements, food intake and growth both in times of health and disease. This can be particularly important if your child is living in an inpatient mental health unit, especially so if your child has a restricted diet (e.g. because of sensory sensitivities in autism) or has developed an eating disorder (e.g. anorexia). A dietitian may need to assess, provide dietary advice and/or recommend a special therapeutic diet, depending on your child's age, nutritional requirements, medication and medical condition.

8. Your and your child's rights

If your child is being cared for and treated under section of the Mental Health Act (MHA), this can affect their (and your) rights. The interplay of the various relevant laws can seem complicated and confusing to families, as well as a source of understandable anxiety. We therefore thought it would be helpful to bring together your child's (and your) most significant rights and entitlements in one section. We hope this will help you better understand what the mental health system is expected to deliver and to explain how you can use the law when advocating for your child.

Please note: This guide offers information not legal advice. While we hope to give a helpful overview of the subject, we advise you to speak to a legal professional if you are in need of legal help or advice.

What the Mental Health Act says

The *Mental Health Act 1989 Code of Practice* says that all patients have a right to be treated in accordance with the law, to have their rights upheld and their views, wishes and feelings respected. They have the right to be kept safe and treated as close to home as reasonably practicable, with their best interests central to all decision-making. This includes your child:

- being kept as fully informed as possible and receiving clear and detailed information concerning their care and treatment, explained in a way they can understand and in an age-appropriate format;
- being treated with dignity and respect and being given as much privacy and confidentiality as anyone else;
- having the least restrictive care and treatment as possible, with the least possible separation from family, carers, friends and community or interruption of their education;
- having the right to keep contact with anyone they wish, either by ward visits (in private if they wish) or by remote means (e.g. telephone, email or Skype - subject to carefully limited exceptions); and

- having the help and support of an Independent Mental Health Advocate (IMHA), if they want or need one.

Important: Those with parental responsibility have a central role in decisions about the admission and treatment of their child. It is therefore essential that those proposing the admission and/or treatment identify who has parental responsibility.

- Please see Chapter 13 on *page 105* for more information on the MHA. You can also read the *Code of Practice: Mental Health Act 1983* here.
<https://www.gov.uk/government/publications/code-of-practice-mental-health-act-1983>

Further reading

Mental Health Act: your rights (Easy Read)

<https://www.nhs.uk/using-the-nhs/nhs-services/mental-health-services/mental-health-act-your-rights-easy-read/>

Code of practice: Mental Health Act 1983 (includes an Easy Read version)

<https://www.gov.uk/government/publications/code-of-practice-mental-health-act-1983>

Your treatment and Care Plan (Easy Read)

<https://assets.nhs.uk/prod/documents/MH-CoP-Your-treatment-and-Plan.pdf>

Your right to have visitors when you are detained in hospital (Easy Read)

<https://assets.nhs.uk/prod/documents/MH-CoP-Visiting.pdf>

What the Mental Capacity Act says

The Mental Capacity Act 2005 (MCA) provides a legal framework for people aged 16 or above who may lack capacity to make a particular decision at the time it needs to be made. It sets out who can take decisions on behalf of such people, in which situations, and how they should go about it.

Please Note: The Act does not generally apply to people under the age of 16. There are two exceptions to this, if the child lacks capacity, as follows.

- The Court of Protection can make decisions about a child's property or finances (or appoint a deputy to make these decisions) if the child is likely to still lack capacity to make financial decisions when they reach the age of 18.
- The MCA does apply to children (also under the age of 16) if they have been subject to ill treatment or wilful neglect.

You can find out more about how the MCA applies to children and young people in Chapter 12 of the MCA, available here. <https://www.gov.uk/government/publications/mental-capacity-act-code-of-practice>

Five principles of the Mental Capacity Act

The MCA is underpinned by five key principles.

1. Every person over the age of 16 has the right to make their own decisions if they have the capacity to do so. Family carers and healthcare or social care staff must assume that a person has the capacity to make decisions, unless it can be established that the person does not have capacity.
2. People should receive support to help them make their own decisions. Before concluding that a person lacks capacity to make a particular decision, it is important to take all possible steps to try to help them reach a decision themselves.
3. People have the right to make decisions that others might think are unwise. A person who makes a decision that others think is unwise should not automatically be labelled as lacking the capacity to make a decision.

4. Any act done for, or any decision made on behalf of, someone who lacks capacity must be in their best interests.
5. Any act done for, or any decision made on behalf of, someone who lacks capacity should be an option that is the least restrictive of their basic rights and freedoms – as long as it is still in their best interests.

The 'best interests' principle

The *MCA Code of Practice* includes guidance about making decisions on behalf of those who lack capacity. In order to maintain the rights of the person being assessed, it describes the process and the steps that are needed to be taken, including:

- encouraging the person to participate and to be as fully involved as possible;
- taking account of all relevant circumstances and the person's views;
- the importance of not making assumptions based on their age, appearance, condition or behaviour;
- whether making the decision could wait if there is a likelihood that the person might regain capacity;
- consulting the people care for and know the person; and
- avoiding restricting the person's rights, by ensuring that any decision made is based upon the least restrictive option available.

Care staff involved in making day-to-day decisions should keep a record of the decision-making process on the person's file, explaining:

- how the decision about the person's best interests was reached;
- what the reasons for reaching the decision were;
- who was consulted to help work out best interests; and
- what particular factors were taken into account.

For major decisions based on the best interests of a person who lacks capacity, it may also be useful for family and other carers to keep a similar kind of record.

Mental Capacity Advocacy

Independent Mental Capacity Advocates (IMCAs) are specialist advocates who provide safeguards for adults when they lack capacity to make important decisions. The IMCA service is provided by the local authority under the MCA.

Appropriate advocacy support must be provided, and support given, to help patients make decisions appropriately. Requesting an advocate is the responsibility of the hospital concerned.

Young people aged 16 or 17 also have a statutory right to an IMCA if they:

- lack capacity to make a specified decision at the time it needs to be made;
- are facing a decision on a long-term move or about serious medical treatment, or are subject to deprivation of liberty safeguards (DoLS); and
- have nobody else who is willing and able to represent them or be consulted in the process of working out their best interests.

The role of an IMCA is to ensure that people are as involved as possible in major decisions about their lives, and that any decisions made on a person's behalf are made in that person's best interests.

The IMCA will make sure that decision makers uphold the person's rights and ensure that they choose the least restrictive option for the person.

You can find out more about the MCA in Chapter 14 on *page 135*.

Further information

Deprivation of Liberty Safeguards: a practical guide

<https://www.lawsociety.org.uk/support-services/advice/articles/deprivation-of-liberty-safeguards-practical-guide/>

Mental Capacity Act Code of Practice

<https://www.gov.uk/government/publications/mental-capacity-act-code-of-practice>

What the Equality Act says

The Equality Act gives children, young people and adults the right to challenge service providers, public bodies and businesses if they are discriminated against because of their:

- age
- disability
- gender reassignment
- marriage or civil partnership (in employment only)
- pregnancy and maternity
- race
- religion or belief
- sex, or
- sexual orientation

These are called 'protected characteristics'. The Act also protects people from harassment, victimisation and discrimination by association (e.g. because you have a disabled child). This is called indirect discrimination. Under-18s are only protected against age discrimination in relation to work.

If you think your child has been discriminated against in relation to their 'protected characteristic', you can:

- try to resolve the it informally with the organisation concerned;
- raise a formal complaint in accordance with their complaints policy; or
- take legal action.

For more information, you may find the 'Ask Listen Do' section in Chapter 12 on *page 104* helpful.

Please note: The Equality Act also includes the duty to make reasonable adjustments for anyone with a disability. Please see links below for further information about this.

Further information

Equality Act 2010: guidance

<https://www.gov.uk/guidance/equality-act-2010-guidance>

Equality Act 2010: how it might affect you

<https://www.gov.uk/government/publications/equality-act-guidance>

Equality Advisory & Support Service

<http://www.equalityadvisoryservice.com/app/home>

Your Rights under the Equalities Act

<https://www.equalityhumanrights.com/en/advice-and-guidance/your-rights-under-equality-act-2010>

The Equality Act and disabled people

<https://www.disabilityrightsuk.org/equality-act-and-disabled-people>

What are reasonable adjustments?

<https://www.equalityhumanrights.com/en/advice-and-guidance/what-are-reasonable-adjustments>

Reasonable adjustments for people with a learning disability in hospital

<https://www.mencap.org.uk/sites/default/files/2018-06/Treat%20me%20well%20top%2010%20reasonable%20adjustments.pdf>

Reasonable adjustments: a legal duty

<https://www.gov.uk/government/publications/reasonable-adjustments-a-legal-duty>

What the Children Act says

Parental responsibility is defined in the Children Act 1989 as: *'all the rights, duties, powers, responsibilities and authority, which by law, a parent of a child has in relation to the child and his property'*.

In practical terms, parental responsibility means the power to make important decisions in relation to a child. In the context of this guide, this can include:

- consenting to medical treatment if it is in the child's interests;
- accessing a child's medical records; and
- representing the child in legal proceedings.

Important decisions such as these should have the agreement of everyone with parental responsibility, if possible.

Who has parental responsibility?

Under the Act, parents who are married at the time of the child's birth both have parental responsibility. The Act sets out who has parental responsibility for a child in all other circumstances. You can find out more about the *Children Act 1989* here <http://www.legislation.gov.uk/ukpga/1989/41/section/3> and parental rights and responsibilities here <https://www.gov.uk/parental-rights-responsibilities>

Your child's rights and involvement in decision-making

The degree to which a child or young person's parents may be involved in decision-making is dependent on their age and ability (or 'competence') to make decisions for themselves. This process is explained below.

When is a child or young person considered competent to give consent?

- **Young people aged 16 or 17 with capacity** are presumed in law to be competent and can therefore consent to their own treatment. However, this does not include some rarer types of procedure (e.g. organ donation, non-therapeutic procedures or research).
- **Young people aged 16 or 17 who are thought to lack capacity.** Decisions are made in accordance with the Mental Capacity Act for this age group however there are three exceptions:
 - only people aged 18 or above can make a Lasting Power of Attorney (LPA);
 - only people aged 18 or above can make an advance decision to refuse medical treatment; and
 - the Court of Protection may only make a statutory will for a person aged 18 or above.
- **Children under 16** may be able to consent to their medical treatment (without parental permission or knowledge) if they are thought to have sufficient understanding and maturity. The way this is decided is called the 'Gillick Test for Competence'. If the child passes this test, they are thought to be 'Gillick competent' and are therefore able to consent to their own treatment, independently of their parents.
- **Children and young people who are not deemed 'competent'** cannot either give or withhold consent to treatment. Decisions therefore will need to be made on their behalf and in their best interests.

'Gillick competence' explained

For anyone under the age of 16 to be considered competent, s/he should have:

- the ability to understand that there is a choice and that choices have consequences;
- the ability to weigh up the information and arrive at a decision;
- the willingness and ability to make a choice (including the choice that someone else should make the decision);

- an understanding of the nature of the proposed treatment or intervention;
- an understanding of the proposed treatment's risks and effects;
- an understanding of the alternatives and the risks attached to them, including no treatment; and
- freedom from undue pressure.

Treatments to which special rules and procedures apply

Please note that neurosurgery for mental disorder, electroconvulsive therapy (ECT) and medication after an initial three-month period require additional consent/second opinion. Please see the *Mental Health Act (MHA) Code of Practice* (Chapters 24 and 25) and MHA (Sections 57 and 58).

Further information

Parents' Guide to 'Mental Capacity'

<https://youngminds.org.uk/find-help/for-parents/parents-guide-to-support-a-z/parents-guide-to-support-mental-capacity-act-2005/>

How do my family member's rights change as they become an adult?

<https://www.challengingbehaviour.org.uk/learning-disability-files/7-How-do-my-family-members-rights-change-as-they-become-an-adult.pdf>

Who needs lasting power of attorney?

<https://www.gov.uk/government/publications/who-needs-a-lasting-power-of-attorney>

What are my child's rights under section?

The summary below contains many of the rights that a child or young person has while subject to the Mental Health Act (MHA). In addition to the MHA,

other relevant legislation on which these rights are based includes: the Mental Capacity Act (MCA) 2005, the Children Acts 1989 and 2004, the Human Rights Act (HRA) 1998 and the Equality Act 2010. (NB: this is not a definitive list.)

Summary of children and young peoples' rights under Mental Health Act section

- Children and young people admitted to hospital for the treatment of mental disorder should be accommodated in an environment that is suitable for their age (subject to their needs). (Section 131A of the Mental Health Act)
- They must be given sufficient verbal and written information about their legal status and their rights, in a format that is accessible for them.
- All patients under the age of 18 should have information explained in a way they can understand and in a format that is appropriate to their age.
- Appropriate advocacy support and legal representation must be provided, and support given, to help patients make decisions appropriately.
- Patients must be kept informed as to how and when they may appeal their detention.
- Patients should be consulted and involved appropriately in their treatment and decision-making, and be told how they can make complaints.
- All treatment should be done, or made, in the patient's best interests.
- Patients must be supported to maintain contact with family and friends and to be visited, subject to carefully limited exceptions.
- Patients under the age of 18 should also have access to age appropriate leisure activities and facilities for visits from parents, guardians, siblings, or carers.

- Arrangements must be in place to enable certain people (e.g legal representatives and advocates) to visit patients in private when needed
- Care and treatment provision will be reasonably adjusted and accessible so as not to put the patient at a disadvantage because of their disability.
- Patients will be given access to their health records if they request this.

Second opinion

Although your child does not have a legal right to a second opinion, you can request one from your child's psychiatrist stating your reasons. Talk to them first to discuss the diagnosis and explain your concerns. If their psychiatrist agrees, a referral to another consultant may take some time to be arranged.

What are my rights when my child is under section?

A parent or a person who has parental responsibility has the right to be involved in their child or young person's care and treatment, as appropriate. They have the right to make decisions on their behalf in certain circumstances or together with others if decisions need to be made in your child's best interests. If you are a nearest relative, you will have additional rights. You can find out more about nearest relatives in Chapter 2 on *page 25*.

As explained previously, the extent of a parent's involvement will depend on the age and ability of their child to make their own decisions, the nature of the decision being made and the restriction in place. This could include:

- having a central role in relation to decisions about the admission and treatment of their child. It is therefore essential that those proposing the admission and/or treatment should identify who has parental responsibility (*MHA Code of Practice*, Chapter 19, para 6);

- being involved in the care and the decision-making process, if the child or young person has capacity and consents to information about their care and treatment being shared (*MHA Code of Practice* Chapter 19, para 21);
- consenting to medical treatment in certain circumstances if it is in the child's interests (Children Act, 1989);
- the right to apply for access to their child or young person's health records, unless their child is not capable of consenting (The Children Act 1989);
- representing them in legal proceedings (The Children Act 1989);
- the right to a family life, in particular, every effort should be made to support parents to support their children. Patients should be able to see all their visitors in private, including in their own bedroom if the patient wishes. (Article 8 of the European Convention on Human Rights (ECHR), *MHA Code of Practice*, Chapter 11, para 4)
- where patients are under 18, the Approved Mental Health Professional (AMHP) should consult with the patient's parents (or other people who have parental responsibility for the patient and not just the nearest relative (*MHA Code of Practice*, Chapter 14, para 67));
- being consulted by the AMPH about any MHA assessments. The AMHP should do everything they can to identify the people who have parental responsibility, and who would be the nearest relative (*MHA Code of Practice*, Chapter 19, para 74);
- those with parental responsibility, the patient's nearest relative (if there is one) or other carers should be involved in preparing the aftercare plan subject to the patient's views (*MHA Code of Practice*, Chapter 34, para 12);
- being fully involved in the person's discharge transition planning, subject to issues of confidentiality and the consent of the patient, as well as those who are to be involved in their care (*MHA Code of Practice* Chapter 19, para 119); and

- care and treatment facilities will be reasonably adjusted and accessible so as not to put the parent(s) at a disadvantage if they have a disability (Equality Act 2010).

Further information

Frequently Asked Questions about Inpatient Care

<https://youngminds.org.uk/find-help/your-guide-to-support/your-guide-to-inpatient-care/frequently-asked-questions-about-inpatient-care/>

Meeting The Challenge - guides for people with a learning disability and supporters

<https://www.mencap.org.uk/advice-and-support/displaying-challenging-behaviour/meeting-challenge-guides-people-learning>

NHS Constitution for England

<https://www.gov.uk/government/publications/the-nhs-constitution-for-england>

What the Human Rights Act says

The Human Rights Act is a UK law that defines a set of fundamental rights and freedoms based upon core principles such as dignity, respect, fairness, equality, and autonomy. The Act is made up of a number of sections called Articles and protocols.

When the Courts are interpreting the articles within the Human Rights Act, they will also draw upon the UN Convention on the Rights of the Child (UN CRC) and the European Convention on Human Rights (ECHR) to ensure that the rights of children and young people are upheld.

The table below contains links to the Articles which are the most relevant when you receive health or care services. Please click on the links for further information.

HUMAN RIGHTS ACT: KEY ARTICLES

Article 2 - the right to life

<https://www.equalityhumanrights.com/en/human-rights-act/article-2-right-life>

Article 3 - the right not to be tortured or treated in an inhuman or degrading way

<https://www.equalityhumanrights.com/en/human-rights-act/article-3-freedom-torture-and-inhuman-or-degrading-treatment>

Article 5 - the right to liberty

<https://www.equalityhumanrights.com/en/human-rights-act/article-5-right-liberty-and-security>

Article 8 - the right to respect for private and family life

<https://www.equalityhumanrights.com/en/human-rights-act/article-8-respect-your-private-and-family-life>

Article 14 - the right not to be discriminated against.

<https://www.equalityhumanrights.com/en/human-rights-act/article-14-protection-discrimination>

If you think your child's human rights have been breached, you should make a complaint to the hospital in which your child is being treated and cared for. It is important to quote the specific part (article) of the Human Rights Act that has been breached. This is often enough to resolve your complaint but, if not, you can seek redress through the court system. You can find out more about how to do this here <https://www.citizensadvice.org.uk/law-and-courts/civil-rights/human-rights/taking-legal-action-about-human-rights/>

Please note: This chapter provides information, not advice. It does not offer comprehensive advice. While we hope that we have given you a helpful rights overview, we advise you to speak to a legal professional if you are in need of legal help or advice.

Further information

The Human Rights Act

<https://www.equalityhumanrights.com/en/human-rights/human-rights-act>

MHA: Human rights and mental health

<https://www.mentalhealth.org.uk/a-to-z/h/human-rights-and-mental-health>

The British Institute of Human Rights (BIHR): Guides and Fact Sheets

<https://www.bihr.org.uk/Pages/Category/guides-and-fact-sheets>

Protecting your human rights when using health and care services

<https://www.citizensadvice.org.uk/health/discrimination-in-health-and-care-services/taking-action-about-discrimination-in-health-and-care-services/protecting-your-human-rights-when-using-health-and-care-services/>

Know your human rights

<https://www.bihr.org.uk/Event/human-rights-in-health-care-advocacy-tool-launch>

Convention on the Rights of the Child

<https://www.equalityhumanrights.com/en/our-human-rights-work/monitoring-and-promoting-un-treaties/convention-rights-child>

What is the European Convention on Human Rights?

<https://www.equalityhumanrights.com/en/what-european-convention-human-rights>

Young people: how our Human Rights Act works for you

<https://youtu.be/TihvizSXzVo>

Using children's rights in mental health policy and practice

<http://www.crae.org.uk/media/125976/mentalhealth-briefing-final-digital-version-.pdf>

9. Restrictive Interventions

Staff in inpatient units can use restrictive interventions in situations where there is a significant and immediate risk of harm to the patient, themselves, or others. In *Positive and Proactive Care*, the Department of Health defines restrictive interventions as:

'deliberate acts on the part of other person(s) that restrict an individual's movement, liberty and/or freedom to act independently in order to

- *take immediate control of a dangerous situation where there is a real possibility of harm to the person or others if no action is undertaken.'*
- end or reduce significantly the danger to the person or others; and
- contain or limit the person's freedom for no longer than is necessary

Restrictive interventions can take several forms, which are outlined below.

Types of Restrictive intervention

What is enhanced observation?

If a person is thought to be in a high level of distress and at immediate risk of suicide, or seriously hurting themselves, staff need to monitor them closely. This is called 'enhanced observation'.

The Mental Health Act Code of Practice (Chapter 26, para 30) explains that enhanced observation is not only watching a person to keep them safe, but should also be therapeutic intervention (e.g. engaging, listening and communicating with the person, and supporting them to engage in activities). Enhanced observation may be provided at intervals (e.g. every 15 mins) based on the person's level of risk, or on a continual basis where the risk is extreme.

Full guidance on enhanced observation can be read in Chapter 26 (paras 28-35) here. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/435512/MHA_Code_of_Practice.PDF

What is physical restraint?

Care staff in hospital assessment and treatment units sometimes use restraint as a last resort if a patient displays challenging behaviour that may put the patient, or others around them, at risk. The *Mental Health Act (MHA) Code of Practice* (Chapter 26, para 36) defines restraint as:

'deliberate acts on the part of other person(s) that restrict a patient's movement, liberty and/or freedom to act independently in order to:

- *take immediate control of a dangerous situation where there is a real possibility of harm to the person or others if no action is undertaken, and*
- *end or reduce significantly the danger to the patient or others.*

The MHA Code of Practice (Chapter 26, paras 36-7) makes it clear that *'restrictive interventions should not be used to punish or for the sole intention of inflicting pain, suffering or humiliation'* and should only:

- *be used for no longer than necessary to prevent harm to the person or to others*
- *be a proportionate response to that harm, and*
- *be the least restrictive option.*

In relation to children and young people specifically, the MHA Code of Practice (Chapter 26, para 53) it highlights the importance of planning, with the young person and their family, to avoid triggers and de-escalate any distress:

'In most cases restrictive interventions will only be used if they form part of the positive behaviour support plan (or equivalent) and have therefore been developed with input from the child or young person and their family.'

Full guidance on physical restraint can be read in Chapter 26 (paras 69-74) available here. <https://assets.publishing.service.gov.uk/government/>

What is prone restraint?

Prone restraint is where a person is held chest down onto any surface, whether or not they have their face down or to the side. The Mental Health Units (Use of Force) Act 2018 states:

'Patients should not be deliberately restrained in a way that impacts on their airway, breathing or circulation. The mouth and/or nose should never be covered and there should be no pressure to the neck region, rib cage and/or abdomen. Unless there are cogent reasons for doing so, there must be no planned or intentional restraint of a person in a prone position (whereby they are forcibly laid on their front) on any surface, not just the floor.'

The Use of Force Act can be read here <http://www.legislation.gov.uk/ukpga/2018/27/enacted>

There is no specific guidance in the *MHA Code of Practice* relating to prone restraint. However, it is widely recognised that restraining someone face down presents a significant risk to their airway, breathing and circulation, and in 2013 the charity MIND launched a campaign to call for its end.

Although prone restraint has not been completely banned, the Department of Health's *Positive and Proactive Care 2014* guidance states 'there must be no planned or intentional restraint of a person in a prone/face down position on any surface, not just the floor.' The CQC also requires health care providers to state the 'exceptional circumstances' leading to the use of prone restraint and for the person who has been restrained in this way to receive immediate medical attention afterwards.

What is mechanical restraint?

Mechanical restraint is the term used to describe when an object (e.g. cuffs, strap or belt) is used to stop or restrict a person's body from moving. The *MHA Code of Practice* defines it as: 'a form of restrictive intervention that

refers to the use of a device to prevent, restrict or subdue movement of a person's body, or part of the body, for the primary purpose of behavioural control.

The MHA Code of Practice states that mechanical restraint should only be used in exceptional circumstances when other 'least restrictive' forms of restriction cannot be safely.

Full guidance on mechanical restraint can be found in Chapter 26 (paras 75-87) available here. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/435512/MHA_Code_of_Practice.PDF

What is chemical restraint?

Chemical restraint is the use of medication to calm or sedate a person quickly, if their behaviour puts them, or others at immediate and serious risk of harm, and if other therapeutic interventions have failed to de-escalate the behaviour. This is also referred to as 'rapid tranquillisation'. Such medication is prescribed in addition to any medication that may have been prescribed for the treatment of an identified physical or mental health illness.

The *MHA Code of Practice* states that rapid tranquillisation should only be a short-term strategy, and its effects should not prevent the patient from understanding and responding to what is said to them. Importantly, oral (by mouth) medication, should be considered before an injection is given.

Full *MHA Code of Practice* guidance on rapid tranquillisation can be found in Chapter 26 (paras 91-102) available here. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/435512/MHA_Code_of_Practice.PDF

What is seclusion?

The *Mental Health Act Code of Practice* (Chapter 26.103) defines seclusion as:

'the supervised confinement and isolation of a patient, away from other patients, in an area from which the patient is prevented from leaving, where it is of immediate necessity for the purpose of

containment of severe behavioural disturbance, which is likely to cause harm to others.'

Staff may occasionally resort to using seclusion in a situation where a patient may be in great distress, as well as a potential risk to themselves or others around them. Used appropriately, seclusion can help the patient recover in their own time in a supervised calm and quiet space. However, any decision to place a child or a young person should be a carefully considered one. As the MHA Code of Practice (Chapter 26, para 7) explains:

Seclusion can be a traumatic experience for any individual but can have particularly adverse implications for the emotional development of a child or young person. This should be taken into consideration in any decision to seclude a child or young person. Careful assessment of the potential effects of seclusion by a trained child and adolescent clinician is required, especially for those children and adolescents with histories of trauma and abuse, where other strategies to de-escalate behaviours may be more appropriate than the use of seclusion.

Full guidance on seclusion can be found in the MHA of Practice: Chapter 26 (paras 103-149). https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/435512/MHA_Code_of_Practice.PDF

What is long-term segregation?

Under the Mental Health Act (MHA), a person can be prevented from 'mixing freely' with other patients in a mental health unit or ward on 'a long-term basis', if a patient's multidisciplinary team and commissioning authority decides the person's behaviour presents a continuous serious risk to other patients or staff.

The *MHA Code of Practice* outlines the features of rooms that should be used for long-term segregation (e.g. should be as homely and personalised as possible, including bathroom facilities, bedroom, separate living room and access to an outside area). Patients should not be isolated from contact with staff, or deprived of access to therapeutic, meaningful and motivating activities. Treatment plans should aim to end long-term segregation.

Following revelations in the media, and a high-profile case of a young person's long-term seclusion in an acute treatment unit, the government commissioned the CQC to review the use of restraint, seclusion and long-term segregation in 2018. The CQC published an interim report on segregation in mental health wards for children and young people, and in wards for people with a learning disability or autism, in May 2019.

This can be viewed here. <https://www.cqc.org.uk/publications/themed-work/interim-report-review-restraint-prolonged-seclusion-segregation-people>

Under what circumstances can restraint and seclusion be used?

The decision to use restraint or seclusion should be based on the least restrictive option necessary to manage risk of harm to the person, or those around them, effectively.

The Mental Capacity Act (Sections 5 and 6) allows for certain acts of restraint to be used. However, the *Mental Health Act (MHA) Code of Practice* makes it clear that this is only if those acts are necessary, proportionate and '*reasonably believed to be in the best interests of the individual*'. The *MHA Code of Practice* also makes it clear that restrictive interventions should only be used in a way that respects human rights.

For someone with a learning disability and/or autism, behaviour that challenges can often be a cry for help when faced with a situation they cannot cope with. Such behaviour communicates an unmet need and serves as a signal to get someone to acknowledge their distress and do something about it. It is therefore important for staff to focus on the cause of the behaviour rather than the behaviour itself.

Guidance on restrictive practices

Restrictive practices should only be carried out in accordance with statutory guidance. Guidance that is referred to as 'statutory' means it has been decided and controlled by law. The person who is responsible for acting on the guidance, must do it.

Non-statutory guidance does not have the same legal basis as statutory guidance. This means that the courts and tribunals do not have to take them into account. However, it can be just as valuable as statutory guidance because it:

- makes the law easier to understand and implement; and
- updates and informs statutory guidance through recognised research, expert opinion and real-life experience.

Key statutory guidance

The Mental Capacity Act Code of Practice

Please read Chapter 14 for more information on the MCA Code of Practice.

https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/497253/Mental-capacity-act-code-of-practice.pdf

The Mental Health Act Code of Practice

Please take the time to read Section 2 'Safe and therapeutic responses to disturbed behaviour', especially sub section 'Children and young people under 18' commencing on page 292 at Para 26.52.

https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/435512/MHA_Code_of_Practice.PDF

Mental Health Units (Use of Force) Act 2018

This important legislation introduces a range of additional measures to improve oversight and management including new requirements for restraint policies, training and data collection with a requirement to appoint a responsible person to increase accountability for the use of force in all mental health units.

You can read the *Mental Health Units (Use of Force) Act 2018* here.

<https://www.legislation.gov.uk/ukpga/2018/27/enacted>

Recently published non-statutory guidance

Positive and Proactive Care: reducing the need for restraint and restrictive intervention

The Reducing the Need for Restraint and Restrictive Intervention guidance aims to help settings and services take action to understand the underlying causes of children and young people's behaviour that challenges, and when these behaviours are more likely to occur.

The guidance also states that education, health and social care settings should put in place a range of measures, including:

'Measures to understand the range of communication used by children and young people to express emotions, including distressed behaviour, should be put in place. Measures to identify triggers of distressed behaviour and to prevent or address it should also be developed with the involvement of the child or young person and their family, and careful assessment, with multi-agency planning and support to create the right environment for education, care and support.'

The guidance also explains the steps that settings and services can take to support children and young people, including through the development of behaviour support plans. It says:

All settings should aim to develop proactive strategies which help reduce the likelihood of behaviours that challenge, leading to the use of restrictive interventions and focus on improving the safety and well-being of children and young people.

You can read the full guidance here. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/812435/reducing-the-need-for-restraint-and-restrictive-intervention.pdf

Recent inquiries and reports

Detention of children and young people with learning disabilities and/or autism

Following recent media reports of human rights abuses of people with autism, learning disability or both in inpatient units, the Joint Committee on Human Rights has carried out an inquiry into the use of restraint and solitary confinement in detention settings. Among other revelations, the JCHR drew attention to the fact that children and young people aged under 18 are the age group most likely to be subject to restrictive interventions. The JCHR published a report in November 2019, making recommendations in order to address this concern and other issues identified in the report. You can read the full report here. <https://publications.parliament.uk/pa/jt201920/jtselect/jtrights/121/121.pdf>

Review of restraint, prolonged seclusion and segregation for people with a mental health problem, a learning disability or autism: Interim report

In response to a high-profile case of a young person being held in long-term segregation, the Secretary of State commissioned the Care Quality Commission (CQC) to investigate restrictive practices in detention settings. The CQC published its interim report, *Segregation in mental health wards for children and young people and in wards for people with a learning disability or autism*, in May 2019.

You can read the interim report here.

<https://www.cqc.org.uk/publications/themed-work/interim-report-review-restraint-prolonged-seclusion-segregation-people>

Communication with and involvement of families

The Mental Health Act (MHA) Code of Practice (Chapter 19, para 21) states that:

It is good practice to involve the child or young person's parents and/or others involved in their care in the decision-making process, if the child or young person consents to information about their care and treatment being shared.

It goes on (26.68) to state:

Where a behavioural disturbance occurs and a restrictive intervention has been used, family members should be informed in accordance with any prior agreements.

If you are told your child has been restrained or put in seclusion, ask staff what happened and what actions were taken to avoid or de-escalate the situation. Also try to find out if a trigger was identified and what steps have been being taken to avoid this happening again.

The MHA Code of Practice (Chapter 26, paragraph 16) also says:

Patients and their families should be as fully involved as possible in developing and reviewing positive behaviour support plans (or equivalents). Patients eligible for support from an independent mental health advocate (IMHA) should be reminded that an IMHA can support them in presenting their views and discussing their positive behaviour support plan (or equivalent). The preparation of positive behaviour support plans (or equivalents) also provides an important opportunity to record the wishes and preferences of families and carers and the involvement they may wish to have in the management of behavioural disturbances. For example, on occasion, family members may wish to be notified if the patient is becoming anxious and to contribute to efforts to de-escalate the situation by speaking to the individual on the phone. People must consent to the involvement of families or advocates if they have capacity to give or refuse such consent.

If your child has been restrained, ask the ward staff if you can help provide any additional information or support that might help meet their needs more effectively. If you have not already been involved, suggest helping with a review of your child's positive behaviour support (PBS) plan.

It can be helpful to keep a dated record of all physical and chemical interventions that you are made aware of, your personal experiences and concerns, any physical injuries and concerns expressed by your loved one including any sudden changes in demeanour.

Bringing Us Together has produced a *Carer's Monitoring Form for Hospital Services* to help you record your thoughts and experiences. The form is not intended to be shared directly with hospital services, but is for personal reference if and when raising concerns or complaints, either with the hospital or commissioner. You can find the form here <https://bringingustogether.org.uk/carers-monitoring-form/>

Further information

Restraint in mental health services: What the guidance says

<https://www.mind.org.uk/media/24416468/restraintguidanceweb1.pdf>

Mental Health Units (Use of Force) Act 2018

http://www.legislation.gov.uk/ukpga/2018/27/pdfs/ukpga_20180027_en.pdf?fbclid=IwAR28bupU37KYsbr3-5vKJz7mlUraHNRy9rDEKuuxP_gxtBSS0IbwxK6V_DM

Positive and Proactive Care: reducing the need for restrictive interventions

https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/300293/JRA_DoH_Guidance_on_RP_web_accessible.pdf

Human rights framework for restraint

https://www.equalityhumanrights.com/en/publication-download/human-rights-framework-restraint?fbclid=IwAR13G_-icSZMsVbL0_SopBXvvXG7_UWnR6gE8LfYqw5l1ONS5Hw9vMkdRAk

Challenging behaviour and learning disabilities: prevention and interventions for people with learning disabilities whose behaviour challenges

<https://www.nice.org.uk/guidance/ng11>

10. When and how can my child be discharged from section?

A patient can be discharged by:

- their responsible clinician
- their nearest relative
- the hospital managers, and
- a Mental Health Tribunal.

Please note: For 'restricted' patients, the Secretary of State for Justice must give their permission before the responsible clinician or the managers can discharge the patient from hospital. A restricted patient is someone who has committed an offence and is held in hospital subject to a restriction imposed by the Secretary of State for Justice.

Discharge from Section 2

The responsible clinician will approve discharge from Section 2 if s/he decides that either the patient no longer requires further formal detention, or that they require a transfer to Section 3 for further treatment.

Patients have the right to appeal to the hospital managers and the mental health tribunal for a review of their Section 2 detention (with the help of an Independent Mental Health Advocate (IMHA), immediately they are sectioned or within the first 14 days of their detention.

The nearest relative can also apply for discharge from Section 2, but the responsible clinician can refuse by issuing a barring report if s/he believes the patient still poses a risk to themselves or others.

Discharge from Section 3

As with Section 2, the responsible clinician will approve discharge from Section 3 if s/he decides that the patient no longer requires further formal detention.

Patients can request a review of their section once during the first six months of their detention, once during the second six months and yearly thereafter.

The nearest relative can also apply for discharge from Section 3 but the responsible clinician can refuse this if s/he believes the patient still poses a risk to themselves or others.

If a barring report is issued, the nearest relative will have the right to apply to the tribunal for discharge if the patient is detained under Section 3.

Appealing a Tribunal decision

A Mental Health Tribunal has the authority to direct the discharge of any patients, where it thinks it is appropriate. Further information about Tribunals can be found on *page 44*. If the Tribunal refuses an application to discharge, and you are your child's nearest relative, you can challenge the decision by appealing to the Upper Tribunal. You will need to seek legal advice as appeals will only be permitted in certain circumstances. Further information is available here. <https://www.gov.uk/mental-health-tribunal/the-tribunals-decision>

Discharge from other sections

For restricted patients, the Secretary of State for Justice must give their permission before your child's responsible clinician or the managers can discharge them from hospital. A restricted patient is someone who has committed an offence and is held in hospital subject to a restriction imposed by the Secretary of State for Justice.

Aftercare

People who have been detained in hospital under Sections 3, 37, 45A, 47, or 48 of the Mental Health Act 1983, or have been discharged under a Community Treatment Order, have a right to 'aftercare' under Section 117 of the Mental Health Act. It should be planned before they leave hospital as part of the discharge planning process.

You can find out more about Section 117 aftercare in Chapter 13 on *page 105* of this guide.

Further information

Discharge from detention

<https://www.rethink.org/advice-information/rights-restrictions/mental-health-laws/discharge-from-detention/>

Mental Health Act 1983: Section 117

<https://www.legislation.gov.uk/ukpga/1983/20/section/117>

When can I apply for discharge or be referred to the Tribunal for a hearing?

https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/716993/t130-eng.pdf

Discharge planning

Planning for discharge, using the Care Programme Approach (CPA) framework, should start as soon as someone is sectioned.

Care, Education and Treatment Reviews

For children and young people, Care Education and Treatment Review (CETR) should take place every three months. At every CETR, the panel will want to know what the care plans are for the future, and whether the patient's care and treatment can be provided in the community. The CETR

review report will make recommendations that the care team is expected to act on.

If you are concerned that recommendations from a previous CETR may not have been completed, you can contact the chair of the CETR. Every area will have their own complaints policy. You can find out more about making raising concerns and making complaints in Chapter 11, on page 00.

Both the CTR/CETR Policy and Guidance document and the CETR Review Code and Toolkit contain discharge steps and standards to help commissioners (and all involved) navigate through the discharge process.

We would recommend that you study the information below and use it to guide you. Here are the links:

Care and Treatment Reviews: Policy and Guidance (includes CETR)

- Leaving hospital: the discharge process and standards: Page 42.
- APPENDIX 3 – Discharge steps and standards: Page 92.

<https://www.england.nhs.uk/publication/care-and-treatment-reviews-policy-and-guidance/>

Care Education and Treatment Review Code and Toolkit (2nd document)

- Section 10: Discharge steps and standards: Page 51.

<https://www.england.nhs.uk/publication/care-and-treatment-review-code-and-toolkit/>

You may also find Bringing us Together's CTR survival guide for families helpful. You can find it here. <https://bringingusstogether.org.uk/wp-content/uploads/2017/08/CTR-Survival-Guide-Aug-2017-1.pdf>

Care Programme Approach

The *Mental Health Act (MHA) Code of Practice* confirms that Care Programme Approach (CPA) should be used for individuals who are at high risk of suffering deterioration, and who need:

- multi-agency support

- active engagement
- intense intervention, and/or
- support with dual diagnosis.

Eligible patients (including those who have been under Sections 3, 37, 45a, 47 or 48) are entitled to CPA, a care coordinator and free Section 117 aftercare (an ongoing funded package of care to help meet their needs once they are discharged). Informal patients will also be entitled to CPA if they meet the local criteria (as each area has its own policy regarding this). You can find out more about Section 117 aftercare in Chapter 13, on *page 105*.

Once the patient is cleared for discharge, a discharge planning meeting should be held. The discharge facilitator will work with the patient, their family, care team and relevant community services to develop the discharge plan, coordinate the required assessments and work to overcome any concerns or issues before the patient is discharged back into the community.

Further information

Leaving Hospital

<https://youngminds.org.uk/find-help/your-guide-to-support/your-guide-to-inpatient-care/leaving-hospital/>

Transition between inpatient mental health settings and community or care home settings: NICE guideline [NG53] Published date: August 2016

<https://www.nice.org.uk/guidance/ng53/>

Transition between inpatient mental health settings and community or care home settings: Quality standard [QS159] Published date: September 2017

<https://www.nice.org.uk/guidance/qs159>

Mental Health Act 1983: Code of Practice Leaving Hospital (Chapter 27 to 34)

https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/435512/MHA_Code_of_Practice.PDF

Leaving hospital: Briefing on discharge from mental health inpatient services

[https://www.bl.uk/britishlibrary/~media/bl/global/social-welfare/pdfs/non-secure/l/e/a/leaving-hospital-minds-good-practice-briefing-17.pdf](https://www.bl.uk/britishlibrary/~/media/bl/global/social-welfare/pdfs/non-secure/l/e/a/leaving-hospital-minds-good-practice-briefing-17.pdf)

A practitioner's guide Hospital Discharge and Human Rights

<https://www.bihr.org.uk/Handlers/Download.ashx?IDMF=285b6830-069d-47b0-be71-0c3ffc404b86>

Meeting the challenge 6:

How do we plan for a successful discharge for my family member?

<https://www.challengingbehaviour.org.uk/learning-disability-files/6-How-do-we-plan-for-a-successful-discharge-for-my-family-member.pdf>

Getting it right for people with learning disabilities:

Discharge and Care after leaving (Page 23)

<https://www.nhs.uk/Livewell/Childrenwithlearningdisability/Documents/NHS-England-Getting-it-right-for-people-with-learning-disabilities-epublication.pdf>

11. Feedback, concerns and complaints

Every hospital should have its own welcome pack or information booklet, which will be given to you on admission. This should include their complaints policy and the steps you need to take. You will also be able to find information on the hospital's website.

It is important to clarify the way in which your comments about a service may be perceived and dealt with. Some organisations operate a tiered system that incorporates feedback, concerns and formal complaints.

Giving feedback

Feedback will consist of good, bad or indifferent comments about your experience of a service. You can give feedback to help improve services or to highlight good practice.

Raising a concern

It is important to raise a concern when you are worried or not happy about something. This is usually tackled by discussing the issue with the relevant member of staff so that it can be dealt with quickly and informally.

Making a complaint

If you raise a concern which has not been dealt with to your satisfaction, you can make a formal complaint to the provider concerned. You will need to do this in writing, explaining your reasons in detail in accordance with their complaints policy, which may state a time limit. It is important to keep records of all correspondence and a diary of events for reference. These will help if you decide to whether or not to escalate (take to a higher level) your complaint, later on.

If you need help making a complaint

If you need advice, your local Patient Advice and Liaison service (PALS) might be able to help you. You can find out more about PALS here.

<https://www.nhs.uk/common-health-questions/nhs-services-and-treatments/what-is-pals-patient-advice-and-liaison-service/>

You could also contact Healthwatch for information about the complaints process and other help available, such as advocacy. You can find out more about Healthwatch here. <https://www.healthwatch.co.uk/your-local-healthwatch/list>

My complaint has still not been resolved

If your complaint remains unresolved, there are two other options. However, these will be assessed using specific criteria before being accepted for review.

Taking your complaint further

Option 1

The first is the Parliamentary and Health Service Ombudsmen service. Their website has a complaint checker tool to confirm if they can help. Here is the link: <https://www.ombudsman.org.uk>.

Option 2

The second is through Judicial Review through the Courts for which you will require legal assistance. This option can be used when you wish to challenge an unlawful act or a decision which you believe not to be in the person's best interests.

Here is a good introduction to Judicial Review: <https://publiclawproject.org.uk/resources/an-introduction-to-judicial-review-2/>

Complaints about the Care, Education and Treatment Review process

For complaints Care, Education and Treatment Review process, please see paragraph 41.4 on page 83 here.

<https://www.england.nhs.uk/wp-content/uploads/2017/03/ctr-policy-v2.pdf>

Complaints about the Mental Health Act not being applied appropriately

For information about this, please see *Mental Health Act Code of Practice* 4.53.

<https://www.gov.uk/government/publications/code-of-practice-mental-health-act-1983>]

Complaints can be made directly to the Care Quality Commission.

<https://www.cqc.org.uk/contact-us/how-complain/complain-about-use-mental-health-act>]

The importance of record-keeping

In addition to your daily diary, using the Bringing Us Together monitoring form to keep record your experiences and significant incidents will really help keep track of everything. It is especially useful if a problem has persisted over a period of time to track what has been happening. You can access the *Carer's Monitoring Form for Hospital Services* here. <https://bringingustogether.org.uk/carers-monitoring-form/>

Further information

Complaining about NHS mental health services - detained (Sectioned) patients

<https://www.citizensadvice.org.uk/health/nhs-and-social-care-complaints/nhs-complaints-who-is-your-complaint-against/mental-health-services-complaints/complaining-about-nhs-mental-health-services-detained-sectioned-patients/>

Organisations that can help you make a complaint about health services

<https://www.citizensadvice.org.uk/health/nhs-and-social-care-complaints/complaining-about-the-nhs/who-you-can-go-to-when-you-have-a-problem-with-the-nhs/organisations-that-can-help-you-make-a-complaint-about-health-services/>

How to complain to the NHS

<https://www.nhs.uk/using-the-nhs/about-the-nhs/how-to-complain-to-the-nhs/>

Making a complaint

https://youngminds.org.uk/media/2802/youngminds_making-a-complaint-resource.pdf

When Things Go Wrong

<https://www.challengingbehaviour.org.uk/information/information-sheets-and-dvds/when-things-go-wrong.html?fbclid=IwAR3piNORXyWh6Tzu1nzCsNxQGuafAO5YrDK80pWsx6lpD8PGnkV1gOtV1Ag>

One Stop Guide for Complaints about Healthcare in England: Getting help with your complaint

https://www.professionalstandards.org.uk/docs/default-source/publications/one-stop-guide-for-complaints/one-stop-guide-for-complaints-about-healthcare-in-england.pdf?sfvrsn=68677e20_4

12. Associated programmes and initiatives

Care Education and Treatment Reviews

NHS England developed the Care and Treatment Review (CTR) programme to improve the care of people with learning disabilities, autism or both whose behaviour is seen as challenging, including those with a mental health condition. For children and young people (between the ages of 0 to 25 still in education), Care, Education and Treatment Reviews (CETR) give an additional focus on education.

These reviews bring together all those involved in the person's care, as well as two independent experts, with the aim of reducing unnecessary admissions to, or lengthy stays in, specialist hospitals for assessment and treatment, and to promote discharge as soon as possible.

Reviews can be held if a person with learning disability and/or autism, and behaviour that challenges, is at risk of being admitted to a mental health hospital to try and develop sustainable care and support to meet their needs in the community. If they are already in hospital, regular CETR reviews can take place to routinely monitor their progress, the suitability of the care being provided and facilitate discharge as soon as possible.

Bringing Us Together has written a guide for families which explain the whole CTR/CETR process. You can read *Care and Treatment Reviews: Family Survival Guide* here. <https://bringingus-together.org.uk/a-family-survival-guide-care-and-treatment-reviews-ctrs/>

STOMP-STAMP

As previously discussed in Chapter 7, NHS England has recognised that children and young people with a learning disability, autism or both are more likely to be given medication (including psychotropic medication) than other children and young people. In response, it has launched the STOMP-STAMP campaign. STOMP stand for Stop the Over-Medication of children and young People with a learning disability, autism or both. STAMP stands for

Supporting Treatment and Appropriate Medication in Paediatrics) campaign to increase awareness of this. According to the STOMP-STAMP principles, children and young people should only be prescribed '*the right medication, at the right time, for the right reason*'.

What is psychotropic medication?

Psychotropic medications affect how the brain works. They include:

- antipsychotic drugs (used to treat psychosis)
- sedatives (used to calm or induce sleep), and
- anxiolytics (prescribed for anxiety and agitation).

Psychotropic medications can be used to treat mental health conditions, such as anxiety, depression, and psychosis. Sometimes doctors prescribe these medications to children and young people because of behaviours that challenge others.

However, psychotropic medication can cause problems if taken for the wrong reasons, in high doses or for long periods of time. Side effects may include putting on weight, feeling tired or 'drugged up'. There may also be a possibility of serious problems with physical health. These medicines can be right for some children and young people to help them live a good life. However, other therapies and types of support can mean psychotropic medications can be reduced or not used at all.

The STOMP-STAMP principles

The STOMP-STAMP principles state that psychotropic medication should only be considered for the management of behaviour that challenges only when:

- alternatives to psychotropic medication alone (e.g. Positive Behaviour Support (PBS)) do not produce positive change within an agreed time;
- treatment for any coexisting mental or physical health problem has not led to a reduction in the behaviour; or
- the risk to the person or others is very severe (e.g. because of violence, aggression or self-injury).

STOMP-STAMP recommends doctors should keep to a number of principles, which include the following.

- Only offer psychotropic medications together with other interventions.
- Complete a functional analysis of the behaviours and symptoms before prescribing medication.
- Ensure that there is a clear diagnosis and this has been reached through a recognised assessment process.
- Clearly evidence and document the prescribing decision.
- Ensure that consent or best interest decisions are made in line with the Mental Capacity Act (MCA).
- Ensure that the young person and their family are consulted, have accessible and comprehensive information about the diagnosis, the prescribed medication (including benefits and side effects) and the planned duration of the treatment.
- Give the young person and their family enough time to consider, reflect and ask questions, and make reasonable adjustments to support their understanding.
- Provide clear guidance to the young person and their family about why and when any additional PRN (as needed) medication might be needed.

Reducing over-medication is only one part of the change needed. More training and support must be made available to help meet people's needs properly so they don't have to challenge those around them to get help.

Improving access to routine health care is also vital because illness is sometimes a trigger for challenging behaviour if the person finds it difficult to communicate their physical pain and/or distress.

You can find out more about STOMP-STAMP, including information on the principles and a family leaflet, here. <https://www.england.nhs.uk/learning-disabilities/improving-health/stamp/>

Ask Listen Do

The *Ask Listen Do* initiative was launched by NHS England to improve the experiences of people using services and their families. The initiative has developed a number of resources to encourage and support good practice in organisations across health, education and social care. It also offers guidance to those using services, families and carers to help them speak up and have their voices heard. Providing feedback, raising concerns or making a complaint can really make a difference to a person's care.

You can read more about the *Ask Listen Do* initiative here. <https://www.england.nhs.uk/learning-disabilities/about/ask-listen-do/>

Further information

Information for people with a learning disability, autistic people, families and carers

<https://www.england.nhs.uk/learning-disabilities/about/ask-listen-do/people-information/>

Information for organisations and practitioners

<https://www.england.nhs.uk/learning-disabilities/about/ask-listen-do/information-for-organisations/>

13. Mental Health Act – a reference guide

This chapter focusses on the Mental Health Act 1983 (MHA). This is the law in England and Wales that states what a person's rights are and how they can be treated if they have a mental disorder.

Please note: This is not an exhaustive guide. However, it aims to give an accessible overview of the most important points in the MHA for families of a person who is admitted to hospital for assessment and treatment under section of the MHA. It is written from the point of view of families, (i.e. not the person with mental health illness, learning disabilities and/or autism and behaviour that challenges others).

What is a mental disorder?

The Mental Health Act (MHA) defines Mental disorder as '*any disorder or disability of the mind*'. Learning disability and autism fall within the Act's definition of mental disorder as explained in the *MHA Code of Practice* (20.7) where associated with '*abnormally aggressive behaviour*' or '*seriously irresponsible conduct*'.

Some people with these diagnoses will be assessed and treated in the community or in hospital as a 'voluntary' or 'informal' patient (i.e. with their consent). In certain circumstances, the MHA gives health professionals the power to detain people who are unwell enough to need to be in hospital for assessment and treatment, in the interests of their health and safety, or for the safety of the public. Patients such as these are called 'formal'.

What is sectioning?

Formal patients can be detained without consent under what is called a 'section'. The Act contains a number of different sections giving the detaining authority the powers to detain in a range of circumstances. These powers should only be applied when there is no less restrictive alternative to detention.

If you have been detained under section, the following people can discharge you:

- responsible clinician
- nearest relative (responsible clinician has the power to block this)
- mental health tribunal, and
- hospital managers.

Mental Health Act principles

The Mental Health Act (MHA) has five overarching principles that should always be considered when making decisions in relation to care, support or treatment provided under the Act.

1. Least restrictive option and maximising independence.
2. Empowerment and involvement.
3. Respect and dignity.
4. Purpose and effectiveness.
5. Efficiency and equity.

The MHA is supported by the *MHA Code of Practice*, which provides statutory guidance to registered medical practitioners, approved clinicians, managers, staff, providers and approved mental health professionals on how they should carry out their functions under the Act.

Further reading

Code of practice: Mental Health Act 1983

<https://www.gov.uk/government/publications/code-of-practice-mental-health-act-1983>

Mental Health Act 1983

<https://www.legislation.gov.uk/ukpga/1983/20/contents>

Mental Health Act assessment

Before someone is admitted to hospital (other than in an emergency) for the assessment or treatment of their mental health, a panel of three professionals (usually two doctors and an Approved Mental Health Professional (AMHP)) must carry out a Mental Health Act (MHA) Assessment to determine whether or not they should be detained under the Act. This is known as 'sectioning'.

The MHA sets out the training, skills and experience expected of the panel members. One of the professionals carrying out the assessment must be 'Section 12 approved'. This means a doctor who has had special training in the diagnosis or treatment of mental disorder.

The Act also recommends that the second doctor should be someone who already knows the person being sectioned, particularly if the first doctor or the AMHP do not.

If the assessment is for a child or young person (up to 18 years old), at least one of the two medical practitioners or the AMHP should be a child and adolescent mental health services (CAMHS) professional.

Where this is not possible and admission to hospital is considered necessary, the AMHP should have access to an AMHP with experience of working in CAMHS. The medical practitioners should consult a CAMHS clinician as soon as possible and involve them as closely as the circumstances of the case allow.

If the child or young person has complex or multiple needs, other clinicians may need to be involved, for example, a learning disability CAMHS consultant if the child or young person has a learning disability.

See *MHA Code of Practice* (Chapter 19, para 73; Chapter 19, para 74; Chapters 14; Chapter 20) for fuller information on the assessment process. These can be read here. <https://www.gov.uk/government/publications/code-of-practice-mental-health-act-1983>

In an emergency

The *MHA Code of Practice* provides guidance about situations where it may be necessary to act quickly, for example, to keep someone safe temporarily or if there is a threat to life.

In an emergency situation, if the failure to treat a child or young person would likely lead to their death or to severe permanent injury, the authorities are allowed to section them without consent. This will usually involve the child or young person being taken to a place of safety (e.g. a hospital) for assessment and treatment.

The treatment given must be no more than necessary and in the best interests of the child or young person. Once the person has been stabilised, legal authority for on-going treatment must be established either on an informal (voluntary) or formal (i.e. under section of the MHA) basis.

For more information about Emergency Treatment, please see *MHA Act Code of Practice* (Chapter 17, para 71).

What is an Approved Mental Health Professional?

An Approved Mental Health Professional (AMHP) is a registered professional, usually a social worker, who is trained and authorised to make certain legal decisions and applications under the Mental Health Act. These responsibilities include whether or not someone should be detained under section and, if this is the case, they are also responsible for coordinating the assessment and admission to hospital.

AMHPs may also be registered professionals such as qualified nurses, occupational therapists or psychologists. Doctors are not allowed to become AMHPs.

An important part of the role is consulting with nearest relatives, carers and others, making sure the person who may need sectioning is interviewed appropriately. They should also ensure that the person knows what their rights are if they are detained under the Mental Health Act (MHA).

When undertaking assessments under the MHA, AMHPs must ensure that people are supported in the least restrictive way possible and their legal rights are maintained.

AMHPs must also comply with other legislation, including the Human Rights Act 1998, Mental Capacity Act 2005, Equality Act 2010, Children Act 1989, National Assistance Act 1948 and Care Standards Act 2000.

Who do AMHPs work for?

AMHPs are approved and permitted by Local Social Service Authorities (LSSAs) to act on their behalf. However, when making decisions within their authority, AMPHs must reach their own independent professional judgment. Local authorities cannot tell AMHPs what decision they must reach in any particular case.

What is the role of an AMHP?

The AMHPs role is very wide-ranging as they have a number of powers and duties in the community, as well as hospital. These are summarised in the table below.

AMHP functions
Making applications for admission to hospital for assessment or treatment under part 2 (Civil patients) (MHA Sections 13(5) and 13(2)).
Informing the patient's nearest relative when detaining under Section 2.
Consulting the patient's nearest relative when considering a Section 3 detention (or guardianship).
Arranging for the safe transfer of patients to hospital on the basis of applications for admission (MHA Section 6(1)).
Making applications for guardianship under part 2 (Civil patients) See <i>MHA Code of Practice</i> Chapter 7.
Checking and validating the basis of any application for admission made by a person's nearest relative (MHA Section 14).
Applying to the county court for the replacement of an unsatisfactory private guardian.
Before a person is discharged, if relevant, the AMPH will ensure that community treatment orders (CTOs) are made and agree the conditions to be included in the CTO (MHA Section 17).
Approving the extension of CTOs (MHA Section 20a).
Approving the revocation (cancelling) of CTOs (MHA Section 17).
Being consulted by responsible clinicians before they make reports confirming the detention or CTOs of patients who have been absent without leave (absconded or left the place in which the CTO says they should live) for more than 28 days.

Applying to the county court for the appointment of an acting nearest relative and the displacement of an existing nearest relative.

Having the right to enter and inspect premises under MHA Section 115.

Applying for warrants to enter premises under MHA Section 135(1).

Taking patients into custody and take them to the place they ought to be when they have (MHA Sections 18 and 138).

Taking and returning other patients who have absconded (MHA Sections 18 and 138).

What is an Independent Mental Health Advocate?

Sometimes it can be difficult for people to speak up for themselves. An advocate is somebody who can work with a person to help them have their say about things.

Independent Mental Health Advocates (IMHAs) mainly work with patients who are subject to the Mental Health Act 1983 (MHA). They are trained to support people to understand their rights under the MHA and participate in decisions about their care and treatment.

Among other things, IMHAs can help patients make a complaint about their mental health service, help them challenge their detention or request a Hospital Managers Review. They will then support them at any subsequent Tribunal or review hearing and help patients exercise their human rights in relation to the use of the Act.

What is the role of an IMHA?

IMHAs act in a supportive role, helping the patient to get and understand information, such as:

- patient rights under the MHA;
- the rights which other people (e.g. the nearest relative) have in relation to them under the MHA;
- the parts of the MHA that apply to the patient;
- any conditions or restrictions applied to the section the patient is subject to;
- medical treatment;

- reasons for the treatment or proposed treatment;
- the legal authority for providing treatment, and the safeguards and other requirements of the MHA that would apply to that treatment;
- helping the patient to exercise their rights;
- helping the patient to prepare for and giving support to them at meetings, including appeals, ward rounds, Care Programme Approach (CPA) meetings, and tribunals;
- helping the patient to communicate with staff; and
- helping the patient access their medical and local authority records.

What can an IMHA do?

An IMHA can:

- visit and interview a patient in private;
- visit and interview any person professionally involved with a patient's treatment;
- represent the patient at ward rounds and CPA reviews;
- raise concerns about a person's experience of care and treatment;
- provide support at Mental Health Review, Tribunals and Hospital Managers Hearings;
- support patients to exercise their rights, which can include representing or speaking on their behalf;
- demand to see and inspect any health and social care records that relate to the patient; and
- help patients obtain information so they understand:
 - their rights under the MHA;
 - the parts of the MHA that apply to them;
 - the medical treatment they are receiving, or might receive, and reasons for that treatment; and
 - the rights that other people have in relation to them under the Act.

Who is eligible for an IMHA?

A person is eligible for the help of an IMHA if they are:

- detained under the MHA – but not under ‘emergency’ orders (i.e. if subject to MHA Sections 4, 5(2), 5(4), 135 and 136);
- liable to be detained under the MHA, including those who are currently on leave of absence from hospital or absent without leave, or those for whom an application or court order for admission has been completed;
- a conditionally discharged restricted patient;
- subject to guardianship (MHA Section 7);
- subject to a MHA Section 17A supervised Community Treatment Order (CTO);
- an informal patient being considered for a MHA ‘Section 57 treatment’ (psychosurgery); and/or
- an informal patient who is under 18 who is being considered for a MHA ‘Section 58a treatment’ (electroconvulsive therapy (ECT)).

Who can contact an IMHA?

If a patient is eligible, they can request support from an IMHA from a member of the ward staff, the responsible clinician or an approved mental health professional (AMHP). A person’s nearest relative, an AMHP or responsible clinician can also ask an IMHA to visit the patient if they are able to understand and agree to this.

If a patient lacks capacity to decide whether to seek help from an IMHA, an IMHA should be appointed for them.

What is a Hospital Manager?

Hospital managers are independent lay people who are specially trained and appointed (but are independent of) the NHS trust concerned. In the case of an independent hospital, they are appointed by the persons(s) in whose name the hospital is registered.

What do Hospital Managers do?

Hospital managers have a range of functions, powers and duties under the MHA. The *MHA Code of Practice* states that:

They have the authority to detain patients under the Act. They have the primary responsibility for seeing that the requirements of the Act are followed. In particular, they must ensure that patients are detained only as the Act allows, that their treatment and care accord fully with its provisions and that they are fully informed of, and are supported in exercising, their statutory rights.

Hospital Managers have a power to discharge most detained patients (see below) and all patients subject to a community treatment order (CTO). The decision about whether or not to discharge someone from MHA section or CTO is made by a panel of three or more hospital managers at a 'Managers Hearing'. Any qualifying patient (or their nearest relative) can request a hearing to consider approval of discharge.

According to the MHA Code of Practice (chapter 38, para 2), hospital managers may not discharge patients who:

'are held under the section 5 holding powers or in a place of safety under sections 135 or 136, or those remanded to hospital under sections 35 or 36 of the Act, or subject to interim hospital orders under section 38, and they may not discharge restricted patients without the consent of the Secretary of State for Justice.'

What is a Second Opinion Appointed Doctor?

A Second Opinion Appointed Doctor (SOAD) is appointed by the Care Quality Commission (CQC) to provide an additional safeguard for patients detained under the Mental Health Act.

All SOADs are experienced and licensed, consultant-level psychiatrists. Their role is to provide an independent medical view on whether it is appropriate for certain treatments to be given to individual patients.

SOADs have a right of access to records, without the patient's consent if necessary, and may ask hospital managers to provide the clinical notes to help inform their decision. Hospital managers are responsible for ensuring that such requests can be fulfilled promptly.

In the absence of consent, a SOAD visit will be needed to allow the following treatment (except in an emergency):

- medication for mental disorder after three months from first administration when a patient is detained under the MHA;
- medication for mental disorder after the first month of a patient being subject to a community treatment order (CTO); and
- electroconvulsive therapy (ECT), at any point during the patient's detention.

Any detained patient being given medication for a mental disorder must be reviewed by a SOAD after the first three months to certify that the treatment is appropriate. The SOAD should take into account the nature and degree of the mental disorder from which the patient is suffering and all other circumstances of the case. The SOAD must also evaluate whether the patient has capacity to consent, or if the patient has the capacity to consent, but has refused to do so.

SOADs are required to consult two people ('statutory consultees') before issuing certificates approving treatment.

One of the statutory consultees must be a nurse; the other must not be either a nurse or a medical doctor. Both must have been professionally concerned with the patient's medical treatment, and neither may be the clinician in charge of the proposed treatment or the responsible clinician.

Please note: If a patient does not have capacity to consent, a SOAD should assess the patient after the first month of being prescribed Mental Health medication.

What is a Mental Health Tribunal?

A Mental Health Tribunal is an independent judicial body that reviews cases of patients who have been detained, conditionally discharged or subject to community treatment orders (CTOs) under the Mental Health Act (MHA).

The Tribunal has the authority to direct the discharge of any of these patients where it thinks it appropriate.

There are three people on the panel:

- a judge (who is in charge of the hearing);

- a tribunal doctor who is a consultant psychiatrist who is fully independent of the hospital in which the patient is detained; and
- a specialist lay member who has detailed knowledge of the Mental Health Act and mental health care.

A tribunal for a child or young person also has three members, which together are known as a 'CAMHS Panel'. Its composition is identical except that, wherever possible, at least one member of the panel will have experience of working with people under 18.

The hospital clinical team (consisting of the patient's doctor, nurse and care coordinator) will also attend the review. The patient is also allowed to have an advocate to help them and a parent or another relative (if they so wish).

IMHAs have a very important role in ensuring that children and young people understand, and are able to exercise, their rights under the MHA. This could include applying to a tribunal (please see *MHA Code of Practice*, Chapter 19, para 107) and to the hospital managers for discharge from detention (please see *MHA Code of Practice* Chapter 38 for further guidance). It is therefore essential that the IMHAs working in CAMHS have experience of working with children and young people, an understanding of children's services and relevant law and policy, as well as an in-depth knowledge of the MHA (please see *MHA Code of Practice* Chapter 19).

Children and young people who are detained under the MHA have the same rights as other patients to apply to the tribunal. It is important that children and young people are informed of their right to apply to the tribunal and are helped to get legal representation at an early stage.

If the patient has not appointed a representative, the tribunal may appoint a legal representative for the patient where:

- (a) the patient has stated that they do not wish to conduct their own case or that they wish to be represented; or
- (b) the patient lacks the capacity to appoint a representative, but the tribunal believes that it is in the patient's best interests for the patient to be represented.

You can find out more about applying to the Mental Health Tribunal here.

<https://www.gov.uk/mental-health-tribunal>

What role do Hospital Managers' play in the tribunal?

The term 'hospital manager' used in this context can be confusing because these kind of hospital managers do not actually work for or manage the hospital. They are independent lay people specially trained and appointed by (but independent of) the NHS Trust concerned or, in the case of an independent hospital, by the person or persons in whose name the hospital is registered.

Hospital managers are under a duty to facilitate the Tribunal process appropriately, including making sure that the patients understand their rights to apply for a Tribunal hearing, advising patients of their entitlement to free legal advice and representation and providing suitable accommodation for the meeting to take place.

Hospital managers have a duty to refer patients who are under the age of 18 to the Tribunal if they have not had a Tribunal hearing after one year of being admitted under section. In cases where a child or young person is unable to have their case considered speedily by the Tribunal, hospital managers should consider asking the Secretary of State to intervene (under Section 67 of the MHA).

Preparation for Tribunal

Where the patient consents, legal representatives and independent doctors should be given prompt access to the patient's medical records to avoid delays to Tribunal proceedings.

People with learning disabilities or autism may need adjustments to be made to ensure they understand the Tribunal's role. A patient (and their nearest relative) may also need support to make informed decisions about whether, when and how to make an application. This support may be provided by IMHAs, or other advocates (*MHA Code of Practice* Chapter 20, para 45).

Professionals preparing social circumstances reports for the Tribunal, must ensure that such reports include any information required in the Tribunal's Practice Directions (*MHA Code of Practice* Chapter 19, para 109). A Practice

Direction is a document that states what specific information the Tribunal panel will require within the reports submitted.

What happens at a Tribunal?

As well as the Tribunal panel, the hearing can be attended by the responsible clinician, hospital manager, care coordinator, the patient, their nearest relative and other family members, legal representative, the patient's advocate, the relevant nurse and doctor. As this is a legal process, the Tribunal will follow a specific agenda led by the judge. The panel will hear evidence from those involved, and study the statements and reports presented.

Important: The patient does not have to prove that they can be discharged. It is up to the professionals, who believe that a patient should continue to be detained or remain under a CTO, to prove their case.

At the end of the presentation of evidence, everyone part from the panel is asked to leave the room. Sometimes, however, hearings do not proceed (the panel adjourns) if there is missing information that would mean that a patient's case cannot be properly heard.

The panel stay in the hearing room and decide whether the legal criteria for detention are met. They consider the information in the reports and the patient's care team's evidence and what the patient and their lawyer have said. This takes about 15-30 minutes.

If the patient wanted to be discharged from Section but that does not happen, their lawyer will advise you on when you can apply again for a tribunal.

Further information

What Is A Mental Health Tribunal Judge And Panel?

<https://youngminds.org.uk/blog/what-is-a-mental-health-tribunal-judge-and-panel/>

A Guide to Mental Health Tribunals for Young People

https://www.rcpsych.ac.uk/docs/default-source/members/faculties/child-and-adolescent-psychiatry/cap-camhs-guide-to-mental-health-tribunals-feb-2016.pdf?sfvrsn=cf42b347_2

When can I apply to or be referred to the Tribunal for a hearing?

https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/716993/t130-eng.pdf

Apply to the Mental Health Tribunal

<https://www.gov.uk/mental-health-tribunal>

How you can ask a mental health tribunal for a decision (Easy Read version)

<https://www.gov.uk/government/publications/how-you-can-ask-a-mental-health-tribunal-for-a-decision-easyread-version>

Information for Nearest Relatives (First Tier Tribunal)

https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/756213/t117-eng.pdf

Mental Health Advocates role in accessing the Tribunal when the person lacks the capacity to request one.

<https://www.youtube.com/watch?v=YFbnNmXGlhg&feature=youtu.be>

Discharge from detention

<https://www.rethink.org/advice-information/rights-restrictions/mental-health-laws/discharge-from-detention/>

Tribunals and inquiries, England and Wales

http://www.legislation.gov.uk/uksi/2008/2699/pdfs/uksi_20082699_en.pdf

Mental Health Act 1983: Code of Practice (Chapter 12)

https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/435512/MHA_Code_of_Practice.PDF

What is a Nearest Relative?

If a person is sectioned under the Mental Health Act (MHA), a 'nearest relative' is identified, as explained below. This is not the same as being someone's 'next of kin' (NOK), though they can be the same person. NOKs have no authority under the MHA.

A nearest relative has certain rights and powers (defined by Section 26 of the Mental Health Act) in respect of a patient for whom they are the nearest relative. They can make applications for admission, order the discharge of their relative from detention (unless certain conditions exist) and, under specific circumstances, apply for a mental health tribunal.

Who can be a Nearest Relative?

The patient's nearest relative is the first highest in the following list that (providing the patient is a UK resident) lives in the UK:

1. Husband, wife or civil partner. Also, cohabitees (including same-sex partners) who have lived together for at least six months. (*Unless permanently separated from the patient by agreement or by court order or where one partner has deserted the other*)
2. A son or daughter (over the age of 18)
3. A father or mother
4. A brother or sister (over the age of 18)
5. A grandparent
6. A grandchild (over the age of 18)

7. An uncle or an aunt (over the age of 18)
8. A nephew or a niece (over the age of 18), or
9. Any unrelated carer or person who has lived with the patient for a period of more than five years.

Please note

Only patients who are not ordinarily resident in the United Kingdom, Channel Islands, or the Isle of Man can have a Nearest Relative who also does not live in those places.

Anyone listed above who lives with, or is the carer of, the patient should be treated as nearest relative in preference to any other claimant.

Where more than one person could be the nearest relative, it is eldest of them that that will be given the role.

A nearest relative will cease to be nearest relative only if they choose to delegate their powers (give them to someone else) or the Court displaces them. If this is the case, they must write to the hospital where the person is detained (or, where the patient is subject to guardianship, the local social services authority department), confirming that they no longer wish to act as the patient's nearest relative and identifying the person they authorise to take their place.

If the patient does not have a nearest relative, the County Court can appoint someone a nearest relative. The patient can also nominate someone they would like to be the nearest relative, however it will be up to the Court to decide who the most suitable person is.

The MHA includes additional provisions to identify the nearest relative of a child or young person with respect to Guardians and interim care orders. You can find out more about this in *MHA Code of Practice* Chapter 5, para 3.

Please note: Restricted patients (including conditionally discharged patients) do not have a nearest relative for the purposes of the Act. This is also the case for patients remanded to hospital under Sections 35 or 36, and patients subject to interim hospital orders under Section 38.

A restricted patient is someone who has committed an offence and is held in hospital subject to a restriction imposed by the Secretary of State for Justice.

Displacement of the Nearest Relative

Identifying a nearest relative can be a complex process and should be undertaken by an Approved Mental Health Professional (AMHP) or someone who has significant experience of using the MHA.

Due to the prescriptive way (see above) in which a nearest relative is selected, there may be occasions where the person identified is not suitable (see below). The nearest relative has a legal responsibility to safeguard the patient's interests and to help ensure that the compulsory powers of the MHA are used appropriately. This means any nearest relative who is thought to be unsuitable must be displaced (set aside) and a suitable replacement found.

Displacement of the nearest relative is carried out by a County Court in accordance with Section 29 of the MHA. This gives the Court the authority to order that the functions of the nearest relative should be carried out by another person or by a local authority (as defined by the Care Act 2014).

The patient, any relative of the patient, anyone with whom the patient is residing or an Approved Mental Health Professional may also make an application to the County Court. They may do so on a number of grounds:

- a. that there is no nearest relative;
- b. that the nearest relative is too ill to take on the role;
- c. that the nearest relative has objected unreasonably to admission;
- d. that the nearest relative has discharged the patient without regard to that person (or other people's) safety; and/or
- e. that the nearest relative is 'otherwise unsuitable'.

Please note: A nearest relative can be displaced if they object to admission. However, but they can appeal this once during the first 12 months of this decision.

Nearest relative rights and functions

As previously mentioned, the MHA requires that Approved Mental Health Professionals (AMHPs) identify a patient's nearest relative (as defined in MHA Section 26).

The hospital managers are required to ensure that a patient detained under the MHA and their nearest relative are given full details of their rights and responsibilities.

The nearest relative has a number of important rights and functions under the Mental Health Act, including the right to:

- request an AMHP's assessment of the need for a person's detention in hospital;
- be informed where practicable before their relative is detained under Section 2 of the MHA;
- be consulted where practicable before an application for Section 3 detention or guardianship of their relative, and have the right to object to this application;
- apply for a person's detention in hospital or under guardianship;
- order the discharge of the patient from detention, guardianship (unless imposed by a court) and Community Treatment Order (CTO);
- be told when the patient is about to be discharged;
- delegate the role to another person;
- make contact with the Independent Mental Health Advocacy service;
- apply to the Mental Health Tribunal if they have been displaced by the County Court once in the first year and once in each subsequent year of the patient's detention (Section 29, para 6; Section 66 para 1 (h); Section 66, para 2(g)). The acting nearest relative has a separate power to make an application;
- apply to the Mental Health Tribunal for the discharge of a patient subject to an unrestricted hospital order (Section 37) in the period between six and 12 months after the making of the hospital order and in any subsequent period of one year; and

- apply for the Mental Health Tribunal for a discharge when the patient is subject to a guardianship order (Section 37) within the first 12 months of the order and in any subsequent 12-month period (Section 69 para 1(b)(ii)).

Further information

MHA Definition of relative' and 'nearest relative'.

<https://www.legislation.gov.uk/ukpga/1983/20/section/26>

Your Nearest Relative - Easy Read

<https://assets.nhs.uk/prod/documents/MH-CoP-Nearest-relative.pdf>

Rethink - Nearest Relative

https://www.rethink.org/carers-family-friends/what-you-need-to-know/nearest-relative?gclid=EAIaIQobChMIrtCpr-qL4gIVzLvtCh2XrQFfEAAAYASAAEgIsIPD_BwE

The rights of the Nearest Relative in Mental Health Sectioning

<http://www.blackpooladvocacyhub.org.uk/the-rights-of-the-nearest-relative-in-mental-health-sectioning>

The identification and rights of the 'Nearest Relative' under the Mental Health Act 1983 (2011)

<https://www.bl.uk/collection-items/identification-and-rights-of-the-nearest-relative-under-the-mental-health-act-1983>

Mental Health Act 1983: Section 66 (Application to Tribunals)

<https://www.legislation.gov.uk/ukpga/1983/20/section/66>

What is a community treatment order?

A community treatment order (CTO) allows patients who have been detained under certain sections of the Mental Health Act to be safely treated in the community, if they no longer need to be in hospital.

A CTO is intended to help patients maintain stable mental health safely outside hospital and to promote recovery, while helping prevent relapse and any harm to the patient or to others.

The CTO will only be agreed subject to certain conditions being met. These conditions will include the person being available for medical examination when needed and complying with a community treatment plan outlining the medications, medical appointments and other aspects of care the doctor believes are necessary. If the person does not stick to the conditions, they could be recalled to hospital and being detained under a section again.

When can a person be discharged under a CTO?

The decision as to whether or not a CTO is the right option for a patient is taken by their responsible clinician (RC) and requires the agreement of an approved mental health professional (AMHP).

A CTO is an option only for patients who meet the criteria set out in the Mental Health Act (MHA), which are that:

- the patient is suffering from a mental disorder of a nature or degree that makes it appropriate for them to receive medical treatment;
- it is necessary for the patient's health or safety, or for the protection of others, that the patient should receive such treatment;
- such treatment can be provided without the patient continuing to be detained in a hospital (subject to the patient being liable to be recalled as mentioned below);
- the responsible clinician recalls the patient to hospital, if required under Section 17E(1) of the Act; and
- appropriate medical treatment is available for the patient.

A CTO lasts initially for up to six months and is renewable for six months in the first instance, and then for periods of one year thereafter. Every time a

responsible clinician wishes to renew a CTO, the person under the order will automatically be given a Hospital Managers Hearing. A person can be discharged from the Community Treatment Order by their responsible clinician, their nearest relative, the hospital managers, and the Tribunal.

Further information

Community Treatment Orders

<https://www.gov.uk/guidance/community-treatment-orders>

Community Treatment Orders Fact Sheet

<https://www.rethink.org/advice-and-information/rights-restrictions/mental-health-laws/community-treatment-orders/>

What is Guardianship?

A guardian can be appointed for a vulnerable person aged 16 and over who has a mental disorder to help them stay safe and well living in their community. They can help reduce the risk of any deterioration in their condition, resulting in an admission to hospital for further assessment and treatment.

The Mental Health Act (MHA) provides a legal framework, which a guardian can use to help a person to live as an independent life, with the fewest restrictions possible.

Guardianship can also be used for people who have a learning disability or autism, even if they do not have a mental illness. However, this is only if they display 'abnormally aggressive or seriously irresponsible conduct', as stated in the MHA Code of Practice (Chapter 20, para 7).

What are the criteria for guardianship?

A guardian can be appointed if the person meets the criteria defined in the MHA at Section 7(2), which states that:

A guardianship application may be made in respect of a patient on the grounds that:

- a. he is suffering from mental disorder of a nature or degree which warrants his reception into guardianship under this Section; and*
- b. it is necessary in the interests of the welfare of the patient or for the protection of other persons that the patient should be so received.*

How is a person assessed for guardianship?

Before a guardianship application is made, an Approved Mental Health Professional (AMHP) and two doctors will have to carry out an assessment. They will decide if the person has a mental disorder and it is necessary for them to be made subject to guardianship, in the interests of their welfare or for the protection of other people (in line with the MHA criteria above).

Who can apply to be a guardian?

The person named as guardian may be either a local social services authority or any other person (including the applicant).

If the proposed guardian is not the local social services authority themselves, the person applying should write a statement that s/he is willing to act as guardian. The proposed guardian cannot be accepted without the local social services authority's approval. If the person's nearest relative objects to the person proposed the application cannot go ahead.

Appealing guardianship

If a person wants to stop being subject to guardianship, they can speak to their guardian, social worker, responsible clinician, nominated medical attendant or social care authority. They can also ask a Mental Health Tribunal to terminate the guardianship.

A person's nearest relative can also end a guardianship by writing to the social care authority.

What authority does a guardian have?

A guardian, once appointed, has the legal authority and power to require the person:

- to live at a particular place (Section 8, para 1(a));
- to attend appointments for medical treatment, work, education or training at a specific time and place, and (Section 8, para 1(b)); and
- to allow a doctor or another named person to see the person at the place where they live (Section 8, para 1(c)).

What can a guardian not do?

- Guardianship must not be used to impose restrictions that amount to a deprivation of liberty (*MHA Code of Practice* Chapter 36, para 5).
- Guardians do not have the right to treat the patient without their permission or to consent to treatment on their behalf (*MHA Code of Practice* Chapter 36, para 6).

Please note: Guardianship does not affect the continued authority of an attorney or deputy appointed under the Mental Capacity Act. However, such attorneys and deputies will not be able to take decisions about where a guardianship patient is to live, or take any other decisions that conflict with decisions made by the guardian (*MHA Code of Practice* Chapter 36, para 5 and 36, para 7).

How long does guardianship last for?

Guardianship initially lasts for six months. It then either expires or can be renewed for another six months. After this, a guardianship is renewed once a year.

Further reading

The Mental Health Act Section 7

<https://www.legislation.gov.uk/ukpga/1983/20/section/7>

Code of practice: Mental Health Act 1983 (Chapter 30)

<https://www.gov.uk/government/publications/code-of-practice-mental-health-act-1983>

Guardianship – easy read

<https://assets.nhs.uk/prod/documents/MH-CoP-Guardianship.pdf>

What is Section 117 aftercare?

Patients who have been detained under Mental Health Sections 3, 37, 45a, 47 or 48 and are discharged from hospital (including on Section 17 leave or under a community treatment order (CTO), under Section 17a) are eligible for something called 'Section 117 aftercare.' Mental Health Act Section 117 places a duty on Clinical Commissioning Groups (CCGs) and Local Authorities (LAs) to provide, or arrange for the provision of, aftercare services for any person to whom this applies.

What does Section 117 aftercare mean?

The *Mental Health Code of Practice* says that CCGs and LAs '*should interpret the definition of aftercare services broadly*' and that these could include health and social care, employment services, supported accommodation, and other services (e.g. to meet wider social needs) if these services '*arises directly from, or is related to, the particular patient's mental disorder, and help to reduce the risk of a deterioration in the patient's mental health condition*'.

When does Section 117 aftercare end?

The duty to provide aftercare services exists until both the CCG and the local authority are satisfied that the patient no longer needs them. Importantly, the *Mental Health Code of Practice* clarifies that even when aftercare provision has been successful (i.e. a patient is well settled in the community), a patient may still continue to need aftercare services.

Section 117 aftercare should continue if a patient is readmitted, even if voluntarily or under Section 2 of the MHA. However, if the patient is readmitted under Section 3, a new Section 117 plan should be created.

Anyone who is eligible for 117 aftercare is entitled to a personal health budget.

Section 117 After-care & Personal Health Budgets

<https://www.rethink.org/news-and-stories/news/2019/nov/section-117-after-care-personal-health-budgets/>

Further information

A simple guide to Section 117 aftercare

<http://www.peteredwardslaw.com/opinion/a-simple-guide-to-section-117-aftercare/>

What is Care Programme Approach?

Care Programme Approach (CPA) is the national framework used to assess, plan and coordinate the aftercare of those who may need support from multiple agencies when they are discharged from mental health hospital.

The ultimate aim of CPA is to keep patients in the community, with as few restrictions as possible, to reduce the risk of them becoming mentally unwell again and being readmitted to hospital.

How does CPA work?

Central to CPA is the CPA care plan. This aims to ensure a transparent, accountable and coordinated approach to meeting wide ranging physical, psychological, emotional and social needs, which are associated with a person's mental disorder. A CPA care plan includes:

- a treatment plan that details medical, nursing, psychological and other therapeutic support for the purpose of meeting individual needs promoting recovery and/or preventing deterioration;
- details regarding any prescribed medications;
- details of any actions to address physical health problems or reduce the likelihood of health inequalities;

- details of how the person will be supported to achieve their personal goals;
- support provided in relation to social needs, such as housing, occupation, finances etc;
- support provided to carers;
- actions to be taken in the event of a deterioration of a person's presentation; and
- guidance on actions to be taken in the event of a crisis.

The CPA requires the clear identification of a named registered professional who has responsibility for co-ordinating the preparation, implementation and evaluation of the CPA care plan.

Planning for discharge using the CPA framework should start when someone is admitted to Mental Health Hospital. A review of the care plan should be carried out every 6 months or sooner, at the request of the patient or anyone involved in providing support, including family or carers.

Chapter 33 of the *Mental Health Act Code of Practice* (page 357) provides guidance regarding aftercare. The guidance covers both aftercare planning and direct payments. Chapter 34 covers the Care Programme Approach (page 362). You can read this here https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/435512/MHA_Code_of_Practice.PDF

CPA for children and young people under the age of 18

Where the patient is under the age of 18, the responsible clinician and the care co-ordinator should bear in mind that the most age-appropriate treatment should be that provided by a child and adolescent mental health service (CAMHS).

Professionals with specialist expertise should also be involved in care planning for people with autistic spectrum disorders or learning disabilities.

It may also be necessary to involve the patient's parent, or whoever will be responsible for looking after the patient, to ensure that they will be ready and able to provide the assistance and support which the patient may need.

Prior to their discharge from hospital, all children and young people should have an assessment of their needs, on which a care plan for their aftercare is based.

Guidance on the duty to provide after-care under Section 117 of the Act is covered in *MHA Code of Practice* Chapter 33. (page 357). You can find this here.

https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/435512/MHA_Code_of_Practice.PDF

Further information

Mental Health Act 1983: Code of Practice (Page 362)

https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/435512/MHA_Code_of_Practice.PDF

Mental Health Act 1983 Code of Practice: Section 117

<https://www.legislation.gov.uk/ukpga/1983/20/section/117>

Care Programme Approach

<https://www.southwestyorkshire.nhs.uk/service-users-and-carers/your-rights/care-programme-approach/>

Making the CPA work for you (2008)

https://webarchive.nationalarchives.gov.uk/20130105012325/http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_083651.pdf

What is Section 17 leave?

A responsible clinician can give Section 17 leave to allow a detained patient a short time away from hospital. This is known as 'leave of absence'. This is often an important part of the patient's treatment plan as they recover to help them reintegrate and ultimately be discharged back home.

As leave carries with it some degree of risk, a decision to grant leave should be decided on only after careful discussion and consideration. The responsible clinician must carry out an assessment in accordance with the legal framework (*Mental Health Act (MHA) Code of Practice*, Chapter 27, para 10) before any decision is made.

How long can Section 17 leave last for?

Leave should be of short duration and not normally more than seven days. Only the patient's responsible clinician can authorise leave of absence to a patient detained under the MHA. If leave is granted, it will be subject to any conditions, which the responsible clinician considers necessary in the interests of the patient or for the protection of other persons.

What is grounds leave?

Section 17 covers time spent away from hospital. Since 'grounds leave' is still within the grounds of the hospital, there is no legal requirement for this type of leave to be authorised under Section 17. Restricted patients may be subject to additional restrictions.

Who is allowed Section 17 leave?

Section 17 leave is permitted for all patients, except for those detained under Sections 5(4), 5(2), 4, 35, 36, 38, 135 and 136 of the MHA.

Further Reading

Mental Health Act Section 17

<https://www.legislation.gov.uk/ukpga/1983/20/section/17>

Mental Health Act Code of Practice

<https://www.gov.uk/government/publications/code-of-practice-mental-health-act-1983>

Recommended reading

Mental Health Act 1983

<https://www.legislation.gov.uk/ukpga/1983/20/contents>

Mental Health Act Code of Practice

<https://www.gov.uk/government/publications/code-of-practice-mental-health-act-1983>

Mental health advocacy & human rights: your guide

http://www.thebromleytrust.org.uk/Indexhibit/files/BIHR_mentalhealthguide.pdf

My family member has been sent to an inpatient unit - what do I need to know?

<https://www.challengingbehaviour.org.uk/learning-disability-files/4-My-family-member-has-been-sent-to-an-inpatient-unit---what-do-I-need-to-know.pdf>

Being Sectioned (in England and Wales)

<https://www.rcpsych.ac.uk/mental-health/treatments-and-wellbeing/being-sectioned>

Making a complaint

https://youngminds.org.uk/media/2802/youngminds_making-a-complaint-resource.pdf

Starting difficult conversations

<https://youngminds.org.uk/media/2800/starting-difficult-conversations.pdf>

Detention under the Mental Health Act and Deprivation of Liberty what is it and how can it be challenged?

[http://www.tvedwards.com/cms/documents/
FINAL__Detention_and_CC_guidance_for_Respond_26_5_14.pdf](http://www.tvedwards.com/cms/documents/FINAL__Detention_and_CC_guidance_for_Respond_26_5_14.pdf)

Mental Health Act: Training and Resource Guide 2018 – Black Country NHS

[https://www.bcpft.nhs.uk/documents/policies/m/1489-mental-
health-act-training-resource/file](https://www.bcpft.nhs.uk/documents/policies/m/1489-mental-health-act-training-resource/file)

14. Mental Capacity Act – a reference guide

What is the Mental Capacity Act?

This chapter focusses on the Mental Capacity Act 2005 (MCA). This law provides a statutory framework for people (aged 16 and over) who lack the mental capacity to make decisions for themselves.

The MCA does not generally apply to people under the age of 16. However, there are two exceptions.

- If a child lacks capacity, and is likely to still lack capacity to make financial decisions when they reach the age of 18, the Court of Protection can make decisions about their property or finances (or appoint a deputy to make these decisions).
- Offences of ill treatment or wilful neglect of a person who lacks capacity can also apply to victims younger than 16.

This chapter also provides guidance for those who have capacity but want to make preparations for a time when they may lack capacity in the future. It sets out who can take decisions, in which situations, and how they should go about this.

Further Information

Mental Capacity Act 2005 <https://www.legislation.gov.uk/ukpga/2005/9/contents>

Mental Capacity Act Code of Practice <https://www.gov.uk/government/publications/mental-capacity-act-code-of-practice>

Using the Mental Capacity Act

<https://www.hft.org.uk/wp-content/uploads/2017/08/Using-the-MCA.pdf>

Making decisions and young people

In this chapter, we refer to 'young people' as anyone aged 16 or 17 years old.

Unless a young person is formally detained under the Mental Health Act (MHA), medical treatment can be given to them with their consent if they are considered 'competent' (as explained below).

Regardless of age, emergency treatment can be given without consent to save the life of, or prevent serious deterioration in the health of, a person.

Young people should be involved as much as possible in decisions about their care, even when they are not able to make decisions on their own. In practice, this could mean:

- giving young people and parents (if involved) information about the treatment;
- giving accessible information leaflets about different treatments;
- asking the young person for their views about the treatment before starting it;
- getting session-by-session feedback on the treatment being given; and
- discussing with the young person and/or parents (as appropriate) other treatment options, and the advantages/disadvantages of each one, if symptoms are not improving.

Please note: This is not an exhaustive guide. However, it aims to give an accessible overview of the most important points in the MCA for families of a person who is admitted to hospital for assessment and treatment under section of the MHA. It is therefore written from the point of view of families (i.e. not the person with mental health illness, learning disabilities and/or autism and behaviour that challenges others).

About capacity

What does 'lack capacity' mean?

One of the most important terms in the Mental Capacity Act (MCA) is 'a person who lacks capacity'. The MCA explains the term (in Part 1, Section 2, para 1, which you can view here <https://www.legislation.gov.uk/ukpga/2005/9/section/2>). It states:

For the purposes of this Act, a person lacks capacity in relation to a matter if at the material time he is unable to make a decision for himself in relation to the matter because of an impairment of, or a disturbance in the functioning of, the mind or brain.

A person lacks capacity if they are unable to make a particular decision, or take a particular action for themselves, at the time the decision or action needs to be taken. This might be because of illness, injury, a learning disability, or mental health problems that affect the way their brain works.

A person's capacity must be assessed specifically in terms of their ability to make a particular decision at the time it needs to be made.

They will be assessed as lacking the capacity to make a specific decision, and needing an IMCA, if they cannot do one or more of the following:

- understand information given to them about the decision;
- retain the information for long enough to make the decision;
- use or weigh up the information as part of the decision-making process; and
- communicate their decision (by any means, e.g. talking, sign language or blinking).

This process is explained in detail below.

How is capacity assessed?

At the heart of the MCA are five statutory principles that underpin the legal requirements in the Act.

1. A person must be assumed to have capacity, unless it is established that they lack capacity.
2. A person is not to be treated as unable to make a decision, unless all practicable steps to help them to do so have been taken without success.
3. A person is not to be treated as lacking capacity to make decision simply because they make an unwise decision.
4. An act done, or decision made for or on behalf of a person who lacks capacity, must be done, or made, in their best interests.
5. Any act done for, or any decision made on behalf of, someone who lacks capacity should be an option that is the least restrictive of their basic rights and freedoms – as long as it is still in their best interests.

The *MCA Code of Practice* includes an important 'two-stage test of capacity'. As stated earlier, people should be assumed to have capacity, unless there is clear evidence otherwise. The focus of the test must be the person's capacity to make a particular decision at the time it needs to be made.

THE 'TWO-STAGE TEST' OF CAPACITY

Stage 1: Does the person have an impairment of, or a disturbance in the functioning of, their mind or brain?

- Does the person have an impairment of the mind or brain, or is there some sort of disturbance affecting the way their mind or brain works, whether temporary or permanent?
- If so, does that impairment or disturbance mean the person is unable to make the decision in question at the time it needs to be made?

Stage 2: Does the impairment or disturbance mean that the person is unable to make a specific decision when they need to?

- Does the person have a general understanding of what decision they need to make and why they need to make it?
- Does the person have a general understanding of the likely consequences of making, or not making, this decision?
- Is the person able to understand, retain, use and weigh up the information relevant to this decision?
- Can the person communicate their decision (by talking, using sign language or any other means)? Would the services of a professional (e.g. a speech and language therapist) be helpful?

If a person cannot do any one of the above things, they will lack the capacity to make the decision. No one can be said to lack capacity on the basis of a particular diagnosis. The second part of the capacity test must always be considered.

If the person is found to lack capacity, a decision will have to be taken in their best interests. You can find out more about best interest decisions later on in this chapter, on *page 141*.

When is a young person considered competent to consent?

- **Young People aged 16 or 17 with capacity** are presumed in law to be competent and can therefore consent to their own treatment. This does not include some rarer types of procedure (e.g. organ donation, non-therapeutic procedures or research). However, a court can override

a decision where it believes treatment would lead, in all probability, to the death – or severe, permanent injury – to the young person.

- **Young people aged 16 and 17 who are thought to lack capacity:** most of the Mental Health Act applies. There are three exceptions.
 - Only people aged 18 and over can make a Lasting Power of Attorney (LPA).
 - Only people aged 18 and over can make an advance decision to refuse medical treatment.
 - The Court of Protection may only make a statutory will for a person aged 18 and over.

Who decides if a person lacks capacity to make a decision?

As previously explained, a person must be assumed to have capacity, unless it is established that they lack capacity. If a person appears to lack capacity to make a specific decision, a 'decision-maker' must follow the test in the MCA to decide if the person has the capacity to make the decision themselves (please see Two-stage Test of Capacity on the previous page).

For medical treatment, the decision-maker would usually be the doctor in charge. For decisions about where someone lives or adult protection proceedings, this would usually be a social worker or care manager. You can find out more about the role of decision-maker later in this chapter, on *page 142*.

The decision-maker also decides if the person needs an Independent Mental Capacity Advocate (IMCA). You can find out more about IMCAs later in this chapter, on *page 147*.

Making day-to-day decisions

Assessments of capacity to take day-to-day decisions require no formal record to be made. However, it is good practice for paid care workers to keep a record of the steps they take when caring for the person concerned.

Practitioners should make a written record of the decision-making process, which is proportionate to the decision being made. They should then share the record with the person and, with their consent, other appropriate people.

Further information

Mental Capacity Act resource pack:

https://www.mencap.org.uk/sites/default/files/2016-06/mental%20capacity%20act%20resource%20pack_1.pdf

Decision-making and mental capacity: NICE guideline [NG108]

<https://www.nice.org.uk/guidance/ng108/chapter/Recommendations>

About 'best interests' decisions

If a person lacks the mental capacity to make a specific and time-related decision, the decision may be taken 'in their best interest' by others. The Mental Capacity Act (MCA) (Section 1, para 5) makes it clear that '*An act done, or decision made, under this Act for or on behalf of a person who lacks capacity must be done, or made, in his best interests.*'

What does 'best interests' mean?

The best interest principle underpins the MCA. The term 'best interest' is not defined in the MCA. However, the Act does say that those concerned must 'have regard to' the *MCA Code of Practice* in the way that people who might lack mental capacity must be cared for.

The *MCA Code of Practice* provides information and guidance about the best interest process and how decision-making is supposed to work in practice. You can read more about this here. <https://www.gov.uk/government/publications/mental-capacity-act-code-of-practice>

The *MCA Code of Practice* (Chapter 5, para 2, page 67) explains who might be involved in making a 'best interests' decision and what it could apply to.

This principle covers all aspects of financial, personal welfare and healthcare decision-making and actions. It applies to anyone making decisions or acting under the provisions of the Act, including:

- *family carers, other carers and care workers*
- *healthcare and social care staff*
- *attorneys appointed under a Lasting Power of Attorney or registered Enduring Power of Attorney*
- *deputies appointed by the court to make decisions on behalf of someone who lacks capacity, and*
- *the Court of Protection.*

Who can be a decision-maker?

Depending on the decision being made, a number of different people may be required to make decisions for, or act on behalf of, someone who lacks capacity to make decisions for themselves. The person making the decision is called the 'decision-maker' and it is their responsibility to work out what would be in the best interests of the person who lacks capacity.

The *Mental Capacity Act Code of Practice* (page 69) explains who can be a decision-maker.

- For most day-to-day decisions the decision-maker will be the carer most directly involved with the person at the time.
- Where the decision involves providing medical treatment, the decision-maker will be the doctor or other member of healthcare staff responsible for carrying out the particular treatment or procedure.
- Where nursing or paid care is provided, the nurse or paid carer will be the decision-maker.
- If a Lasting Power of Attorney (or Enduring Power of Attorney) has been made and registered, or a deputy has been appointed under a court order, the attorney or deputy will be the decision-maker, for decisions within the scope of their authority.

What does the decision-maker do?

The person's wishes and feelings should always be central in the decision-making process and the person should be consulted where possible. Also, carers and family members have a right to be consulted, as appropriate.

According to the *MCA Code of Practice*, a decision-maker must:

- follow the 'Two-Stage' test in the MCA to decide if the person has the capacity to make the decision themselves;
- decide if the person needs an Independent Mental Capacity Advocate (IMCA);
- take into account the information the IMCA provides when working out whether the particular decision is in the best interests of the person; and
- receive a report and closure form from the IMCA on completion of their role.

Best interests meetings

For most day-to-day actions or decisions, the decision-maker will be the carer most directly involved with the person at the time. If making a decision in someone's best interests is complex and cannot be easily made by the decision-maker, even with the support of a health practitioner colleague in the case of medical treatment, a best interests meeting is likely to be required.

The sole purpose of a formal best interests meeting is to make a specific decision about medical treatment or social care for someone who has been assessed as lacking the mental capacity needed to make the decision themselves. The meeting brings together those who know the person the best with selected care staff and health professionals involved in supporting the person, in order to make a joint decision in their best interest.

As previously mentioned, the term 'best interest' is not defined in the Mental Capacity Act. However, the Act does say that those concerned must 'have regard to' the *MCA Code of Practice* in the way that people who might lack mental capacity must be cared for.

The *MCA Code of Practice* provides information and guidance about the best interest process and how decision-making is supposed to work in practice.

You can read it here <https://www.gov.uk/government/publications/mental-capacity-act-code-of-practice>

The decision-making process

To assist with decision-making, the 'Best Interests Checklist' on the following page will help everyone understand what is important to the person, what they love doing or would hate to do.

A 'balance sheet' approach

For bigger decisions, such as a change to where a person lives or a serious medical procedure, it has been recommended that decision-makers should also use a 'balance sheet approach'. This means that they should look at and evaluate all the factors involved in the decision. This could include:

- benefits of the change or procedure;
- disadvantages of the change or procedure;
- possible consequences of the decision and likelihood of these occurring; and
- striking a balance between possible benefits and disadvantages.

A change or procedure should only be viewed to be in the person's best interests if the benefits outweigh the disadvantages. Decision-makers must take into account all the relevant factors, not just those they think are important. They must also provide evidence that the process has acted in the best interest of the person concerned.

You can find out more about carrying out best interests assessments here <https://www.39essex.com/updated-guide-to-best-interests/>

BEST INTERESTS CHECKLIST	✓
Encourage participation - Do whatever is possible (e.g. visual support, easy read information) to help and encourage the person to take part in making the decision.	
Identify all relevant circumstances - Try to identify all the things that the person would take into account if they were making the decision themselves.	
Find out the person's views - Take into account the person's past and present wishes and feelings, any beliefs and values (e.g. religious, cultural, moral or political) and any other factors that would be likely to influence the decision in question if the person were making the decision themselves.	
Avoid discrimination - Do not make assumptions about someone's best interests simply on the basis of the person's age, appearance, condition or behaviour.	
Assess whether the person might regain capacity - Consider whether the person is likely to regain capacity (e.g. after receiving medical treatment). If so, can the decision wait until then?	
If the decision concerns life-sustaining treatment - Do not be motivated in any way by a desire to bring about the person's death or make assumptions about the person's quality of life.	
<p>Consult others - Consult as many relevant people as possible, including anyone previously named by the person, close relatives, carers, friends or others for their views about the person's best interests.</p> <p>For decisions concerning major medical treatment or where the person should live and where there is no one who fits into any of the above categories, an Independent Mental Capacity Advocate (IMCA) must be consulted.</p> <p>Be mindful of the person's right to keep their affairs private, restrict involvement to those listed above and process data in accordance with data protection law.</p>	
Avoid restricting the person's rights - Are there other options that may be less restrictive of the person's rights?	
Take all of this into account - Weigh up all of these factors in order to work out what is in the person's best interests.	
Ensure that you record your best interest decision. This is important not only to keep an accurate record but also as evidence should your decision or decision-making processes later be challenged.	

Recording the decision

The decision-maker should record the process, as well as the decisions made to provide evidence that the decision-maker has acted in the best interest of the person. They will need to confirm that the panel has considered the checklist, together with anything else that the person would think important. They must also include the person's wishes and feelings and why any alternatives were rejected.

Sometimes when making these important decisions, people might have different views about the person's best interests. It's important for the decision-maker to also explain how any disagreements were dealt with.

Families of children and young people may find *Young Minds' Parents guide to mental capacity* helpful. You can read this here [https://](https://youngminds.org.uk/find-help/for-parents/parents-guide-to-support-a-z/parents-guide-to-support-mental-capacity-act-2005/)

youngminds.org.uk/find-help/for-parents/parents-guide-to-support-a-z/parents-guide-to-support-mental-capacity-act-2005/

What if I feel I am not being appropriately consulted?

If you are concerned that you are not being consulted about the welfare of your loved one, you can write to the decision-maker and express your concerns. If you are then not satisfied with their response, you can make a formal complaint in writing to the provider concerned, in accordance with their complaints policy.

What if I disagree with the decision?

If you disagree with the decision that is made, you can:

- check that an independent advocate has been involved
- ask for a second opinion
- ask the decision-maker for a best interests meeting
- ask for a mediation
- apply for a court of protection.

You can find out more about making decisions and disputes here <https://www.ouh.nhs.uk/patient-guide/safeguarding/documents/health-workers-guide.pdf>

What is an Independent Mental Capacity Advocate?

Independent Mental Capacity Advocates (IMCAs) are specialist advocates who provide safeguards for adults when they lack capacity to make some important decisions.

The IMCA service is provided under the Mental Capacity Act (MCA). The *MCA Code of Practice* (Chapter 10, para 8) states that '*Local authorities or NHS organisations are responsible for instructing an IMCA to represent a person who lacks capacity. In these circumstances they are called the 'responsible body'.*

People over the age of 16 have a statutory right to an IMCA if they:

- lack capacity to make a specified decision at the time it needs to be made;
- are facing a decision about a long-term move or about serious medical treatment, or are subject to deprivation of liberty safeguards (DoLS); and/or
- have nobody else who is willing and able to represent them or be consulted in the process of working out their best interests.

What does an IMCA do?

The role of an IMCA is to ensure that people are as involved as possible in major decisions about their lives, and that any decisions made on a person's behalf are made in that person's best interests. They:

- provide statutory advocacy;
- are instructed to support and represent people who lack capacity to make decisions on specific issues;
- have a right to meet in private the person they are supporting;
- are allowed access to relevant healthcare records and social care records;
- provide support and representation specifically while the decision is being made; and
- act quickly so their report can form part of decision-making.

The IMCA will make sure that decision-makers uphold the person's rights and ensure that they choose the least restrictive option for the person.

Please note

- a. The IMCA does not make decisions and does not do capacity tests. The IMCA provides information that the decision-maker must take into consideration in reaching a decision in the person's best interests.
- b. In situations where an urgent decision is needed quickly (e.g. to save life or when serious medical intervention is needed), a decision will immediately be made in their best interests without consulting an IMCA.

Further information

Independent Mental Capacity Advocacy (IMCA) – Voice Ability

<https://www.voiceability.org/about-advocacy/independent-mental-capacity-advocacy>

Making decisions The Independent Mental Capacity Advocate (IMCA) service

https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/365629/making-decisions-opg606-1207.pdf

Recommended reading

Mental Capacity Act 2005

<https://www.legislation.gov.uk/ukpga/2005/9/contents>

Mental Capacity Act Code of Practice

<https://www.gov.uk/government/publications/mental-capacity-act-code-of-practice>

How does the Act apply to children and young people? (Page 216)

<https://www.gov.uk/government/publications/mental-capacity-act-code-of-practice>

How do my family member's rights change as they become an adult?

<https://www.challengingbehaviour.org.uk/learning-disability-files/7-How-do-my-family-members-rights-change-as-they-become-an-adult.pdf>

My Adult – Still My Child

<http://myadultstillmychild.co.uk/>

Making decisions - A guide for family, friends and other unpaid carers

https://professionals.carers.org/sites/default/files/the-mental-capacity-act-a-guide-for-family-friends-other-unpaid-carers-web-version-2029_0.pdf

Making decisions: The Independent Mental Capacity Advocate (IMCA) service

https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/365629/making-decisions-opg606-1207.pdf

The Mental Capacity Act - Mencap

<https://www.mencap.org.uk/advice-and-support/mental-capacity-act>

Making everyday decisions post 16 | Down's Syndrome Association

<https://www.downs-syndrome.org.uk/for-families-and-carers/making-everyday-decisions-post-16/>

Getting legal authority to make decisions about money, property & welfare

[https://www.challengingbehaviour.org.uk/learning-disability-files/15-Making-Decisions-\(new-no.\).pdf](https://www.challengingbehaviour.org.uk/learning-disability-files/15-Making-Decisions-(new-no.).pdf)

Best Interest Meetings Guidance

<https://www.scie.org.uk/files/mca/directory/best-interests-meetings-guidance.pdf?res=true>

Glossary

Advance decision

An advance decision allows a person to decide in advance about specific treatments that they do not want to receive in the future. Its purpose is to ensure that, if they are not able to make decisions at the time, they are not forced to receive treatment that they would not want.

Advocacy

Sometimes, it can be difficult for a person make a decision if the choices are hard to understand, especially if they live with a learning disability. An independent advocate is someone who can help people who lack capacity (see below) to make important decisions (e.g. about their health care). They can help a person to understand what the decision is about and explain the choices available. They support the person to ask questions if they are not sure what to do, and to make sure that their voice and final decision are heard.

Aftercare

Please see 'Section 117 Aftercare'.

Antipsychotic medication

These drugs are mainly used to treat a range of mental health conditions such as schizophrenia and other psychoses, agitation, severe anxiety, mania and violent or dangerously impulsive behaviour.

Approved Clinician

An Approved Clinician is a mental health professional approved by the Secretary of State to act as an approved clinician for the purposes of the Mental Health Act. Some decisions under the Act can only be taken by people who are Approved Clinicians.

Approved Mental Health Professional

An Approved Mental Health Professional (AMPH) is a social worker or other professional approved by a local authority to carry out a variety of functions under the Mental Health Act (e.g. making applications for the detention of individuals in hospital).

Assessment and Treatment Unit

An Assessment and Treatment Unit (ATU) is a hospital inpatient unit designed to provide hopefully short-term secure placements for people with learning disabilities, autism or both, who have been admitted following a crisis in the community. While in the ATU, a patient's needs are assessed and a treatment programme is established. When ready, they are discharged back into the community, with support if necessary.

Autism

Autism is a term used to describe a group of developmental disorders (including Asperger Syndrome and Pathological Demand Avoidance) that affect a person across their lifespan, from childhood through to later life. The core difficulties individuals with autism relate to:

- communication and language
- social interaction and emotional expression, and
- social imagination.

In addition, individuals with autism may differ from other people in how they process sensory information. They may also display patterns of restricted and repetitive behaviour. People with autism may experience anxiety at times as a result of the core difficulties associated with the condition.

Behaviour Support Plan

A behaviour support plan aims to understand and manage behaviour in children and adults who have learning disabilities and display behaviour that others may find challenging. A good behaviour support plan sets out possible triggers and provides alternative ways of meeting a person's needs to avoid them resorting to challenging behaviour. All strategies should be based upon the least restrictive principles in relation to managing risk.

Best interests

If a person is unable to make a decision due to a lack of mental capacity (e.g. consent to medical treatment), any decision must be made in the person's best interests, in accordance with the best interests process stated in the Mental Capacity Act 2005. (Please see 'best interests principles' below).

Best interest principles

Section 1 of the Mental Capacity Act 2005 sets out the five 'statutory principles' or values that underpin the legal requirements in the Act, listed below.

Principle 1: A person must be assumed to have capacity unless it is established that he lacks capacity.

Principle 2: A person is not to be treated as unable to make a decision unless all practicable steps to help him to do so have been taken without success.

Principle 3: A person is not to be treated as unable to make a decision merely because he makes an unwise decision.

Principle 4: An act done, or decision made, under this Act for or on behalf of a person who lacks capacity must be done, or made, in his best interests.

Principle 5: Before the act is done, or the decision is made, regard must be had to whether the purpose for which it is needed can be as effectively achieved in a way that is less restrictive of the person's rights and freedom of action.

Capacity

Mental capacity is the ability of an individual to make their own decisions. Decisions about mental capacity, where there is uncertainty, are governed by the Mental Capacity Act (2005). A capacity check has to be for a specific reason and carried out at the time it needs to be made, as capacity can come and go.

Care and Treatment Review

A Care and Treatment Review (CTR) is a review carried out for an adult living with a learning disability and/or autism who is either at risk of admission to,

or is an inpatient in, a hospital Assessment and Treatment Unit (ATU). The aim of a CTR will be to avoid admission wherever possible, make sure that ongoing inpatient treatment meets the person's needs or to plan their discharge from hospital.

Care Coordinator

This is a mental health professional that coordinates the care of a young person.

Care Education and Treatment Review

A Care Education and Treatment Review (CETR) is a review carried out for a child or young person living with a learning disability and/or autism who is either at risk of admission to, or is an inpatient in, a hospital assessment and treatment unit (ATU). The aim of a CETR will be to avoid admission wherever possible, make sure that ongoing inpatient treatment meets the person's needs or to plan their discharge from hospital. A CETR is the same as a CTR but also includes education alongside health and care.

Care Programme Approach

Care Programme Approach (CPA) provides a programme of community care, which is managed by a care coordinator in line with an agreed care plan. CPA is for patients who have a mental health problem, a learning disability or who are otherwise vulnerable and need additional support in the community to stay safe and well.

CPA Meeting

CPA Meetings are held in hospital regularly to review and adapt a patient's treatment plan to best meet their needs. CPA brings together members of the hospital, family and other healthcare and education professionals (CAMHS, Social care, school, etc.) who are involved in the care and treatment of the child or young person. The CPA care coordinator will also inform and coordinate the discharge process, to make sure that everyone works together to provide appropriate care and support during and after discharge.

Care Plan

A Care Plan sets out in detail how a person's needs are to be met. The Plan is then used by all those involved to ensure that continuity of care is maintained, and needs are met appropriately and consistently.

Care Review

A Care review is held to check that a person's current needs are being met. The review will be carried out with the organisation responsible for providing the care and support.

Care Quality Commission

The Care Quality Commission (CQC) regulates all health and adult social care in England.

Case Manager

Case managers assess, plan, facilitate and coordinate the services required to meet your child's needs. They should liaise with all those involved in your child's education, treatment and care, including you, your child, inpatient and community services, local authorities and educational provisions.

Challenging behaviour

Challenging Behaviour: A Unified Approach, Royal College of Psychiatrists et al, 2007 (page 14), defines 'challenging behaviour' as behaviour 'of such an intensity, frequency or duration as to threaten the quality of life and/or the physical safety of the individual or others, and is likely to lead to responses that are restrictive, aversive or result in exclusion.'

It is important to recognise that 'challenging behaviour' is not a diagnosis or a condition in itself. In people with learning disability, autism or both, challenging behaviour often communicates an unmet need. If this need is met, the need for the behaviour disappears. (Please also see 'Positive Behaviour Support' below).

Child and Adolescent Mental Health Services

Child and Adolescent Mental Health Services (CAMHS) provide specialist mental health services for children and young people experiencing emotional or behavioural wellbeing, and psychiatric problems up to the age of 18,

including those living with learning disability or autism. They also work with the whole family to help them support the young person.

Child in need

A child in need is defined as a child who:

- (a) is unlikely to achieve or maintain, or to have the opportunity of achieving or maintaining, a reasonable standard of health or development without the provision of specified services by a local authority;
- (b) their health or development is likely to be significantly impaired, or further impaired, without the provision of such services; or
- (c) is disabled.

Children Act

The Children Act 1989 is a key piece of legislation dealing with the responsibilities of individuals and the state towards children and young people in meeting their welfare needs.

Civil Patient

A civil patient is a patient who has not been convicted of a criminal offence.

Clinical Commissioning Group

A Clinical Commissioning Group (CCG) is a clinically led organisation that has two important roles: they are responsible for commissioning community and secondary care services for their local populations; and they have a legal duty to support quality improvement in general practice. Commissioning involves deciding what services are needed for diverse local populations and ensuring that they are provided.

Code of Practice

A Code of Practice sets out written rules explaining how people should act and behave when doing their jobs. This guide refers to both the MHA and the MCA. These provide statutory guidance to registered medical practitioners, approved clinicians, managers, staff, providers and approved mental health professionals on how they should carry out their functions under these Acts.

Commissioner

A commissioner is someone who is responsible for planning and delivering a specified service, over which s/he has authority. In the context of this guide, the commissioner may be responsible to a local or regional organisation for the delivery of health, social care or education services. Their authority will be governed by their contracted role and terms of reference.

Community Treatment Order

A Community Treatment Order (CTO) is a legal authority that allows a patient to be discharged from hospital under certain conditions. Community patients are expected to comply with the conditions specified in the CTO or face the possibility of recall to hospital for further medical treatment if necessary.

Competency

The degree to which a child or young person has the ability (mental capacity) to be able to understand and make their own decisions regarding their care and treatment.

Consent

Before anyone over the age of 16 is given any medical treatment, test or examination, they must provide their consent in accordance with the Mental Capacity Act.

For children under 16 the 'Gillick Test for Competence' provides the means to determine 'competence' to make a decision. In an emergency, obtaining consent may not be necessary.

Consent can be given by the patient verbally, indicated non-verbally or in writing. It must be obtained voluntarily, having provided the patient with sufficient information with which to make an informed choice.

Court of Protection

The Court of Protection was set up under the Mental Capacity Act. It exists to safeguard vulnerable people and deals with financial or welfare matters relating to people who lack capacity to take decisions for themselves.

Deprivation of Liberty Safeguards

Deprivation of Liberty Safeguards (DoLS) are part of the Mental Capacity Act. DoLS exist to make sure people who cannot consent to their care arrangements in a care home or hospital are looked after in a way that does not inappropriately restrict their freedom. To deprive a person of their liberty, care homes and hospitals must request standard authorisation from a local authority.

Deputy

A deputy is a person appointed by the Court of Protection under the Mental Capacity Act 2005 (MCA) to take specified decisions on behalf of someone who lacks capacity to take those decisions themselves.

Detained

A person is detained if they are being kept in hospital under a Section of the Mental Health Act and are not free to leave.

Detention

This refers to a patient who is held compulsorily in hospital under the Mental Health Act for a period of assessment or medical treatment.

Dietetic therapies

Therapies that relate to diet and nutrition.

Discharge

The process of ending a period of confinement in hospital under mental health section.

Displacement

Any Nearest Relative thought to be unsuitable by a County Court can be 'displaced' (removed) as the result of an application by the patient, any relative of the patient, anyone with whom the patient is residing or an Approved Mental Health Professional. Another person is then appointed.

Dynamic Register

A Dynamic Register is used by local health and care teams to identify and prioritise the needs of people living with learning disabilities and/or autism who also have behaviour that challenge or mental illness, and who may be at risk of admission to mental health hospital. This might be as a result of a change in needs and/or a failure in their care and support.

Electroconvulsive therapy

Electroconvulsive therapy (ECT) is a treatment that involves sending an electrical current to stimulate the brain. It is used for treatment-resistant depression, mania and catatonia.

Enduring Power of Attorney

Enduring Power of Attorney (EPA) gives the appointed person the authority to manage the property and financial affairs of another person should they become unable to make financial decisions. EPAs can no longer be created and have been replaced by Lasting Power of Attorney (LPA) (please see below).

Equality Act

The Equality Act protects a person if they are discriminated against because of: age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex and sexual orientation. Organisations have a legal duty to comply with the Equality Act.

Family Therapist

A family therapist is a professional who works with the whole family. A family therapist helps families to think about changes they can make so everyone gets on better.

Formal admission

Admission to a hospital for care and treatment under a section of the Mental Health Act.

Formal patient

A formal patient is a person who has been detained (or kept) in hospital, without their consent, under the terms of the Mental Health Act.

General Practitioner

General Practitioners (GPs) provide confidential patient consultations and primary medical care for patients of all ages within a community-based setting. GPs have knowledge of a broad range of illnesses, treat all common medical conditions and refer patients to hospitals and other medical services for urgent and specialist treatment.

Gillick Competence

This is a standard used to decide whether or not a child under 16 has sufficient understanding of the nature, purpose, and consequences of a proposed treatment, in order to provide consent in their own right, without parental knowledge or agreement.

Grounds leave

Grounds leave is a period of time that a detained patient is permitted to spend outside the hospital buildings, but still within the grounds of the hospital. Except for certain restricted patients, no formal procedure is required to allow patients to move within a hospital or its grounds.

Guardian

A Guardian has the legal authority to provide help and support to a vulnerable patient (aged 16 or over) in the community for their own welfare or to protect other people where achieving positive outcomes without the use of such an authority would not be possible.

Care professional

This refers to all staff who may be involved in patient care, both qualified and non-qualified.

Hospital managers

Also known as Mental Health Act managers, these professionals have certain duties under the Mental Health Act and are responsible for administering the use of the Act in the hospital (e.g. hearing patients' applications to be discharged).

Hospital managers' hearing

This is a meeting held to review the need for a patient to continue to be detained under mental health Section. The hospital managers' panel has the power to discharge a patient if they decide that detention is no longer required.

Human rights

Human rights are the basic rights and freedoms that belong to all people. In the UK, a person's human rights are protected by the Human Rights Act 1998.

Independent Mental Capacity Advocate

If a person has an illness or disability that results in them lacking the mental capacity required to make a specific decision, an IMCA can be appointed to advocate for the person, help them with decision-making, make sure that their rights are upheld and their voice is heard.

Independent Mental Health Advocate

An Independent Mental Health Advocate (IMHA) is an independent professional who is trained to work within the framework of the Mental Health Act 1983. They support people to understand their rights under the Mental Health Act and to participate in decisions about their care and treatment.

Informal patient

This is a patient who is attending the hospital on a voluntary (with their consent) basis.

Interim care order

If a Local Authority believes a child to be at risk, it can apply for a court to consider whether a child should be taken into care. The Court can issue an Interim Care Order (ICO). This is a temporary order that gives the LA parental responsibility during the court proceedings. This order only lasts until the end of the court case.

Judicial Review

A Judicial Review is a type of court procedure in which a Judge reviews a public authority's decision or action, and decides whether it is lawful or not.

Key worker

A key worker is a care professional who takes a key role in co-ordinating the care of the patient, promoting continuity in accordance with the Care Plan and ensuring the patient knows where to obtain information and advice. The key worker also acts as a central point of contact for patients, their family or carers.

Lasting Power of Attorney

A lasting power of attorney (LPA) is a legal document that allows a person to appoint one or more people (known as 'attorneys') to help them make decisions, or to make decisions on their behalf, should they in future develop an illness or disability, which prevents them from making their own decisions.

Learning Disability

According to the Department of Health and Social Care's *Valuing People* (2001) policy paper, a person with a learning disability is someone who, from childhood, has had a significantly reduced ability to understand new or complex information, to learn new skills and to cope independently.

Least restrictive (principle)

The Mental Capacity Act (2005) states that, when making a decision on behalf of someone who lacks mental capacity, any decision must consider if it is possible to decide or act in a way that would interfere less with the

person's rights and freedoms of action, or whether there is a need to decide or act at all.

Legislation

Legislation is a law or a set of laws that have been passed by Parliament.

Local Area Emergency Protocol

Part of the NHS England Care and Treatment programme, the local area emergency protocol is used when someone living with a learning disability and/or autism and displaying challenging behaviour is at imminent risk of being admitted to a hospital assessment and treatment unit (ATU). An urgent meeting or teleconference is held, to try to help the person remain in their community with the right support and to avoid them being admitted to an ATU.

Local Authority

A local authority (LA) is an organisation that is officially responsible for all the public services and facilities in a particular area. Their legal duties include the identification, assessment, education and support of disabled children and young people, providing a Local Offer (a list of local health, education and social care services), and the assessment and support of all residents (including carers) who have eligible social care needs.

Looked after child

A child who has been in the care of their local authority for more than 24 hours is known as a 'looked after child'. Looked after children are also often referred to as 'children in care'.

Mental Capacity

Please see 'Capacity'.

Mental Capacity Act

The Mental Capacity Act (MCA) is a law that protects and supports people who may have difficulty in making some of their own decisions. It ensures that they are given all necessary support to make every decision they are

able to make, and to contribute towards any decisions made about their lives that they are unable to make themselves.

Mental Capacity Assessment

Sometimes, as the result of a disability or illness, a person might find it difficult to make their own decisions and need some help. Anyone aged 16 and above can be assessed, using the Mental Capacity Act, to work out if they have the mental capacity to make a particular decision. This is called a mental capacity assessment. A person is considered to lack capacity if they cannot do any of these four things:

- understand information given to them about a particular decision;
- retain that information long enough to be able to make the decision;
- weigh up the information available to make the decision; and
- communicate their decision.

Mental disorder

Mental disorder as defined by the Mental Health Act is 'any disorder or disability of the mind'.

Mental Health Act

The Mental Health Act (MHA) is the law that governs the assessment, treatment and rights of people with a mental health disorder, who may be subject to compulsory detention and treatment. The law gives health professionals power (in certain circumstances and without consent) to detain, assess and treat people with mental disorders in the interests of their health and safety, and/or for public safety.

Mental Health Act principles

The five overarching principles of the MHA are:

- Least restrictive option and maximising independence
- Empowerment and involvement
- Respect and dignity
- Purpose and effectiveness
- Efficiency and equity

Mental Health Tribunal

This is a formal meeting in which an independent panel looks at the decision to keep a person in hospital. It has the authority to direct the discharge of any of patients, where it thinks it appropriate.

Multidisciplinary team

A multidisciplinary team (MDT) is made up of a number of professionals from different specialties within health, social care and education working together to meet the needs of patients with complex needs.

National Institute of Clinical Excellence

The National Institute for Health and Care Excellence (NICE) provides national guidance and advice to improve health and social care.

Nearest Relative

The nearest relative is usually a family member who has specific rights and responsibilities under the Mental Health Act (MHA) in respect of a patient for whom they are the nearest relative. Their rights include being kept appropriately informed, requesting an independent assessment of the need for detention, requesting discharge from detention and applying to the Mental Health Tribunal for discharge.

Next of kin

A person who is someone's next of kin is their closest living blood relative. For a child or young person under 18, this will usually be their parents. The degree to which parents are involved in decision-making will depend upon the age and 'competence' of their child or young person to make decisions for themselves. Next of kin is not the same as 'nearest relative' (see above).

Occupational therapy

Occupational therapists work with adults and children of all ages with a wide range of conditions, including people who may have mental health illness, physical or learning disabilities, to help them continue with life skills, work and leisure activities as independently as possible. They treat patients

through specific activities and adaptations to enable them to reach their maximum level of function and independence.

Ombudsman

The role of the independent Parliamentary and Health Service Ombudsman (PHSO) is to investigate and make final decisions on complaints against the NHS in England, UK government departments or other UK public organisations, where it has not been possible to resolve them using the respective local complaints mechanisms.

Parental Responsibility

Under the Children Act 1989, parental responsibility means all the rights, duties, powers, responsibilities and authority that, by law, a parent of a child has in relation to the child and his or her property.

Patient Advice and Liaison Service

Patient Advice and Liaison Service (PALS) is an all-age, confidential service providing advice, support and information to help patients, families and carers navigate NHS services. PALS staff answer questions and hear compliments, comments, concerns or complaints about NHS services. They can help to resolve problems by discussing the available options and offering further assistance, if required.

Person-centred support

This helps a person plan all aspects of their life. Putting the person at the heart of their care gives them the opportunity to take control of the things that are important to them and the outcomes that they want to achieve. Person-centred planning is an ongoing process, requiring regular reviews to make allowances for any changes in need or priority.

Psychiatric intensive care unit

A psychiatric intensive care unit (PICU) is a secure (locked) ward in a hospital, which provides crisis care for patients experiencing an acute deterioration in their mental health that poses a serious risk to themselves or to others. PICU stays should normally only be short (a few weeks) and a patient returned to a less restrictive environment as soon as possible.

Psychiatrist

A psychiatrist is a doctor who has undergone additional training to specialise in psychiatry. Psychiatry is the study of mental disorders. Psychiatrists treat a range of mental health problems and conditions, including depression, anxiety, substance misuse and eating disorders.

Psychologist

Psychology is the scientific study of the mind, and how it affects and influences behaviour, examining things such as thoughts and emotions, communication and memory. Clinical psychologists work with a wide range of mental and physical health problems, including anxiety, depression, learning difficulties, and relationship issues.

Psychotropic medication

These are drugs that affect psychological function (the way the brain works). They include drugs to treat a wide range of conditions, such as depression, severe anxiety, bipolar disorder, psychosis, schizoaffective disorder and schizophrenia.

Psychosurgery

Psychosurgery (also known as neurosurgery) is a surgical operation that destroys brain tissue to treat psychological disorders. This is not recommended by the National Institute for Clinical Excellence (NICE) and is only performed in very rare cases, when all other interventions have failed.

Physiotherapist

Physiotherapists help people who have a range of movement problems caused by injury, illness or disability, through movement and exercise, manual therapy, education and advice.

Positive Behaviour Support

Positive Behaviour Support (PBS) is a person-centred and structured approach to supporting people with a learning disability and/or autism who

display challenging behaviours. PBS focuses supporting positive behaviours and teaching new skills, rather than trying to contain the behaviours. Challenging behaviours are assessed to identify what they mean for the person (its 'function' or 'purpose'), and then support is given to adapt the environment, make reasonable adjustments and help a person develop the skills they need to meet the behaviour's function, so there is no longer any need for it.

Positive Behaviour Support plan

A PBS plan is a person-centred plan, which is developed following a functional behaviour assessment (please see 'Positive Behaviour Support' above). The plan provides a number of strategies to help understand and manage the challenging behaviour an individual may display. This results in a better quality of life for the person as the behaviour is not only understood, but also their needs are better met, without them having to resort to challenging behaviour.

Primary Care

Primary health care is the first point of contact for most people who need help and advice about health issues. The majority of primary care is provided by general practitioners (GPs), as well as dentists, opticians and community pharmacists in the community. GPs are usually supported in their practice by nurses and may have access to other professionals, such as a pharmacist or occupational therapist.

Psychological therapy

Consists of a range of 'talking' and/or creative therapies that can be used to help patients and their therapists to better understand and treat a number of mental illnesses and psychological problems. This can include one to one therapy sessions with a psychologist, family therapy or by using creative art, drama and music. Care teams should include parents or carers appropriately.

Reasonable adjustments

If you have a disability, public organisations (e.g. health care providers, schools, Local Authorities and shops) have a duty under the Equality Act to take reasonable steps to remove the barriers you may face because of your

disability. They must make 'reasonable adjustments' to make sure that a person with a disability is not disadvantaged and that their services are accessible. These could include, for example, alterations to building access to cater for wheelchair users, providing accessible information, offering longer appointments, or booking a patient in at the start or end of the day to minimise waiting.

Referral

Many of the more specialist health services are not available directly and a referral has to be made through a lead professional or a GP. This is so that the receiving team can check that they are the correct service that can meet a person's needs.

Responsible Clinician

A Responsible Clinician (RC) is the approved clinician with overall responsibility for a person's care and treatment while they are under the Mental Health Act. Certain decisions (e.g. renewing a patient's detention or placing a patient on a community treatment order) can only be taken by the RC.

Restraint

Physical restraint is a type of restrictive intervention that involves any direct physical contact where the intention is to prevent, restrict, or subdue movement of the body (or part of the body) of another person.

Restricted Patient

A restricted patient is someone with a mental disorder who has committed a crime and is detained in hospital for treatment, subject to special controls by the Justice Secretary, due to the level of risk they pose.

Second Opinion Appointed Doctor

A Second Opinion Appointed Doctor (SOAD) is a doctor appointed by the Care Quality Commission to approve certain forms of treatment under the Mental Health Act.

Seclusion

If a person is detained under the Mental Health Act, and displays challenging behaviour that puts others at severe risk of harm, the *MHA Code of Practice* (see above) allows for that person to be isolated away from other patients, against their will, in a place in which they can be safely supervised. Any seclusion or segregation must be undertaken only in a manner that is compliant with human rights.

Section 117 aftercare

A person who has been detained under certain Mental Health Act Sections, (3, 37, 45a, 47 or 48), is entitled to free aftercare services upon discharge from hospital under MHA Section 117. This is a package of health and/or social care commissioned to meet the person's aftercare needs.

'Section 12 approved' doctor

A decision to detain (or section) someone under the Mental Health Act usually requires the agreement of three professionals: an approved mental health practitioner and two doctors. One of the two doctors must be Section 12 approved, which means s/he would have had special training in the diagnosis or treatment of mental disorder.

Section 17 leave

Under the Mental Health Act, a Responsible Clinician (RC) is able to grant a detained patient leave of absence from hospital. It is the only lawful way that a detained patient can be absent from the hospital, even for a very short period of time.

Sectioning

'Sectioning' or 'being sectioned' means being admitted to hospital without the patient's consent for mental health assessment and treatment, in accordance with the Mental Health Act (see above).

Sensory processing

Sensory processing is the way in which the brain receives and makes sense of information received through the senses (including taste, smell, sight, sound, touch, body position and balance/movement). Many people living

with autism have difficulty processing even the most every-day sensory information (e.g. common sounds or soft touch can be felt as painful). Their senses can appear over- or under-sensitive, or both. This can result in sensory overload, which can be very distressing and result in withdrawal, challenging behaviour or meltdown.

Speech and language therapy

A speech and language therapist (SALT) provides treatment, support, advice and care for children and adults who have difficulties with communication (speaking, understanding and using language, understanding and getting on with others), eating, drinking or swallowing.

Statutory consultee

Second Opinion Appointed Doctors (SOADs) are required to consult with two people concerned with the patient's treatment prior to issuing a certificate approving treatment. These people are known as 'statutory consultees'. For guidance on who can carry out this role, please refer to the *Mental Health Act Code of Practice*, Chapter 25, paras 53 – 59.

Statutory guidance

Guidance that is referred to as 'statutory' means it has been decided and controlled by law. While statutory guidance may not impose a legal duty to comply, those to whom the guidance is directed must follow it unless there's a good reason not to. All noncompliance must be recorded as this could result in a legal challenge.

Stopping over medication of people with a learning disability, autism or both

Stopping The Over-Medication of People with learning disability, autism or both (STOMP) is an NHS England campaign to stop psychotropic drugs being wrongly used to overmedicate patients with learning disabilities and/or autism as a means to manage 'challenging behaviour'.

STOMP- STAMP

STOMP is explained above. STAMP stands for Supporting Treatment and Appropriate Medication in Paediatrics. The STOMP-STAMP campaign has

similar aims to STOMP, but is aimed at children and young people with a learning disability, autism or both.

Supervised Community Treatment

Allows patients to be released from hospital and treated in the community under a community treatment order. Community patients are expected to comply with the conditions specified or face the possibility of recall to hospital for further medical treatment if necessary.

Therapeutic Interventions

These are a range of therapies and activities designed to improve mental health and wellbeing, for example: physical activities, dietetic or drug-based interventions and psychological (talking) therapies.

Tier 4

CAMHS services are delivered across four tiers or levels of complexity. Tier 1 provides early intervention and prevention services, Tier 2 is early help and targeted services, Tier 3 a range of specialist CAMHS provision including eating disorder services and finally Tier 4 for those with more severe and specialised care and support needs.

Two-stage test of capacity

This is a test to decide whether or not a person has the capacity to make a particular decision. The following two questions must be answered.

- 1.** Is there an impairment of or disturbance in the functioning of a person's mind or brain? *If so,*
- 2.** Is the impairment or disturbance sufficient that the person lacks the capacity to make a particular decision?

Voluntary patient

This is a patient who has agreed to be admitted to hospital for mental health assessment or treatment voluntarily.

Ward Round meetings

These are weekly meetings held on the hospital ward to discuss the weekly progress of all patients on the ward.

Acronyms

AC	Approved Clinician
AMHP	Approved Mental Health Practitioner
ATU	Assessment and Treatment Unit
BIHR	British Institute of Human Rights
CAMHS	Child and Adolescent Mental Health Service
CCG	Clinical Commissioning Group
CETR	Care, Education and Treatment Review
CPA	Care Programme Approach
CQC	Care Quality Commission
CTO	Community Treatment Order
CTR	Care and Treatment Review
DoLS	Deprivation of Liberty Safeguards
ECHR	European Convention on Human Rights
ECT	Electroconvulsive therapy
GP	General Practitioner
HRA	Human Rights Act
IAPT	Improving Access to Psychological Therapies
IMCA	Independent Mental Capacity Advocate
IMHA	Independent Mental Health Advocate
LA	Local Authority
LPA	Lasting Power of Attorney
LSSA	Local Social Service Authorities
MCA	Mental Capacity Act
MDT	Multidisciplinary Team

MH	Mental Health
MHA	Mental Health Act
NICE	National Institute for Clinical Excellence
NOK	Next of kin
NR	Nearest Relative
OT	Occupational Therapist
PALS	Patient Advice and Liaison Service
PBS	Positive Behaviour Support
PICU	Psychiatric Intensive Care Unit
PRN	<i>pro re nata</i> : a latin term meaning 'as needed medicine'
RC	Responsible Clinician
SALT	Speech and language therapy/therapist
SCIE	Social Care Institute for Excellence
SOAD	Second Opinion Appointed Doctor
STAMP	Supporting Treatment and Appropriate Medication in Paediatrics
STOMP	Stopping The Over-Medication of People with a learning disability, autism or both
UNCRC	United Nations Convention on the Rights of the Child

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Disclaimer

This CAMHS Tier 4 guide has been written by and for parents to provide information about the mental health care system for children and young people under 18 with a learning disability or autism and challenging behaviour, who are thought to be experiencing a mental health difficulty.

The process that families encounter is governed by a number of laws and codes of practice. The legal system is immensely complicated, and we have done our best to try and make this information accessible, understandable and as accurate as possible.

Though the principal author and editorial team do not have any formal legal training, we do have significant lived experience. However, we would stress that we are not providing legal advice. Readers are advised to contact a legal representative for professional support, if necessary.

This guide refers to governmental legislation, NHS policy and guidance, as published and updated as of December 2019.

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