Department
of Health

Stronger Code: Better Care

Government response to the Consultation on the Mental Health Act 1983: Code of Practice

January 2015

Title:
Stronger Code: Better Care – Government response to the Consultation on the Mental Health Act 1983: Code of Practice

Author:
Mental Health Act Code of Practice Review Team, Social Care, Local Government and Care Partnerships Directorate, Department of Health

Document purpose:
Consultation Response

Publication date:
January 2015

Target audience:
Executive directors of health and social care provider organisations; service managers, governance leads and executive quality leads in health and social care services; staff working in health and social care services; enforcement and inspection staff; chairs (and members) of local safeguarding adults boards; lecturers and those who deliver professional training and training in positive behaviour support (or equivalent) and the use of restrictive interventions; academic and research staff; people who use services, family members, carers and parents of people receiving services; independent advocates and organisations; police and people working in criminal justice settings; people supporting victims, professional regulatory bodies; Tribunal staff, local authorities; legal representatives; security staff working in health and social care settings; commissioners of health and social care services.

Contact details:
MHA Code Review, Department of Health 313A Richmond House 79 Whitehall
London SW1A 2NS

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Ministerial Foreword

We are very pleased to introduce this response to the consultation on revising the Mental Health Act 1983: Code of Practice ("the Code"). It is really important to us that a revised Code truly reflects the views and needs of those most affected by it. This is the underlying message behind our consultation and this response: ***Stronger Code: Better Care***.

When we consider that in 2013-14, there were more than 53,000 detentions[1] in England under the Mental Health Act 1983 ("the Act"), we know that the Code really matters to those individuals, their families and carers. It is enormously important too for the healthcare and social care professionals, police, ambulance services and other professionals who come into contact with individuals subject to the Act. It is also important to health commissioners, the Care Quality Commission and the First-tier Tribunal.

In publishing ***Transforming care: A national response to Winterbourne View Hospital*** (2012)[2] and ***Closing the Gap: Priorities for Essential Change in Mental Health*** (2014),[3] we committed to improving the lives of people with mental health conditions, including those with a learning disability. ***Transforming Care*** also committed the Department of Health to review and consult on a revised Code to address the need to improve the quality of care received by patients detained under the Act.

Since the Code was last revised in 2008, there have been substantial changes and updates in legislation, policy, case law, and professional practice. The consultation gave respondents an opportunity to evaluate how policies are being delivered and realised in practice, in areas including the use of restrictive interventions, seclusion, use of police powers to detain people in places of safety, and the use of community treatment orders.

The consultation received almost 350 responses. We are grateful to all who responded and, following consultation, we have made significant amendments to the Code. It is fair to say that every single response has influenced the final revised Code to some extent. We are confident that, in terms of the duration of the consultation, the range of individuals and groups who responded, the various events held nationwide for stakeholders, and the reasonable adjustments made to enable individuals with learning disability and/or other disabilities to participate, this consultation was inclusive, accessible, and received responses from a diverse and broadly representative audience.

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[1] Health and Social Care Information Centre (HSCIC). *Inpatients formally detained in hospitals under the Mental Health Act 1983, and patients subject to supervised community treatment: Annual report, England 2013/14*. 2014. www.hscic.gov.uk/catalogue/PUB15812/inp-det-m-h-a-1983-sup-com-eng-13-14-rep.pdf http://www.hscic.gov.uk/catalogue/PUB15812/inp-det-m-h-a-1983-sup-com-eng-13-14-exp-tab-v2.xls

[2] Department of Health. *Transforming care: A national response to Winterbourne View Hospital*. Department of Health Review. 2012. www.gov.uk/government/uploads/system/uploads/attachment_data/file/213215/final-report.pdf

[3] Department of Health. *Closing the Gap: Priorities for essential change in mental health*. 2014. www.gov.uk/government/uploads/system/uploads/attachment_data/file/281250/Closing_the_gap_V2_-_17_Feb_2014.pdf

This response provides a high-level summary of what we heard from respondents during the consultation, what major changes we have made to specific Code chapters and what we were asked to change but did not. We hope that everyone with an interest in mental health will find it informative and will consider it alongside the published revised Code and updated Reference Guide, which will be published later this year.

The Rt Hon Jeremy Hunt MP
Secretary of State for Health

The Rt Hon Norman Lamb MP
Minister of State for Care and Support

1.0 Introduction

1.1 The ***Mental Health Act 1983: Code of Practice*** ("the Code") gives guidance to health care and social care professionals to inform their practice, safeguard patients' rights and ensure compliance with the law. The Code also aims to help people who are detained or otherwise subject to the Mental Health Act ("the Act"), and their families, carers and advocates know their rights. This response accompanies the proposed Code laid in Parliament on 15 January 2015.[4]

1.2 In publishing ***Transforming care: A national response to Winterbourne View Hospital*** and ***Closing the Gap: Priorities for Essential Change in Mental Health***[5] we committed to improving mental health services. *Closing the Gap* sets out 25 priority actions to improve the provision of mental health care, promote recovery and the experience of patients, their families and carers. ***Transforming Care*** also committed the Department of Health to review and consult on a revised Code to address the need to improve the quality of care received by patients detained under the Act.

1.3 Since the Code was last published in 2008, there have also been substantial changes and updates in legislation, policy, case law, and professional practice. A revised Code is needed which reflects and embeds developments since 2008 in areas including: the use of restrictive interventions; use of police powers to detain people in places of safety; and the use of community treatment orders (CTOs).

1.4 Amongst other developments, the consultation asked respondents to consider: five new guiding principles; updated guidance on how to support children and young people, the use of restrictive interventions including seclusion; police powers and places of safety; and new chapters about care planning, human rights and equality and health inequalities, support for victims and links between the Act and the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards.

1.5 Between 7 July-12 September 2014, the Department of Health led on a consultation with the Ministry of Justice about a new draft Code – ***Stronger Code: Better Care***[6] – for use in England. We allowed several, generally large or national stakeholder organisations, additional time to return responses where requested. This response takes into consideration 344 responses received up to 29 September. In addition we received further responses and input from our consultation events, from our steering group of health and care professionals and from an Expert Reference Group of former patients and carers.

1.6 The consultation response aims to provide: firstly, a summary of overarching messages and key themes identified from the consultation; and secondly, an overview of general trends identified by the consultation on a chapter-by-chapter basis.

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[4] Department of Health. *Mental Health Act 1983: Code of Practice*. 2015. www.gov.uk/government/publications/code-of-practice-mental-health-act-1983

[5] Department of Health. *Closing the Gap: Priorities for essential change in mental health*. 2014. www.gov.uk/government/uploads/system/uploads/attachment_data/file/281250/Closing_the_gap_V2_-_17_Feb_2014.pdf. Department of Health. Transforming care: A national response to Winterbourne View Hospital. Department of Health Review. 2012. www.gov.uk/government/uploads/system/uploads/attachment_data/file/213215/final-report.pdf

[6] Department of Health. *Mental Health Act 1983: Draft Code of Practice for consultation*. 2014. www.gov.uk/government/uploads/system/uploads/attachment_data/file/329778/DoH_Code_of_Practice_accessible.pdf. Department of Health. *Stronger Code: Better Care. Consultation on proposed changes to the Code of Practice: Mental Health Act 1983*. 2014. www.gov.uk/government/uploads/system/uploads/attachment_data/file/327653/Doh_Consultation_for_web.pdf

1.7 Owing to the large volume of responses, which in many cases were very detailed and put forward a range of views and ideas, this Response does not attempt to analyse these in great depth or respond to each suggestion made. This Response is a synopsis of consultation feedback and information received as part of the ongoing review, including legislative changes, case law and stakeholder engagement since July 2014. Each chapter is reviewed under the sub-headings "what we heard", "what we've done" and, if appropriate, we have provided a summary of changes we decided not to make under the heading "what we've not done" and our reasons for this, including in some cases alternative approaches. We have also included a list of further actions in the Action Plan.

1.8 Suggested changes that would have required amendments to the Act were not within the scope of the consultation and the Code review. That said, we have noted these concerns, and will take them forward should a suitable opportunity arise. For example, our accompanying Equality Analysis[7] indicates two changes we wish to consider.

1.9 The exception to this is in relation to section 135 and section 136 (see Chapter 16 of the Code), relating to police powers and places of safety, which the Government separately consulted on in 2014 to explore potential changes to the primary legislation. Any comments received on these two sections through our consultation on the Code were fed into the joint wider review of section 135 and section 136, published by the Home Office and the Department of Health in December 2014.[8]

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[7] Department of Health. *Equality for all: Mental Health Act 1983: Code of Practice: Equality Analysis*. 2015. https://www.gov.uk/government/consultations/changes-to-mental-health-act-1983-code-of-practice

[8] Department of Health and Home Office. *Review of the Operation of Sections 135 and 136 of the Mental Health Act 1983: Review Report and Recommendations*. 2014. www.gov.uk/government/uploads/system/uploads/attachment_data/file/389202/S135_and_S136_of_the_Mental_Health_Act_-_full_outcome.pdf

2.0 Involvement and participation

2.1 Between 7 July and 12 September 2014, the Department of Health ran a public consultation in conjunction with the Ministry of Justice, seeking views on 36 questions relating to the revised Code. An “easy read” version of the consultation document and shorter feedback form with 20 questions was also available). Both versions of the consultation documents were available electronically, by pdf/email or by printed copy, and respondents could also submit responses via our online site.

2.2 We extended the consultation period to 29 September, on request, for a number of larger stakeholders. Overall, there were 344 responses to the consultation, with 47% (162 responses) being from individuals, 41% (142 responses) from organisations or groups. 12% of respondents (40 responses) did not state who they were representing.[9]

2.3 We sought responses from a wide-ranging audience, holding several events for stakeholders including patients, carers, families, legal representatives, social workers, mental healthcare professionals, professional bodies and commissioners, and utilising a range of face-to-face and digital techniques targeting different stakeholder groups. This included holding events on inpatient wards and in community settings.

2.4 Of the 162 responses from individuals, 141 provided information about their gender. Of these, 49% were men and 51% were women. Ninety-nine responses provided information about their age. Of these, 14% were aged 15 years or under, 0% were aged 16-24, 14% were 25-34 years, 20% were 35-44 years, 27% were 45-54 years, 21% were 55-64 years and 3% were 65 or older.

2.5 91 of the 162 individual responses provided information about their ethnicity. Of these, 89% were White, 4% were from mixed ethnic groups, 3% were Black or Black British, 2% were Asian or Asian British and 1% were from other ethnic groups.

2.6 83 of the 162 responses from individuals provided information about whether they had a long-standing physical or mental health condition or disability. Of these, 20% said they had a condition and 80% did not. All of the demographic percentages related only to individual responses, not to the individuals submitting responses on behalf of organisations or groups or participating in events.

2.7 There were generally no statistically significant differences in the feedback expressed according to whether responses were from individuals or organisations, men or women, people from different age or ethnic groups, service user, carer or professional roles or varying locations.

2.8 We consider that, in terms of the duration of the consultation, the range of individuals and groups who responded, the various events held nationwide for stakeholders, (see below) and the reasonable adjustments made for individuals with learning disability and other disabilities to participate, this consultation was inclusive, accessible to and received responses from a diverse and broadly representative audience.

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[9] Information on who responded is based on the independent analysis of responses provided by The Evidence Centre (see below). The Evidence Centre. *Stronger Code: Better Care: Feedback from the consultation about revising the Mental Health Act (1983) Code of Practice*. 2014. Unpublished.

Processing responses

2.9 In addition to the systematic review of each chapter by Government officials, we commissioned an independent organisation, The Evidence Centre.[10]

2.10 The Evidence Centre drew together key themes and analysed responses to the consultation. Each response was read and comments extracted about each consultation question. Information about Code chapters in respect of which no specific consultation question was asked, or where comments did not respond to a specific question or chapter were also extracted. Key trends were identified, focusing on identifying points made by a number of people or organisations. Emphasis was also placed on identifying practical suggestions for redrafting of the Code (rather than the Act, which was outside the remit of the consultation).

2.11 The key findings are summarised in the next section of this response (see Overarching messages). Responses were generally favourable about the changes we proposed to the Code and provided a wide range of suggestions for its continued improvement.

Consultation events:

2.12 As part of the consultation we held more than 25 consultation regional and national events, including events dedicated to a specific theme (e.g. on equality), and a range of events targeting people with particular characteristics (e.g. children and young people under 18, deaf patients, female patients, patients with a learning disability, and carers). This included holding open consultation events, dedicated events in community settings and events on inpatient wards. One event was organised jointly with Black Mental Health UK and focused on the views and experiences of the black African-Caribbean community. They gave feedback of their negative experiences in relation to the operation of the Act in practice.

2.13 These events were crucial in obtaining the views of the widest range of patients possible, including those currently detained, those who have no or limited access to the internet, or those who are unable to read and write. This emphasised that feedback was not being routinely gathered from all patients, and underlined the need for all patients' views to be routinely sought and recorded and, where that is not possible, for the views of independent mental health advocates (IMHAs) and other advocates, families and carers to be sought and recorded. The Department of Health gained valuable insights into how to engage with patients, former patients and their representatives and seek their views, and this consultation process itself advanced equality of opportunity and fostered good relations between groups.

2.14 A full list of Code of Practice consultation and engagement events is shown in the following table:

Figure 1: Consultation events held during the consultation

Date	Event	Location
7 July	Regional public consultation event	Leeds
16 July	Regional public consultation event	Birmingham
22 July	Service users and carers consultation event	Leeds
25 July	College of Social Work event	London
28 July	Regional public consultation event	Taunton
30 July	Service users and carers consultation event	London

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[10] Ibid.

Date	Event	Location
30 July	CQCs Service User Reference Panel	London
31 July	Equality public consultation event	London
5 August AM	Regional public consultation event	London
5 August PM	Regional public consultation event	London
12 August	Inpatient event	Calderstones NHS Foundation Trust
August	Community Care magazine podcast	Online
26 August	Inpatient event	East London NHS Foundation Trust
28 August	Regional public consultation event	London
29 August	Inpatient event	St. Andrew's Healthcare, Northampton
3 September	Inpatient event	West London Mental Health NSH Trust, Broadmoor Hospital
3 September	Royal College of Psychiatrists event	London
4 September	Justice and probation stakeholders event	London and Leeds
5 September	Inpatient event	Partnerships in Care, Manchester
5 September	Inpatient event	Mersey Care NHS Trust, Ashworth Hospital
8 September	Standing Commission on Carers event	London
12 September	4 inpatient events and 1 professionals event	Nottinghamshire Healthcare NHS Trust, Rampton Hospital
13 September	Carers consultation event	Nottinghamshire Healthcare NHS Trust, Wathwood Hospital, Rotherham
17 September	Community consultation event with Black Mental Health UK	London
20 September	Carers consultation event	Nottinghamshire Healthcare NHS Trust, Rampton Hospital
22 September	Webchat	WeNurses online
7 October	Children and young people inpatient event	South London and Maudsley NHS Foundation Trust

Equality Impact:

2.15 We asked questions in the consultation document to explore the equality impact of the changes proposed in the revised Code, including the new dedicated chapter on human rights (chapter 3: Human rights, equality and health inequalities), and whether human rights and human rights are adequately protected, and if not, what changes could be made. We also asked whether the Code provides sufficient information in relation to individuals where additional safeguards or considerations may be required, for example due to age or disability. The analysis of these responses is also included in our accompanying Equality Analysis.[11]

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[11] Department of Health. *Equality for all: Mental Health Act 1983: Code of Practice: Equality Analysis*. 2015. https://www.gov.uk/government/consultations/changes-to-mental-health-act-1983-code-of-practice

3.0 Overarching messages

1. Respondents welcomed the draft revised Code

Consultation responses contained many suggestions for rewording specific paragraphs in the Code, but overall the draft revised Code was welcomed. Responses generally indicated that the Code was well-structured, was an improvement on the previous Code and contained valuable new chapters.

2. Key areas of agreement

There was broad agreement that the proposed guiding principles of the Code provided a sound framework, that guidance about children, young people and other vulnerable groups was clearer than previously, that cross-border arrangements with Wales were clear and that the impact assessment covered core issues.

3. Key areas for suggested change

Respondents made many suggestions for developing the Code further. Common themes were:

- editing the wording to ensure consistency and reduce jargon, so it is easier for service users, carers and family members, professionals and other stakeholders to understand the Code;
- providing an easy read version and taking steps to make the Code widely accessible;
- emphasising the roles of family members, carers and advocates in processes and decisions;
- emphasising the need for staff awareness and training; and
- emphasising the role of commissioners and organisations such as the Care Quality Commission (CQC) in ensuring high quality mental health services are provided to service users.

See also the “Summary of key themes” section of this Response.

4.0 Code Introduction

What we asked you to consider

4.1 The consultation invited responses to these four questions:

Question 1: In your opinion do you believe that the additions to the Code provide sufficient assurance that all commissioners, local authorities and health and care professionals will understand what is expected of them? If not, what more should be included in the Code?

Question 2: Should the proposed Code provide more guidance about appropriate governance arrangements for monitoring duties and powers under the Act? If so, what guidance should be included?

Question 3: In your opinion should any parts of the Code be more specific to determine what 'good' service looks like? If so, please indicate which parts should be more specific and how.

Question 4: In your opinion does the proposed Code provide adequate guidance on local complaints and resolution procedures, specific to the Act? If it does not, please indicate any additional guidance that should be provided.

What we heard

4.2 These four questions related directly to the Introduction and other questions also fed into this. Responses to all four questions indicated that more guidance was desirable.

What we've done

4.3 On question 1, we provided further guidance throughout the Code about those to whom specific guidance is addressed as statutory guidance (or beneficial but not statutory guidance) and made this more explicit in the Introduction by way of tables.[12] We have used the terms "must", "should", "may/could/can" terminology, which are explained in the Introduction so that everyone knows what is expected of them. We have also updated the guidance to clarify how the CQC would inspect against the new Code.

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[12] Department of Health. Introduction, *Mental Health Act 1983: Code of Practice*. 2015. https://www.gov.uk/government/consultations/changes-to-mental-health-act-1983-code-of-practice, paragraphs II-VII.

Figure 2: Definitions of must, should, and may/could/can used in the Code[13]

Terminology	How it is to be understood	Exceptions
Must	Reflects legal obligations which is it essential to follow	No exceptions
Should	For those to whom this is statutory guidance see paragraphs II-V For those to whom it is not statutory guidance VI-VII	See paragraphs II-VII. Any exceptions should be documented and recorded including the reason for this. Patients, their families and carers, regulators, commissioners and other professionals may ask to see this.
May/Could/Can	For those to whom it is not statutory guidance. Reflects guidance to be followed wherever possible.	Good practice but exceptions permissible

4.4 In addition, the Department will work with system partners to identify examples and case studies of good practice and what should happen in specific situations to aid compliance. By providing these outside the Code we can ensure they are regularly updated, can be relevant to real life situations and fit for purpose (Action 1).

4.5 On question 4, we have provided further guidance and cross-referred to other relevant material about complaints (in chapter 4) so that people can more easily raise any concerns about care and treatment under the Act. This includes information in relation to whistleblowing and safeguarding.

What we've not done

4.6 Some responses related to people questioning the legal status of the Code for particular groups. Whilst we have redrafted this section to make it clearer to address, some of these comments would have required changes to the Act, which was beyond the scope of the revised Code.

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[13] Department of Health. Introduction, *Mental Health Act 1983: Code of Practice*. 2015. https://www.gov.uk/government/consultations/changes-to-mental-health-act-1983-code-of-practice, Figure iii.

5.0 Using the Code

Chapter 1: Guiding principles

Chapter 2: Mental disorder definition

Chapter 3: Human rights, equality and health inequalities

5.1 This first group of chapters set out the underlying principles for care, treatment and support under the Act. We set out five new guiding principles and a new chapter (Chapter 3), emphasising some of the main points in relation to ensuring human rights and equality and to reduce health inequalities whilst caring for patients subject to the Act. Question 5 relates to chapter 5 and question 6 relates to chapter 3.

5.2 The consultation invited responses to these two questions:

Question 5: To what extent do the proposed guiding principles set the correct framework for care, support and treatment under the Act? Are there any additional principles which may be beneficial?

Question 6: In your opinion does the proposed Code of Practice ensure that human rights and equality are adequately protected in the use of the Act? Do you have suggestions on where and how the Code could be further strengthened in this regard? Can you provide evidence or examples of the equality impact of the Act?

Chapter 1: Guiding principles

What we heard

5.3 We received generally positive responses to the proposed guiding principles in chapter 1, with 67% of respondents being supportive of the new guiding principles. We also received some suggestions for clarification, amendment and amplification, and the importance of applying the principles in practice was emphasised. A small number of respondents preferred the 2008 principles.

What we've done

5.4 Following consultation, we have made further changes to the principles to strengthen, clarify and reword a number of them. In particular, we have now changed "empowerment and participation" to "empowerment and involvement", to confirm that patients should not just participate but that they should be directly involved in their own care. They should be encouraged and supported to involve their family, carers, advocates and others where they wish to do so.

5.5 We have clarified that commissioners, providers, professionals and others providing care under the Act are now expected to document and justify any decision to depart from the Code or a particular guiding principle. We are also stating that the CQC will look for evidence of this during their inspections and commissioners may use it as part of their contract monitoring. Throughout the document we have referred to the guiding principles to enhance their importance.

5.6 We intend to work with a range of professionals to develop case studies to give examples of good practice, which will go on the Code's web portal. By placing case studies on a web portal, these can be more easily updated and more useful to stakeholders (Action 1).

5.7 We will be working to promote awareness of the principles among patients, their families, carers and professionals through implementation of the revised Code, including through our Accessibility and Awareness project (Action 2).

What we've not done

5.8 Some respondents suggested additional principles or comments that related to specific parts of the Act. Where appropriate, these specific suggestions have been incorporated into relevant chapters. Some responses thought that the guiding principles should be contained in the Act in a similar manner to the Mental Capacity Act 2005 principles. This is not in the scope of the current project, but may be considered as part of any future project to consider the primary legislation (Action 10).

Chapter 2: Mental disorder definition

5.9 The consultation did not ask a specific question relating to this chapter and we received only a small number of responses (fewer than 10) which discussed the definition of mental disorder. Some comments in relation to other questions were also relevant to this chapter.

What we heard

5.10 Responses included comments that:

- that the current definition of mental disorder is too broad, and that it should not include learning disability or autism;
- the list of clinically recognised conditions at the start of the draft chapter 2 which could fall into the definition of mental disorder is misleading when compared to the Act, which makes it clear that mental disorder can cover 'any disorder or disability of the mind'; and,
- the additional wording at the end of draft paragraph 2.8 to clarify that, while alcohol or drug dependence alone is not a mental disorder under the Act, intoxication should not be used to exclude people from places of safety (as stated in draft paragraph 16.32).
- the Code should include further guidance on the use of the Act in general hospitals; and
- professionals do not always apply the learning disability qualification stringently enough.

What we've done

5.11 The 'intoxication and places of safety' suggestion has been considered within chapter 16 (Police powers and places of safety).

5.12 In response to concerns about the application of the learning disability qualification, we have amended this chapter to include further guidance about the need to record their reasons for concluding that the qualification is met (i.e. that the person's conduct is abnormally aggressive or seriously irresponsible, and why it relates to the person's learning disability and is not attributable to other factors such as an unmet physical health, social or emotional need).

What we've not done

5.13 Changes to the definition of "mental disorder" require primary legislation and are beyond the scope of the review of the Code. We have therefore not amended the Code to amend or remove the list of mental disorders, as we consider this provides a helpful non-exhaustive list. The Act's definition of "mental disorder" makes it clear there is no definitive exhaustive list of mental disorders that may come within the scope of the Act. These issues will be considered as part of any future consideration of potential changes to primary legislation (Action 10).

5.14 We have not provided further guidance on use of the Act in general hospitals because we consider that the Code already provides guidance on the application of the Act in the most common contexts in which it will arise (e.g. emergency applications for detention in chapter 15 and the use of holding powers in chapter 18). It is more appropriate for general hospitals to have their own local guidance/policies in place covering matters that are peripheral to the Code and the Act, e.g. referral of people with a mental disorder to the correct services.

Chapter 3: Human rights, equality and health inequalities

Consultation Q6 refers

In your opinion does the proposed Code of Practice ensure that human rights and equality are adequately protected in the use of the Act? Do you have suggestions on where and how the Code could be further strengthened in this regard? Can you provide evidence or examples of the equality impact of the Act?

5.15 Q6 comprised three sub-questions and responses to all three sub questions indicated that more guidance was needed. 29% of all responses commented on all or part of this question.

What we heard

5.16 63% of respondents who answered all or part of Q6 commented that they considered the proposed Code ensured that human rights and equality are adequately protected and several suggestions were made for strengthening the Code regarding equality, human rights issues and health inequalities. Q20 and Q31 are closely linked to Q6.

5.17 We received suggestions including providing information for patients and appropriate staff training which we have included in Chapter 3 and throughout the Code. Other suggestions included providing services and support for specific groups, e.g. deaf patients.

The last part of Q6 asked: "Can you provide evidence or examples of the equality impact of the Act?"

5.18 This question was substantively different to the others because it asked people and organisations to comment about the equality impacts of the application of the Act as well as the Code. Whilst few responses provided specific evidence or examples of the equality impacts of the Act, a small number suggested potential impacts, including comments about the implications of the application of the Act to children and young people. Ethnicity, race and equality was raised by several responders, who commented that black and minority ethnic (BME) groups are over-represented in mental health detention and that other groups may also be disadvantaged and disempowered within the mental health system or be at increased risk of requiring safeguarding and experiencing social exclusion.

What we've done

5.19 Consultation comments and the revised Equality Analysis[14] have informed further revisions to the Code. The Equality Analysis is available alongside this document on EA. It provides more detailed information on both what we heard and on the changes made and on further action to support improvements.

5.20 Specific guidance was included in Chapter 3 and also other chapters. In particular, in Chapter 3 additional guidance was given on the human rights and equality policy (paragraph 3.15) and what was expected in this of providers and commissioners. Further guidance was also incorporated on health inequalities and physical healthcare (see also Chapter 24).

5.21 In relation to the equality impacts for children and young people, we have made significant revisions to Chapter 19 on children and young people in the revised Code, addressing many of the concerns raised by stakeholders and patients, considering this the most appropriate place for these amendments.

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[14] Department of Health. *Equality for all: Mental Health Act 1983: Code of Practice: Equality Analysis*. 2015. https://www.gov.uk/government/consultations/changes-to-mental-health-act-1983-code-of-practice

5.22 In response to concerns about over-representation of BME groups in mental health detention and that other groups may also be disadvantaged and disempowered within the mental health system, we have included further guidance for commissioners and providers about monitoring equality impacts to obtain more robust evidence on this. The action plan accompanying the Equality Analysis contains further actions to support this.[15]

5.23 There were post-consultation changes to this chapter which we considered were more appropriate to locate in other chapters, e.g. a new section on 'Promoting good physical health' is in chapter 24. Some respondents commented that detained women are vulnerable to sexual harassment and assault. Guidance in chapter 8 on single sex accommodation and accommodation and separate facilities for other reasons (paragraphs 8.25-8.28) has been updated and related material added which provides further guidance.

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[15] Ibid, figure 3.

6.0 Protecting patients' rights and autonomy

Chapter 4: Information for patients, nearest relatives, carers and others

Chapter 5: The nearest relative

Chapter 6: Independent mental health advocates (IMHAs)

Chapter 7: Attorneys and deputies

Chapter 8: Privacy, dignity and safety

Chapter 9: Wishes expressed in advance

Chapter 10: Confidentiality and information sharing

Chapter 11: Visiting patients in hospital

Chapter 12: The Tribunal

6.1 These chapters are particularly relevant to patients, their families and carers. We did not make substantial changes to these existing chapters before consultation, but following the consultation we have provided greater clarity in the Introduction around the CQC's role should help patients better understand their rights and what they can expect when subject to the Act.

6.2 The consultation invited responses to these six questions which relate to patients' rights and autonomy:

Question 7: In what ways could the Code say more to ensure that people have a say in their own care and that their wishes and feelings are taken into account?

Question 8: What additional information in relation to the provision of independent mental health advocates would it be helpful to include?

Question 9: How should the Code be updated to reflect the use of electronic media in a patient's correspondence and communications under section 134?

Question 10: How can the Code be more specific about aspects relating to the right to have visitors and access to family and friends?

Question 11: Is any further guidance required to ensure the avoidance of blanket restrictions? If so what guidance is needed?

Question 12: In your opinion what additional guidance Is required in relation to the rights and roles of families and carers?

Chapter 4: Information for patients, nearest relatives, carers and others

6.3 Consultation question 7 relates to this chapter:

Question 7: In what ways could the Code say more to ensure that people have a say in their own care and that their wishes and feelings are taken into account?

6.4 Empowerment and involvement is one of five proposed guiding principles in the new Code. This builds on the participation principle from the 2008 Code. This means that individuals subject to the Act should have opportunities to be involved in the planning, development and review of their own care, support and treatment. This principle also applies to family members, carers, and others with an interest in the welfare of the patient.

What we heard

6.5 A quarter of all respondents commented on this question/chapter, with most agreeing that the Code should emphasise involvement as a key principle. Specifically, we heard that families and carers should be involved only with the person's agreement if the person has capacity to decide whether they should be involved. Respondents wanted the Code to make it clear that patients should be offered proactive support to involve their families and carers rather than relying on professionals to involve others only if this is requested by the patient or on their behalf.

What we've done

6.6 Following the consultation:

- we have changed the "empowerment and participation" guiding principle to the "empowerment and involvement" principle, to emphasise that patients should not just participate in their own care but that they should be directly involved in decisions about their own care. We are also encouraging and supporting patients to involve families, carers, advocates and others where they wish to do so;
- we included more practical information for carers, to draw attention to the availability of carers' centres and similar services that can advise carers on the Act, the Code and other issues: paragraph 4.6; and
- we revised paragraph 4.30 in the Code to make it more responsive to an individual patient's wishes about having information shared with their nearest relative. The Code emphasises that professionals should discuss with patients at the earliest possible time what information they are happy to share with their nearest relative and what information they wish to be kept private.

Chapter 5: The nearest relative

What we heard

6.7 The consultation did not ask a specific question about this chapter. Less than 5% of responses mentioned this chapter. Comments included wishing to see the distinction between the 'nearest relative' (as identified by section 26 of the Act) and the carer reinforced and a recognition that, if the patient's nearest relative is not their main carer, the carer may have the most relevant information to share with the nearest relative regarding the care and best interests of the cared for person.

6.8 Some comments concerned the adverse effects of the section 26 definition of "nearest relative" for unmarried fathers of patients (discussed further in the Equality Analysis), and suggested that the Code needs to better define, or reassess the meaning of the term 'nearest relative'.

What we've done

6.9 We have strengthened paragraph 5.2 of the Code to reflect that professionals should involve the main carer if they are not the patient's nearest relative.

6.10 We have clarified in paragraph 5.10 the particular decision in relation to which a person may lack capacity, i.e. the decision to make an application to displace their nearest relative in paragraph 5.10.

What we've not done

6.11 In relation to the definition of "nearest relative", no further action is possible. Amendments to the definition would require primary legislation, which is beyond the scope of the Code review. We have noted these concerns in the action plan for the Equality Analysis and will seek to consider these further where there is a suitable opportunity to amend the primary legislation (see also Action 10 to this Consultation Response).[16]

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[16] Department of Health. *Equality for All: Mental Health Act 1983: Code of Practice 2015: Equality Analysis*. 2015. https://www.gov.uk/government/consultations/changes-to-mental-health-act-1983-code-of-practice

Chapter 6: Independent mental health advocates (IMHAs)

6.12 Consultation question 8 related to this chapter:

Question 8: What additional information in relation to the provision of independent mental health advocates would it be helpful to include?

6.13 Section 130A of the Act already requires local authority to make arrangements for IMHAs to be available to support particular ('qualifying') patients. The IMHAs role includes helping patients to understand their rights and to exercise these rights, which can include representing them and speaking on their behalf. Section 130C of the Act sets out who is eligible to receive IMHA support.

6.14 We know from consultation responses received from large stakeholder organisations that IMHA services are not always available, or even if they are available, they may not meet the patient's particular needs. Patients with a learning disability, autism or other cultural communication difficulties may find generic IMHA services unsuitable for their needs.

6.15 Responsibility for commissioning appropriate IMHA services which reflects the diversity of the local population rests with local authorities.

6.16 The consultation sought responses on whether to change the Code (paragraph 6.12 in the draft Code refers) in relation to patients who lack capacity to decide whether to seek help from an IMHA to reinforce best practice that, in those circumstances, an IMHA should be introduced to the patient to explain what help is available. This measure will help to improve the support provided to people lacking capacity.

What we heard

6.17 Around one in six respondents (16%) commented on this question, with broad agreement that what the draft Code said on IMHAs was useful. Overall, respondents thought that the revised Code should provide clearer guidance or information on IMHAs, including greater information provision on these - for example, stating from the outset that IMHAs provision was a statutory duty for local authorities. Respondents also wanted a revised Code to emphasise enhanced access and coverage, to clarify responsibilities of the IMHA and to include clearer guidance on the roles of IMHAs.

What we've done

6.18 We have strengthened paragraph 6.1 to highlight the role of the IMHA. In paragraph 6.4, we have added some detail about the relationship between IMHA and other statutory advocacy services, in particular cross-referring to guidance on independent advocacy under the Care Act 2014 and independent mental capacity advocates (IMCA) services.[17] We have also added paragraphs (6.5-6.6) explaining the duty in the Act on local authorities to commission adequate IMHA services for their local areas, which reflect the diversity of the local population including IMHAs who can respond to the specific needs of particular groups of patients such as patients from minority cultural or ethnic backgrounds, patients with physical impairments and/or sensory impairments, and/or patients with learning disabilities and/or autism spectrum disorders.

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[17] See for example: Department of Health. *Care and Support Statutory Guidance issued under the Care Act*. 2014. https://www.gov.uk/government/publications/care-act-2014-statutory-guidance-for-implementation and Department for Constitutional Affairs (now Ministry of Justice). *Mental Capacity Act 2005. Code of Practice*. 2007. https://www.gov.uk/government/publications/mental-capacity-act-code-of-practice

What we've not done

6.19 We have not included a requirement to make IMHA services opt-out rather than opt-in. This would require primary legislation which places it beyond the scope of this revision of the Code (Action 10). While we respect the desire of proponents of an opt-out system to ensure every qualifying patient has the opportunity to benefit from the support of an IMHA, any opt-out system would need to be carefully designed to protect patient confidentiality and patient's article 8 rights, particularly for patients who do not want their detention, CTO or guardianship under the Act to be revealed to any third party.

Chapter 7: Attorneys and deputies

6.20 The consultation did not ask a specific question about this chapter, and less than 5% of responses mentioned this chapter.

What we heard

6.21 No significant changes were requested.

What we've done

6.22 Following the consultation, we made a small amendment to paragraph 7.1, emphasising that deputies are court-appointed under the Mental Capacity Act 2005.

Chapter 8: Privacy, dignity and safety

6.23 Consultation questions 9, 10 and 11 relate to this chapter:

Question 9: How should the Code be updated to reflect the use of electronic media in a patient's correspondence and communications under section 134?

Question 10: How can the Code be more specific about aspects relating to the right to have visitors and access to family and friends?

Question 11: Is any further guidance required to ensure the avoidance of blanket restrictions? If so what guidance is needed?

6.24 Chapter 8 deals with the privacy, safety and dignity of detained patients, including access to telephones and other mobile computing devices, access to the internet, and the use of searches.

6.25 Privacy, safety and dignity are important elements in a therapeutic environment, and hospital staff should respect a patient's privacy as far as possible, while ensuring the safety of the patient and others. Patients should have every opportunity to maintain contact with their family and friends by telephone, and hospitals should ensure they have policies for the use of mobile phones and computing devices.

6.26 Sleeping and bathroom areas should be segregated to protect the needs of patients of different genders and transgender patients. The nature of engagement with patients and of therapeutic environments and the structure and quality of life on a ward are important in encouraging patients to remain in the ward and in minimising a culture of containment. This chapter also includes guidance on conducting personal and other searches, on enhanced security, physical security and on a blanket locked door policy.

What we heard

6.27 About 20% of all respondents commented on one or more of these questions. For Q9, responses suggested a number of considerations which an updated Code should reflect on account of the greater use of electronic media in communications compared to the 2008 Code. These included promoting wider access to the internet, social media and video conferencing and addressing the issue of withholding access to electronic media as a form of punishment.

6.28 Responses to Q10 indicated that guidance on blanket restrictions should be strengthened around visiting hours, visiting areas and grounds for imposing restrictions, which we have done. For Q11, the majority of responses indicated that further guidance is required to avoid blanket restrictions. This included guidance on what constitutes blanket restrictions, outlining potential impacts and providing examples of good practice.

What we've done

6.29 Following consultation, we have included more guidance on the use of mobile phones, cameras and video and voice recording functions on electronic devices, and social media. Two thirds of respondents who commented on Q11 wanted the Code to provide additional guidance, particularly on the scope, practicalities and impacts of blanket restrictions. We have strengthened the guidance on these by providing details in a new section, stating that these should not normally be used and, if used, that there should be proper scrutiny and oversight.

6.30 We have also clarified the guidance on the use of separate sleeping and bathroom facilities for men and women and provided cross references to related guidance (paragraphs 8.25-8.26).

Chapter 9: Wishes expressed in advance

6.31 The Department did not ask a consultation question specifically about wishes expressed in advance, but this topic is covered by Q7 (see Chapter 4) about helping people have a say in their own care. Responses to other questions also mentioned advance wishes and advance decisions and these comments are provided in those specific chapters to provide the correct context.

What we heard

6.32 Fewer than 5% of all respondents commented on this chapter. Overall, responses on this Chapter were neutral and made the following suggestions: that the Code needs to guide staff away from unhelpful 'blanket' approaches to confidentiality, which can foster a culture that excludes families and can sever ties between inpatients and community support structures; and that advance statements of wishes can be extremely important in situations where people temporarily lack capacity when unwell.

6.33 During consultation, we received reports that patients, families and carers lacked understanding or even awareness of the Code. Even if they were aware of the Code, many were unaware of their rights under the Act, how to be involved in discussions about care and treatment or how to seek redress if safeguards are not being appropriately applied.

What we've done

6.34 The Department's Accessibility and Awareness project will develop a range of materials in different formats that will support greater awareness of the Code. It will include materials on how to involve patients in discussions about care and treatment when they are well and wishes expressed in advance statements.

What we've not done

6.35 We have not made any significant changes to the Code, as we considered these concerns could be more effectively addressed through the Department's Accessibility and Awareness project (see above).

Chapter 10: Confidentiality and information sharing

6.36 The Department did not ask a consultation question specifically about this chapter.

6.37 The law on confidentiality is the same for patients subject to the Act as it is for any other patients, except where the Act states otherwise. Under the Act, there are some situations where confidential information about a patient is legally authorised to be disclosed, even if the patient does not consent to this. Guidance is given on the sharing of information by professionals and agencies to manage serious risks which certain patients pose to others.

What we heard

6.38 Fewer than 5% of all respondents commented on this chapter. No major concerns were raised about the draft Code, but respondents suggested a few minor drafting amendments. Of these, it was recommended that any professional proposing to disclose confidential patient information about a patient who lacks capacity to consent to the disclosure should consult with their organisation's Caldicott Guardian.[18]

What we've done

6.39 We have made textual changes to emphasise the importance of consulting with Caldicott Guardians in line with what we heard during the consultation.

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[18] A Caldicott Guardian is the senior person in the organisation responsible for protecting the confidentiality of patient and service-user information and enabling appropriate information-sharing. Each NHS commissioner, NHS provider and local authority with social services responsibilites is required to have a Caldicott Guardian. It is also good practice for independent sector providers of NHS-funded services to have a Caldicott Guardian. See Department of Health. Chapter 10, footnote 1, *Mental Health Act 1983: Code of Practice*. 2015. https://www.gov.uk/government/consultations/changes-to-mental-health-act-1983-code-of-practice

Chapter 11: Visiting patients in hospital

6.40 Consultation question 12 relates to this chapter:

Question 12: In your opinion what additional guidance is required in relation to the rights and roles of families and carers?

6.41 This chapter covers visiting patients in hospital and when it may be necessary to consider the exclusion of visitors. It includes particular considerations for child visitors and how far an individual should be placed from their family and/or local community.

6.42 All patients have a right to maintain contact with family and friends and to be allowed visits, subject to carefully limited exceptions. The Act gives certain people the right to visit patients in private and arrangements must be in place to enable this to happen. Hospital managers have the right, under certain circumstances, to restrict or refuse visitors, or require them to leave.

6.43 All hospitals should have written policies and procedures concerning the arrangements for children and young people who visit patients or who are themselves patients.

What we heard

6.44 About a fifth of all responses commented on this chapter. Most respondents were less concerned with the substance of Chapter 11 (visiting patients in hospital) and more concerned with the section 26 definition of "nearest relative", reflecting a prevailing view that families and carers should be enabled and supported to play a full part in the care and planning for the patient. The responses highlighted the way some people currently felt marginalised by staff. The CQC suggested that the views of the patient should be paramount when deciding how much others – including relatives and carers – are involved: CQC considered that all references to the rights and roles of families and carers throughout the Code should emphasise the patient's own preference.

6.45 We also received comments that the Code should:

- require more practical support to be made available for carers and families who have to travel to visit patients in out-of-area placements;
- clarify restrictions on visits by children; and
- clarify guidance on "reasonable visiting hours" and when visits might be appropriate outside these times.

What we've done

6.46 The revised Code:

- emphasises that professionals should discuss with patients to discuss at the earliest possible time what information they are happy to share with their nearest relative and what information they wish to be kept private. Paragraph 5.2 of the Code has also been strengthened to reflect that professionals should involve the main carer if they are not the patient's nearest relative. We have also included relevant information in Chapter 14 of the Code.
- now reflects consultation views that it is good practice to consider the needs of family and carers who have to travel to visit patients in out-of-area placements.
- emphasises that visits by children should only take place after risk assessments are undertaken: paragraph 11.18.

- provides that visitors should only be in clinical areas under supervision for the safety or both visitors and patients: paragraph 11.7. The ***Jimmy Savile Investigation: Broadmoor Hospital*** report published in June 2014 recommended that, in particular where security is an issue, no-one without a proper qualification should be allowed unsupervised in a clinical area.[19]

What we've not done

6.47 We have not amended the draft Code in respect of "reasonable visiting hours" and when visits might be appropriate outside these. This is because we consider these issues are appropriate for local organisations to decide on a case-by-case basis.

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[19] Department of Health. *Jimmy Savile Investigation: Broadmoor Hospital*. 2014. https://www.gov.uk/government/publications/jimmy-savile-investigation-broadmoor-hospital

Chapter 12: The Tribunal

6.48 This chapter provides guidance on the role of the Tribunal, an independent judicial body, and on the related duties on hospital managers and others. Tribunals review cases of detained patients and patients subject to community treatment orders and guardianship under the Act.

What we heard

6.49 The Department did not ask a consultation question specifically about the Tribunal and less than 5% of responses received referred to Tribunals, although response to some other questions were also relevant. Apart from making a small number of minor clarifications to the text, we have left this chapter largely unchanged.

What we've done

6.50 The principal change we have made relates to clarifying that Tribunal staff should be appropriately trained or will have appropriate skills to support the patients they will meet e.g. being able to support an individual with a learning disability, or who does not speak English, or has a sensory impairment (paragraph 12.39).

6.51 Paragraph 12.20 in the draft Code referred to hospitals being able to admit a child or young person to an adult ward in exceptional circumstances only. We have removed this paragraph because this issue is covered in more detail in Chapter 19 (Children and young people under the age of 18), which is the most appropriate place in the Code to include it.

7.0 Assessment, transport and admission to hospital

Chapter 13: Mental capacity and deprivation of liberty

Chapter 14: Applications for detention in hospital

Chapter 15: Emergency applications for detention

Chapter 16: Police powers and places of safety

Chapter 17: Transport of patients

Chapter 18: Holding powers

7.1 This group includes those chapters related to when a person may first encounter MHA provisions. The changes relate to police powers, changes regarding the location of patients close to their home, use of sections 2 and 3 and a chapter (Chapter 13) clarifying whether the Act or the Mental Capacity Act should be used.

7.2 The consultation invited responses to these five questions which relate to assessment, transport and admission to hospital:

Question 13: Is there any other guidance on the interface that you think would be helpful and if so, what? Do you think that this is sufficiently user friendly to help your professional practice?

Question 14: What further guidance could the Code give professionals to support their decision making between the choice of adopting section 2 or section 3 for individual patients?

Question 15: Considering the options above, what further guidance should be included in relation to where individuals should be geographically located, when detained, within the remit of the current legislative framework?

Question 16: What guidance could the Code give to local governance systems to ensure that AMHPs are not put in this position?

Question 17: To what extent do the changes to Chapter 16 on police powers, address concerns around the use of sections 135 and 136? What further changes are required?

Chapter 13: Mental capacity and deprivation of liberty

7.3 Consultation question 13 relates to this chapter.

Question 13: Is there any other guidance on the interface that you think would be helpful and if so, what? Do you think that this is sufficiently user friendly to help your professional practice?

What we heard

7.4 22% of respondents commented on this section. A majority of respondents considered that the draft Code was not user-friendly, although a third of respondents considered that the draft version was. 75% of respondents considered that further guidance would be helpful, for example by making best practice examples more realistic, updating the Code to take case law since 2008 into account and improving flowcharts.

What we've done

7.5 Taking into account the responses from the consultation, we have made substantial amendments to this chapter in the Code, although we have retained most of the previous structure of the chapter.

7.6 We have made this chapter easier to read and more relevant for healthcare and legal professionals. Our changes are summarised as follows, with italic headings corresponding to sub-sections within the chapter.

Why read this chapter?

- We have now included definitions used for the purposes of the chapter and have also added a note on age and the applicability of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS).

What is the MCA 2005?

- This section is substantially revised and now includes a reference to the right to refuse to consent to electro-convulsive therapy (ECT).

How does the MCA define lack of capacity?

- We have added paragraphs on diagnostic and functional testing and also on ensuring that a capacity assessment is recorded in an individual's care/treatment record, including recording diagnostic or functional testing outcomes.

Care planning

- An additional reference states the need to adhere to section 4 of the MCA, which sets out a checklist of factors to be followed to determine what is in a person's best interests.

The Court of Protection

- This section now appears earlier in this chapter.

Acts that can be performed under the MCA

- Revised to make clear that the MCA can be relied upon to treat mental disorder where the patient lacks capacity and the patient's treatment is not regulated by Part 4 of the Act.

Treatment for physical conditions of patients detained under the Mental Health Act

- This section has been comprehensively rewritten to improve its clarity.

Authorisations under the Deprivation of Liberty Safeguards

- This section has been rewritten and clarified.

Detention under the Act or deprivation of liberty under a DoL authorisation or Court of Protection order

- We have improved the clarity of this section and also improved the options grid. Amendments include easier to read paragraphs on what makes a person ineligible for a DoL authorisation or Court of Protection order.

ECT and *Complex Cases*

- We have improved ECT guidance and updated the case study used in the Code.

Chapter 14: Applications for detention in hospital

7.7 Chapter 14 includes information in relation to the detention of patients in hospital under Part 2 of the Act. Maintaining regular and close contact with family, friends and local community can facilitate a patient's recovery. It is therefore crucial that individuals are not placed for long periods of time in hospitals far from family and friends. The consultation sought views on ways to address this within the existing legislative framework, including the following possible options:

- ensuring that NHS commissioners, section 12 doctors and approved mental health professionals (AMHPs) should make all reasonable efforts to place individuals, especially children and young people and/or individuals with a learning disability, as close to home and/or family as possible;
- the commissioner should ensure that the family and main carer (if not a family member) are involved in the decision about where to locate an individual, are informed of the reasons for the decision taken and given the opportunity to challenge decisions;
- hospital managers should inform an appropriate family member and/or a main carer that the commissioner should have involved them in the decision about where to locate the individual and should have been given reasons for the decision and informed that they can ask the commissioner to review the decision; and
- if, in order to meet the patient's care needs satisfactorily, it is not possible for the commissioner to place a patient in a hospital that is also convenient for family and friends to access, then the commissioner should consider whether they can provide any additional assistance as part of the care package.

7.8 Consultation questions 14-16 relate to this chapter:

Question 14: What further guidance could the Code give professionals to support their decision making between the choice of adopting section 2 or section 3 for individual patients?

Question 15: Considering the options above, what further guidance should be included in relation to where individuals should be geographically located, when detained, within the remit of the current legislative framework?

Question 16: What guidance could the Code give to local governance systems to ensure that AMHPs are not put in this position?

What we heard

7.9 14% of respondents commented on these questions, with around two thirds recommending that further revisions to the Code should be made in areas such as including case studies and flow charts, clarifying roles, ensuring proper documentation and ensuring those with specific needs received an assessment from a suitable party.

7.10 The main theme was emphasising that commissioners and providers take responsibility for ensuring sufficient beds. Stakeholders and patients were particularly keen to ensure that there was clarity around the responsibilities of commissioners with regards to placing patients in appropriate settings. Approved Mental Health Professionals (AMHPs) felt strongly that they are put often in difficult situations when told by providers that no beds are available. Others suggested that the Department of Health and NHS England should draw up specific commissioning guidance with regards to section 140 of the Act.

What we've done

7.11 We amended the Code to give guidance that:

- emphasises family and carer involvement in determining admission;
- refers to section 140 of the Act, which provides that clinical commissioning groups (CCG's) have a duty to notify local authorities in their areas of arrangements which are in force for the reception of patients in cases of special urgency or the provision of appropriate accommodation or facilities specifically designed for patients under the age of 18 (paragraphs 14.77-14.86);
- when a patient's carer/family informs the commissioner of difficulties in visiting the patient because of the distance that they need to travel, the commissioner should consider whether they can provide any assistance to support the patient's carer/family to visit and maintain contact with the patient (paragraph 14.85);
- local recording and reporting mechanisms should be in place to ensure the details of any delays in placing patients, and the impacts on patients, their family/carers, provider staff and other professionals are reported appropriately. It is made clear that AMHPs should be supported by their local authority in these circumstances and should not be expected by commissioners and providers to address the delay alone (paragraph 14.86); and
- local authorities, providers, NHS commissioners, police forces and ambulance services should have in place a clear joint policy for the safe and appropriate admission of people in their local area. We have also given guidance that in order to promote a patient's recovery, NHS commissioners and providers should work together to take steps, with appropriate input from section 12 doctors and AMHPs, to place individuals, as close as is reasonably possible to a location that the patient identifies they would like to be close to (e.g. their home or close to a family member/carer) (paragraphs 14.80-14.81).

7.12 Guidance has been incorporated in chapters 14 and 23 in relation to patients who have dementia. A number of stakeholders felt that this was required given the additional considerations that may be required to support patients with dementia and the increasing numbers that have been diagnosed.

7.13 We have also added guidance on people detained under the Immigration Act 1971 or Nationality, Immigration and Asylum Act 2002; as these are especially vulnerable groups and professionals should pay special attention to identifying their needs and acting accordingly.

What we've not done

7.14 While we have included guidance that commissioners should have a policy in place so that a decision about where a patient is placed can be challenged, we have not provided any further guidance on challenges about where a patient is placed. We will address this in further detail via the commissioning guidance we will draw up with NHS England in due course (Action 4).

7.15 We received requests for the Code to include a separate chapter on immigration detainees held within immigration removal centres (IRCs). Although we have included references to IRCs within Chapter 14, we have decided not to devote a further chapter to IRCs so as not to increase the size of the Code further. The Department will continue to discuss IRCs with the Home Office and NHS England, including whether further joint guidance on IRCs is necessary (Action 5).

Chapter 15: Emergency applications for detention

7.16 The Act permits an application to detain a person for assessment to be made under section 4 on the basis of a single medical recommendation only in very limited circumstances. This chapter provides guidance on making emergency applications.

What we heard

7.17 The Department did not ask a consultation question specifically about this chapter, which less than 1% of respondents commented on. Respondents suggested that the Code should include guidance for AMHPs that, when making an application for detention, the nearest relative should be informed at the same time or within a reasonable time afterwards (unless the patient requests otherwise or does not have a nearest relative).

What we've done

7.18 We have revised the Code to take this suggestion into account (paragraph 15.4). The considerations in paragraph 14.62 should also be considered in deciding whether to inform the nearest relative against the patient's wishes.

Chapter 16: Police powers and places of safety

7.19 Police officers have power of entry to private premises pursuant to a warrant issued by a magistrate under the Act, and power to temporarily remove people from such premises and from public places to a place of safety, provided that specified criteria are met. Approved mental health professionals (AMHPs), doctors and police officers should be aware of the guidance in this chapter.

7.20 Consultation question 17 relates to this chapter.

Question 17: To what extent do the changes to Chapter 16 on police powers, address concerns around the use of sections 135 and 136? What further changes are required?

What we heard

7.21 We should make it clear that the police powers under sections 135 and 136 of the Act have been under close scrutiny for the past two years, separate to this consultation, and have also been subject to a joint Department of Health and Home Office Review (as set out below).[20]

7.22 This has itself necessitated a number of changes to this chapter, and many of the consultation responses made further, though small, improvements to the initial revisions we made to the Code, such as making clarifications, pointing out inconsistencies, and helping with logical order and flow.

7.23 The Government's view is that police cells should not be used to detain children and young people under sections 135/136 of the Act. One of the sections 135 and 136 Review's[21] core recommendations is that legislation is amended so that children and young people are never taken to police cells if detained under section 135 or 136 – in effect, banning the use of police cells. Implementation of this will first require amending the primary legislation (sections 135/136). The Police and Criminal Evidence Act Code C will also have to be amended in line with any changes to sections 135/136 to reflect that a police station can no longer be used as a place of safety for under 18 year olds, and the revision to Code C would first require a statutory consultation and a statutory instrument. Changes both to sections 135/136 of the Act in primary legislation, as well as to the Police and Criminal Evidence Act Code C, are outside the scope of the Code and its revision.

7.24 8% of all respondents commented on this chapter and question. Many of the responses sought clarification on how section 135 and 136 operate, in particular:

- describing all the reasons for applying for a section 135 warrant;
- listing all the criteria that the AMHPs can rely on to obtain a warrant;
- clarifying when a voluntary assessment may be made in a person's own home;
- clarifying when the police may use their powers under section 136 within a hospital;
- whether a person, detained under section 136, can be discharged after a doctor assesses them even if they have not seen by an AMHP; and
- numerous small amendments, for example to ensure consistency between paragraphs.

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[20] Department of Health and Home Office. *Review of the Operation of Sections 135 and 136 of the Mental Health Act 1983: Review Report and Recommendations*. 2014. www.gov.uk/government/uploads/system/uploads/attachment_data/file/389202/S135_and_S136_of_the_Mental_Health_Act_-_full_outcome.pdf

[21] Ibid

What we've done

7.25 We incorporated numerous suggestions about amending the Code, many of which served to help clarify the responsibility of specific professionals during section 135 and 136 processes. In light of the responses received during the consultation we have also made the following specific changes:

- setting out in more detail the reasons and criteria for applying for a section 135 warrant, including the words "neglected or kept otherwise than under proper control", which appear in the Act, but previously not in the Code;
- clarifying that, following entry pursuant to a section 135 warrant, where a person consents and it is considered safe and appropriate to do so, a mental health assessment can take place in the person's home;
- clarifying when police may be called to a hospital to use their section 136 powers (not to wards, but to hospital grounds or other public parts of the hospital such as publically accessible parts of an A&E department); and
- clarifying that where a doctor assesses a person subject to section 136 and concludes that the person has no mental disorder, then that person must be discharged, even if not seen by an AMHP.

7.26 We have also made some other amendments, following the public consultation. In particular:

- following a number of responses from AMHPs, we have provided further guidance regarding the detention of people far from home, and stated that geographical boundaries should not be a barrier to admittance to a place of safety; and
- although not a point directly arising from the consultation responses we received, following discussions with the Home Office we have added further detail about the requirements for police to consider using their power of entry under Section 17(1)(e) of the Police and Criminal Evidence Act 1984 (PACE) in cases where it might save life or limb or prevent serious damage to property. We also clarified the rights and safeguards that pertain to people detained in police custody as contained in PACE Code of Practice C.

What we've not done

7.27 We have not made changes to the Code which go beyond the scope of the Act. Suggestions that have not been incorporated include:

- stating that if an ambulance is not in attendance at the outset, they should attend within 30 minutes of being requested, unless the local policy states an earlier response time. This matter is outside the scope of the Code, although the ambulance service introduced a protocol for these responses in 2014;
- stating that a place of safety suite may not be an appropriate place to bring a person who is clearly intoxicated. We believe that whether a place of safety is appropriate should be considered on a case-by-case basis and that the Code is correct to state that managers of places of safety should not put blanket policies in place that turn people away just because are, or may be, intoxicated; and
- stating that acute hospital accident and emergency departments will not always be able to provide a safe and suitable place for section 136 patients. Our position is set out in the Code, namely that professionals should consider the options available to them in different circumstances.

Chapter 17: Transport of patients

7.28 Patients may need to be transported between different locations. This chapter informs how patients should be conveyed whilst maintaining their dignity and privacy consistent with managing any risks to health and safety, or that of other people.

7.29 NHS commissioners, those responsible for hospitals, ambulance and transport services, NHS-funded providers and the police should agree joint local policies to ensure that patients can be conveyed without delay. When transport between hospitals is required, hospital managers should make appropriate arrangements. The Code provides guidance on transporting patients to hospital on the basis of an application for detention, on transporting patients who abscond and on transporting patients who are subject to a community treatment order who are recalled to hospital.

7.30 There were no specific consultation questions relating to this chapter.

What we heard

7.31 Less than 5% of respondents submitted responses to this chapter and the majority of responses supported the draft Code. We received suggestions to make changes, for example adding a specific reference to communicating with the patient, family and carers about transporting patients. We also received suggestions relating to special considerations for young people, for clarity around locally agreed policies and for clearer support for AMHPs.

What we've done

7.32 We have amended the Code to:

- give good practice guidance that patients should be informed as soon as possible of the reasons for any planned transfers, and supported to discuss a planned transfer with family, friends or carers (paragraph 17.2);
- provide that commissioners should consider what assistance can be given as part of the care package to support family or friends to visit patients in out of area placements, particularly for patients under 18 (paragraph 17.3);
- provide that the patient's gender and cultural sensitivities should be considered when considering the most appropriate method for transporting a patient (paragraph 17.5); and
- referencing the local crisis care policies and transport agreements that should be in place in line with the Crisis Care Concordat (paragraph 17.21).

Chapter 18: Holding powers

7.33 Doctors and approved clinicians have ‘holding powers’ under section 5(2) of the Act and certain nurses have the same powers under section 5(4) of the Act. This chapter provides guidance on the nature of this power, monitoring its use, the nomination of deputies if necessary, the role of hospital managers, and how patients should be assessed before invoking ‘holding powers’. It also provides guidance on the transfer of those subject to this power, to other hospitals. There were no specific consultation questions relating to this chapter.

What we heard

7.34 Less than 5% of respondents submitted responses to this chapter. We received suggestions that the Code should state more explicitly that an on-call psychiatrist within a mental health trust cannot make a holding application for a physician working for another trust. On the whole, the majority of responses supported the current draft Code.

What we’ve done

7.35 We have made a number of small changes to the Code in view of consultation responses. These include amending paragraph 18.2 to add that decision makers should always consider whether a less restrictive alternative to detention is available. This aligns with the least restrictive option and maximising independence guiding principle.

7.36 In the ***Transfer to other hospitals*** section, we have clarified the wording regarding a patient’s capacity (or lack of capacity) to consent to a transfer to another hospital.

What we’ve not done

7.37 Responses suggested that the Code should state more explicitly that an on-call psychiatrist within a mental health trust cannot make a holding application for a physician working for another trust. The Act and the Code already make it clear that it is the doctor in charge of the in-patient’s treatment who must make this application and we do not consider that further clarification is required.

7.38 We were asked to consider amending the Code so that if a hospital in-patient is not free to leave and lacks capacity, that an authorisation to detain the person under the DoLS in the Mental Capacity Act 2005 should then be considered rather than the holding powers under the Act. We did not agree to incorporate this change into the Code because the holding powers can only be exercised if an application ought to have been made to admit the patient under the Act. If this is the case, then DoLS should have previously been considered and rejected for the patient.

7.39 In the section ***Action once section 5(4) is used***, respondents suggested that, if the doctor or approved clinician arrives before the end of the 6 hour emergency holding period, then. the holding power should not lapse on their arrival, but only when they assess the person and decide that detention under the holding power is unnecessary. As section 5(2) already states that the holding power lapses when the doctor or approved clinician arrives at the place where the patient is being detained, this amendment would be inconsistent with the Act.

8.0 Additional considerations for specific patients subject to the Act

Chapter 19: Children and young people under the age of 18

Chapter 20: People with learning disabilities or autistic spectrum disorders

Chapter 21: People with personality disorders

Chapter 22: Patients concerned with criminal proceedings

8.1 Chapters 19-22 give guidance on considerations relevant to particular groups of patients, including a new chapter (chapter 19) about children and young people under the age of 18, and individuals with learning disabilities, autistic spectrum conditions or personality disorders. There is also a chapter on patients concerned with criminal proceedings, including those who are subject to Secretary of State for Justice Restrictions (usually referred to as restricted patients).

8.2 We asked four questions about these chapters as part of the consultation:

Question 18: In relation to the 'zone of parental control', do you think that this is a helpful term? If not, do you have any suggestions for an alternative term or is it sufficient to explain that there are limits to decisions that parents can take for their children?

Question 19: Further guidance has been provided on when a young person who has capacity might not be able to consent, but the term 'overwhelmed' has been removed as this was thought to be confusing. Are the relevant sections clearer?

Question 20: Does the Code provide sufficient information in relation to individuals where additional safeguards or considerations may be required, e.g. due to age, or disability? Please note any instances where information is not sufficient.

Question 21: What are your views on how the process for transferring restricted patients under Section 19 of the Act 1983, between secure hospitals could be improved?

8.3 Under question 20 we received comments about the need for additional guidance being required to support patients for other reasons e.g. because a patient has dementia or they are an immigration detainee. We decided that it was best to include relevant guidance in specific chapters. This information is included under the "what we've done" section for the relevant chapters.

Chapter 19: Children and young people under the age of 18

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

8.5 This chapter provides guidance on the role of those with parental responsibility for a child or young person; confidentiality and sharing information; how children and young people should be safeguarded where admission to hospital is not appropriate and on decisions on admission and treatment.

8.6 The following two questions relate to this chapter:

Question 18: In relation to the 'zone of parental control', do you think that this is a helpful term? If not, do you have any suggestions for an alternative term or is it sufficient to explain that there are limits to decisions that parents can take for their children?

Question 19: Further guidance has been provided on when a young person who has capacity might not be able to consent, but the term 'overwhelmed' has been removed as this was thought to be confusing. Are the relevant sections clearer?

What we heard

8.7 16% of respondents commented on this chapter and questions, with more than 80% of responses affirming that revisions made to the chapter had made the Code clearer. Respondents suggested that we make changes to the Code in the following two areas: changing the term "zone of parental control" to "scope of parental responsibility"; and, updating guidance on consent of a person with parental responsibility as it relates to deprivation of liberty.

What we've done

8.8 We considered whether to retain the term "zone of parental control" and also considered the position of deprivation of liberty and parental consent. The "zone of parental control" refers to the decisions that those with parental responsibility can be reasonably expected to make in relation to the admission and/or treatment of a child of young person, but the term has long been considered confusing to parents, children and young people (CYP) and some practitioners. Following the consultation, a number of alternatives were submitted by members of the public and professional organisations. After considering these suggestions, and further discussion with CYP mental health practitioners, the revised Code now uses the term 'scope of parental responsibility' instead of "zone of parental control". The new term complemented language about decision-making and parental responsibility and was considered to be less legalistic in its tone.

8.9 There have been long standing concerns by parents, children and young people, the police and mental health practitioners about under 18 year olds being taken to police cells under section 136 of the Act when a health based place of safety has not been available. We have amended chapter 19 so that it now states that police cells should not be used as a place of safety for under 18s unless there are exceptional circumstances which make this course of action absolutely necessary and this should be reflected clearly in the local policy for section 136. We consider that the Code is now as unequivocal as possible on this point.

Amendments not related to the consultation

8.10 Prior to the Supreme Court's judgment in Cheshire West,[22] case law had established that persons with parental responsibility cannot authorise a deprivation of liberty. Cheshire West has clarified the elements establishing a deprivation of liberty, but did not expressly decide whether a person with parental responsibility could, and if so in what circumstances, consent to restrictions that would, without their consent, amount to a deprivation of liberty.

8.11 In determining whether a person with parental responsibility can consent to the arrangements which would, without their consent, amount to a deprivation of liberty, we have advised that practitioners will need to consider and apply developments in case law following Cheshire West and we have given some guidance in relation to this.

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[22] P v Cheshire West and Chester Council and another and P and Q v Surrey County Council. 2014. WLR 2. https://www.supremecourt.uk/decided-cases/docs/UKSC_2012_0068_Judgment.pdf

Chapter 20: People with learning disabilities or autistic spectrum disorders

8.12 This chapter is of particular relevance to people with learning disabilities, autistic spectrum disorders or both, including patients who are children or young people. People with learning disabilities are entitled to the same rights and protections as other patients under the Act and the Code. Professionals and practitioners working with people with learning disabilities should also be familiar with the Mental Capacity Act 2005 (MCA) and the Equality Act 2010. The chapter identifies the key issues from the MCA and the Equality Act that should be considered and provides guidance about the detention of people with learning disabilities. The definition of learning disabilities provided in the Act is stated and guidance is given on that and autistic spectrum conditions.

8.13 The following question relates to this chapter:

Question 20: Does the Code provide sufficient information in relation to individuals where additional safeguards or considerations may be required, e.g. due to age, or disability? Please note any instances where information is not sufficient.

What we heard

8.14 5% of respondents commented on this question or chapter. Responses were generally positive and recognised the aim of the chapter as seeking to prevent excessive use of the Act to detain people with a learning disability or autism.

8.15 The consultation produced generally constructive criticism around strengthening this chapter, to ensure that detention is a last resort, whilst recognising that there may be reasons other than mental illness for challenging behaviour.

What we've done

8.16 We made several significant changes to this chapter. We have strengthened the Code to recognise: that 'hospitals are not homes'; that the least restrictive way of achieving the proposed assessment or treatment must be identified; and given further guidance on assessment and treatment of, and alternatives to detention for people with learning disability and autism spectrum conditions.

8.17 Guidance is now included so that professionals will record on the relevant forms their reasons for coming to the conclusion that the individual's conduct is abnormally aggressive or seriously irresponsible, and why it relates to the person's learning disability and is not attributable to other factors such as an unmet physical health, social or emotional needs.

8.18 We have reduced the subjectivity of terms such as 'abnormally aggressive' and 'seriously irresponsible': To address this, we have re-inserted the series of 'relevant factors to consider' in assessing whether a patient's learning disability is associated with seriously irresponsible or abnormally aggressive behaviour from the 2008 Code.

8.19 We have placed greater emphasis on the helpful role that can be played by families and friends: In response, the recommendation to consult family and friends as 'experts by experience' has been strengthened.

8.20 There is also now clarification about which parts of this chapter refer to learning disability only, which parts to autism only, and which parts to both learning disability and autism. Parts of the chapter have been re-ordered and there are more explicit references to learning disability and autism. Additionally, a description of autism (taken from *Think Autism*) and approved by the National Autism Society has been incorporated.[23] We have therefore

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[23] Department of Health. *Think Autism: fulfilling and rewarding lives, the strategy for adults with autism in England: an update.* 2014. https://www.gov.uk/government/publications/think-autism-an-update-to-the-government-adult-autism-strategy

reordered parts of this chapter, ensuring that possible reasons other than mental illness for challenging behaviour (unmet physical, social, emotional or support needs) are highlighted and emphasised.

What we've not done

8.21 There were further suggestions to add detail to this chapter, for example on training or the role of an IMCA, which have not been included because that information is found elsewhere in the Code. We consider that this chapter should be read and understood in the context of the Code as a whole, and we have improved cross-referencing within the Code to facilitate this.

Chapter 21: People with personality disorders

8.22 Chapter 21 has already been updated to take account of the development of services, in particular the transition from the Dangerous and Severe Personality Disorder (DSPD) programme to the Offender Personality Disorder strategy agreed between Department of Health and Ministry of Justice Ministers in 2011, and a restatement that people with personality disorder should be treated the same way under the Act as people with other mental disorders.

8.23 The following question relates to this chapter (and also to chapters 6, 19, 20 and 22).

Question 21: What are your views on how the process for transferring restricted patients under Section 19 of the Act 1983, between secure hospitals could be improved?

What we heard

8.24 11% of respondents commented on this chapter and question and these responses indicated that this chapter already provides sufficient information in the version of the Code reviewed at consultation.

What we've done

8.25 We have not made any significant changes.

Chapter 22: Patients concerned with criminal proceedings

8.26 This chapter provides guidance on the use of the Act to arrange treatment for mentally disordered people who come into contact with the criminal justice system (part 3 patients), including a section specifically relating to children and young people who are also subject to criminal proceedings and to those subject to restrictions.

8.27 Where a court gives a hospital order with restrictions under section 37 and 41 of the Act, there are certain obligations with regard to the management of these patients, commonly referred to as "restricted patients".

8.28 People subject to criminal proceedings have the same rights to psychiatric assessment and treatment as anyone else. It is essential that all those involved in the treatment and care of restricted patients understand their respective roles and responsibilities and the points at which the consent of the Secretary of State for Justice is required.

What we heard

8.29 10% of respondents commented on this chapter. In general, comments received did not affect what the Code says, but related to areas where we need to achieve cross-Government support to facilitate improvements to working practices or procedures.

What we've done

8.30 The 2008 version of the Code included information on 'restricted patients' in several chapters, which made it difficult to find the right information. We have therefore made the identification of relevant advice on managing restricted patients throughout the revised Code easier by improved cross-referencing (Action 6).

8.31 We have included some additional guidance in relation to transporting part 3 patients, including to and from court and urgent hospital transfers, and in relation to sections 47/49 and 48/49, including supporting immigration detainees (see also chapter 14). Further guidance has been included in relation to the conditional discharge of restricted part 3 patients, including those convicted of very serious crimes. In addition to the guidance in the Code, Ministry of Justice officials will also ensure that conditional discharge reports for patients convicted of serious crimes are subject to additional scrutiny, including, where necessary, through dialogue with the responsible clinician.

8.32 A new section on multi-agency protection arrangements (MAPPA) has been included to clarify the role of health services in assessing and managing the risk of MAPPA eligible part 3 patients. In addition, the Department of Health and Ministry of Justice will also work on refresher training for responsible clinicians, in conjunction with the Royal College of Psychiatrists, focusing particularly on the need to manage restricted patients within the MAPPA framework, where they have been convicted of serious offences and on the need to adopt a properly investigative approach to any concerns that arise during supervision (Action 7).

9.0 Care, support and treatment in hospital

Chapter 23: The appropriate medical treatment test

Chapter 24: Medical treatment

Chapter 25: Treatments subject to special rules and procedures

Chapter 26: Safe and therapeutic responses to behavioural disturbance

9.1 This group of chapters provides guidance in relation to the care, support and treatment of patients in hospital. The main changes are in the new chapter 26, on the use of restraint, seclusion and segregation. These changes are designed to support ***Closing the Gap*** action 9 on reducing the use of restraint and action 11 on taking action to improve care and where necessary protect patients.

9.2 We asked two questions during the consultation which relate to these chapters:

Question 22: In your opinion does the Code adequately address the issues surrounding restrictive practices to ensure their minimisation and safe application? If not, what further guidance do you recommend?

Question 23: In your opinion do the proposed review requirements relating to mechanical restraint, seclusion and long term segregation adequately help safeguard patients? If not, what further guidance do you recommend?

Chapter 23: The appropriate medical treatment test

9.3 This chapter provides guidance on the application of the appropriate medical treatment test and the criteria for detention or a community treatment order (CTO) under the Act.

What we heard

9.4 There was no specific consultation question about this chapter and less than 5% of respondents commented on the chapter. The comments received generally suggested that wording in this chapter could be clarified. We also heard that guidance should be included about support for patients with dementia.

What we've done

9.5 Significant changes include suggestions that: the definition of appropriate medical treatment could be more evident; that a statement of what the concept of availability of treatment meant in practice should be included; and, that there should be reference to considering a patient's views and experiences regarding treatment.

9.6 We have clarified guidance on appropriate medical treatment and availability. In response to questions on other parts of the Code we have now included guidance to support patients who have dementia.

Chapter 24: Medical treatment

9.7 This chapter gives guidance on medical treatment for mental disorder under the Act, especially treatment given without a patient's consent.

9.8 Treatment must be appropriate to the patient's mental health condition and take account of the person's wishes or feelings and advance decisions. The chapter provides guidance about appropriate treatment; treatments to which special rules and procedures apply; the treatment of detained patients and patients under community treatment orders; and on issues of capacity and consent. It also gives guidance on treatment plans, explaining their importance, and provides a summary of the treatment of incapacitated patients and the interface between the Act and the Mental Capacity Act.

What we heard

9.9 There was no specific consultation question about this chapter and less than 5% of respondents commented on the chapter. Of the responses we received, these concerned relatively minor editorial suggestions to improve clarity, which we have made. However, we have made important changes to this chapter, unrelated to the consultation or in response to comments received in relation to other chapters, as set out below.

What we've done

9.10 The revised Code now promotes the reduction of health inequalities, in particular in relation to the quality of physical healthcare received by patients detained under the Act. It provides that commissioners and providers should ensure that patients with a mental disorder receive physical healthcare that is equivalent to that received by people without a mental disorder. It also provides that the physical needs of patient should be assessed routinely alongside their psychological needs and that commissioners should seek to ensure that long term physical health conditions do not go undiagnosed or untreated, and that patients receive regular oral health and sensory assessments. It also now gives guidance on nutrition and diet. To reflect these changes the chapter is now called 'Medical Treatment'.

9.11 In response to comments received, we have updated the Code so it now refers to Part 4A consent certificates (Form CTO 12), which have been introduced by regulations made under the Act since the 2008 Code was published. Form CTO12 is the "certificate that confirms that a community patient has capacity to consent (or if under 16 is competent to consent) to treatment and has done so", and which is completed by the approved clinician in charge of the patient's treatment. Part 4A consent certificates were introduced into reg 28(1A) of the Mental Health (Hospital, Guardianship and Treatment) (England) Regulations 2008 by the Mental Health (Hospital, Guardianship and Treatment) (England) (Amendment) Regulations 2012/1118.

9.12 We have also included further guidance about the initial three month period during which medication for mental disorder can be given without consent/certification.

Chapter 25: Treatments subject to special rules and procedures

9.13 This chapter gives guidance on the special rules and procedures in the Act for certain types of medical treatment for mental disorder.

9.14 The chapter provides guidance on the 'clinician in charge of treatment' and the treatments under section 57, or 58, or 58A of the Act. Guidance is given on second opinion approved doctor (SOAD) certificates and a summary of the circumstances in which certificates cease to authorise treatment, even though they have not been withdrawn is provided.

What we heard

9.15 There was no specific consultation question about this chapter and less than 5% of respondents made comments. Comments generally suggested clarifications to wording, which we have adopted where this would make the Code clearer.

What we've done

9.16 The following three changes were the most significant:

- amendment to refer to part 4A consent certificates (Form CTO 12) to reflect changes in regulations (this change was also made to chapter 24);
- further guidance is included about statutory consultees (the people whom a SOAD must consult before issuing certificates approving treatment); and
- we have now clarified the circumstances in which a certificate authorising treatment issued by an approved clinician under section 58 or section 58A will cease to authorise treatment.

Chapter 26: Safe and therapeutic responses to behavioural disturbance

9.17 This chapter provides guidance for providers, professionals and practitioners on how to manage disturbed behaviour. It requires providers to have restrictive intervention reduction programmes and policies on various matters. The chapter makes clear that restrictive interventions should only be undertaken in a manner which respects human rights. It requires and provides guidance on individual assessments and behaviour support plans. It provides a definition of restrictive intervention for the purposes of the chapter and gives guidance on particular types of restrictive interventions. Guidance is given on the particular needs of children and young people and on the importance of appropriate staff training.

9.18 The consultation asked two questions about this chapter:

Question 22: In your opinion does the Code adequately address the issues surrounding restrictive practices to ensure their minimisation and safe application? If not, what further guidance do you recommend?

Question 23: In your opinion do the proposed review requirements relating to mechanical restraint, seclusion and long term segregation adequately help safeguard patients? If not, what further guidance do you recommend?

What we heard

9.19 28% of responses commented on these questions or chapter. With regard to Question 22, 47% of all responses indicated that the Code adequately addressed issues surrounding restrictive practices, with 53% considering that this was not the case. We received suggestions that terms should be defined more explicitly, that the role of the police, trainees and deputies should be clarified, and that the importance of staff training and refresher sessions should be stated.

9.20 In respect of Question 23, 47% of responses about this question indicated that the proposed review requirements were adequate in helping to safeguard patients, although 53% did not think this was the case. Suggestions included clarifying definitions, emphasising the importance of staff training, being realistic about the timeframe for review and highlighting the monitoring and scrutiny process.

What we've done

9.21 Besides several revisions to terminology and phraseology to improve clarity, we made several key changes in response to consultation responses:

- seclusion and long-term segregation: The revised Code drafting establishes greater rigour and tighter review arrangements than the previous (2008) Code, though is now less stringent than the version consulted on due to implementation issues highlighted by a range of stakeholders;
- greater clarity has been provided concerning the roles of doctors and the role of 'duty doctors' within review processes;
- a requirement has been added that rapid tranquillisation be undertaken in a manner consistent with General Medical Council good practice guidance;
- additional paragraphs are introduced in response to stakeholder comments regarding security assessments. Some stakeholders have suggested that an additional chapters should be developed with a sole focus on forensic secure service settings, but we think the additional guidance is sufficient;

- greater acknowledgement is given throughout this chapter to the need for family and/or carer engagement and to the positive contribution families and carers can make to robust assessment, therapeutic service delivery and improved outcomes;
- amendments have been made to ensure the greater involvement of IMHAs (where the patient is eligible and wants one) in treatment, positive behaviour support planning or equivalent. This includes ensuring consultation prior to the planned use of restrictive interventions, involvement in seclusion and long-term segregation reviews;
- greater clarity is now given on the nature of restrictive intervention reduction programmes, with fuller guidance being available in ***Positive and Proactive Care***;[24]
- the term 'positive behaviour support plans or equivalents' is now incorporated throughout the chapter (and wider Code) in recognition of equivalent models within different service contexts. Greater clarity has been provided on what elements of positive behaviour support plans would be expected within alternative forms of care planning in order to meet the requirements of the Code: in essence the Code places a stronger emphasis on proactive planning and calls for personalised, transparent planning of de-escalation strategies and restrictive interventions; and
- the revised Code ensures greater alignment to ***Positive and Proactive Care***[25] (without unnecessarily replicating content) in order to reassert key messages regarding prone (face down) restraint and the use of pain-based techniques.

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[24] Department of Health. *Positive and Proactive Care: reducing the need for restrictive interventions*. 2014. www.gov.uk/government/publications/positive-and-proactive-care-reducing-restrictive-interventions

[25] Ibid

10.0 Leaving hospital

Chapter 27: Leave of absence

Chapter 28: Absence without leave

Chapter 29: Community treatment orders (CTO)

Chapter 30: Guardianship

Chapter 31: Guardianship, leave of absence or CTO ?

Chapter 32: Detention and CTO: renewal, extension and discharge

Chapter 33: After-care

Chapter 34: Care programme approach

10.1 This group of chapters provides information for patients on leave of absence, who are being treated in the community or being considered for discharge including into guardianship. These changes support promotion of the least restrictive option and autonomy principle and action 1 in ***Closing the Gap*** about high quality mental health services focused on recovery.

10.2 We asked four questions during the consultation which relate to these chapters. Question 25 also relates to chapter 38 in the Professional responsibilities group:

Question 25: What are your views on the options proposed as a means of increasing and improving the transparency of decision-making for discharge and reviews?

Question 26: Does the revised chapter provide as much guidance as possible, within the current legislative framework, to ensure that CTOs are used effectively and appropriately to support patients to maintain stable mental health outside hospital and to promote recovery, in line with the principle of least restrictive option and autonomy? If not, what further guidance do you suggest?

Question 27: What further information in relation to the care programme approach (CPA) in chapter 34 would be helpful to include in the Code?

Question 28: How clear is the drafting on how the provisions of the Measure apply to individuals receiving services across the English/Welsh Border? What further guidance would be helpful and why?

Chapter 27: Leave of absence

10.3 Patients detained in hospital have the right to leave hospital lawfully only if they have leave of absence from their responsible clinician under section 17 of the Act.

10.4 This chapter gives guidance on who has the power to grant leave of absence, leave for restricted patients, short- and long-term leave, escorted leave, leave to reside in other hospitals, and recall from leave.

What we heard

10.5 There was no specific consultation question about this chapter and less than 5% of respondents made comments. Comments generally suggested rewording, which we have made where this would make the Code clearer.

10.6 Question 25 included an option about the long-term use of section 17 leave. Responses to this question were generally in favour of providing further guidance to reduce the long-term use of section 17 leave and about the need to document why it was appropriate.

What we've done

10.7 The following two changes in response to issues raised during consultation are the most significant:

- there is further guidance on leave for Part 3 restricted patients, escorted leave to Northern Ireland and the inclusion of photographs in a patient's notes to assist in identification if necessary (e.g. if the patient is absent without leave or has absconded); and
- clarifying that use of section 17 leave should normally be of short duration, and that professionals should document why use of longer term leave is more appropriate than, e.g. a CTO. (See also changes to chapter 31.)

Chapter 28: Absence without leave

10.8 This chapter provides guidance on action to be taken when patients are absent without leave (AWOL), or have otherwise absconded from legal custody under the Act, including when patients are to be considered to be AWOL.

10.9 Hospital managers should also have policies in place outlining actions necessary in this eventuality and the Code provides guidance about the matters that should be covered by such policies.

What we heard

10.10 There was no specific consultation question about this chapter and less than 5% of respondents made comments.

What we've done

10.11 No significant changes have been made.

Chapter 29: Community treatment orders (CTO)

10.12 CTO allows suitable patients to be treated safely in the community rather than in hospital. This chapter gives guidance about the use of CTOs, patients for whom they are suitable, and providing and managing care planning and support in the community. Certain conditions may be attached to a CTO and information should be provided for patients and others about the CTO.

10.13 The chapter includes guidance on circumstances that might lead to recall to hospital and the procedure that should be followed and on revoking a CTO, reviewing a CTO and discharging patients from a CTO. Hospital managers, AMHPs and responsible clinicians should, in particular, note the guidance in this chapter.

10.14 CTOs are also covered in other chapters (e.g. chapters 31 and 32).

What we heard

10.15 A number of concerns were raised about this chapter, in addition to wider concerns about the primary legislation on CTOs.

10.16 Many people felt strongly about CTOs and 17% of all respondents commented on it. Many reflected wider concerns about the primary legislation on CTOs which were outside the scope of the consultation. 28% of those who commented on this chapter considered the balance was right. A number of detailed suggestions were made, many of which reflected a desire for the Code to go into more detail on specific points. These are outlined below.

What we've done

10.17 We have made clear that conditions attached to a CTO must not be so restrictive that they deprive the patient of their liberty (paragraph 29.31).

10.18 We adopted suggestions about recording the reasons for decisions relating to CTO conditions, including in relation to the reasons for variation and suspension of CTO conditions (paragraphs 29.40 and 29.42).

10.19 We also took on board comments that: written reasons for the revocation of a CTO should be given to the patient and (where appropriate) their nearest relative; and hospital managers should notify the patient and (where appropriate) their nearest relative when they have referred the patient's case to the First-tier Tribunal.

What we've not done

10.20 We have not taken on board any comments which would require changing the Act or which suggested that the Code should explicitly discourage the use of CTOs. Our view remains that the decision whether to place a particular patient on a CTO is a matter for clinical judgement in the light of the other available options. We will consider this potential changes at the next suitable opportunity to change primary legislation (Action 10).

Chapter 30: Guardianship

10.21 Guardianship enables patients to receive care outside hospital where it cannot be provided without the use of compulsory powers. This chapter provides guidance on guardianship, in particular, on its purpose, on assessing a patient for guardianship, on the responsibilities of local authorities and on the components of effective guardianship.

What we heard and what we've done

10.22 There was no specific consultation question about this chapter and less than 5% of respondents made comments. These were generally about the minor rephrasing of existing Code paragraphs and, accordingly, no significant changes have been made.

Chapter 31: Guardianship, leave of absence or CTO?

10.23 An unrestricted patient may be subject to the powers of the Act while living in the community by one of three ways: guardianship, leave of absence or a community treatment order (CTO). This chapter provides guidance on deciding between these three options.

What we heard

10.24 There was no specific consultation question about this chapter, although Q25 is related. Less than 5% of respondents made comments specifically on the chapter, with comments supporting the changes we made to the version of the Code consulted upon under Q25 (see also chapters 32 and 27).

What we’ve done

10.25 We have clarified guidance on whether a CTO or leave of absence should be used, including to make decisions more accountable and transparent and to discourage inappropriate use of long-term section 17 leave (see also chapter 27).

Chapter 32: Detention and CTO: renewal, extension and discharge

10.26 A patient's detention or community treatment order (CTO) may by extended or renewed by the responsible clinician. This must be done before the period of detention or CTO expires. This chapter provides guidance on how the procedures in the Act for reviewing the detention or CTO and deciding whether to discharge or whether to renew the detention or extend a CTO. It provides guidance on the role and responsibilities of the responsible clinician and the role of the patient's nearest relative, including the nearest relative's power of discharge. (Note: The changes to this chapter should also be considered alongside the changes to chapter 38.)

What we heard

10.27 A third of all respondents commented on this chapter or on Questions 25 and 26 which relate to it. Responses were generally supportive of all the options to improve transparency and accountability, although a large majority of respondents thought that the Code needed additional guidance on, for example, acknowledging the role that carers can play and concerns about potential conflicts of interest arising from the requirement that the second professional, who must agree to the renewal of the patient's detention must have been professionally involved with the patient's care and treatment. In practice, this often means that the responsible clinician and second professional work for the same organisation, increasing the risk that there may be incentives for them to make decisions for reasons other than clinical ones.

What we've done

10.28 In chapter 32, and also chapter 38, we have included new guidance to promote the role of the patient, their nearest relative, carer and advocate in any decisions to consider discharge, renewal or extension, and to ensure that any reasons are fully documented. Chapter 38 also includes revised guidance on how hospital managers' panels should exercise their powers in reviewing detention or CTOs, including in 'uncontested cases'. Combined these changes should promote accountability and transparency in decisions, and enable greater scrutiny and, if required, challenge, and mitigate concerns raised about the role of the responsible clinician.

10.29 The Act makes it clear that decisions to discharge or renew detention or extend a CTO can only be made on clinical grounds. In light of the feedback received, we added a sentence (paragraph 32.2) to confirm that renewal or discharge should be made purely on clinical factors and the reasons for the decision should be fully documented. This supports our objective to improve clinical accountability and enable the patient, carers and hospital managers to fully understand the reasons for the decision.

10.30 In relation to the process for extending CTOs, we have added new guidance (paragraphs 32.11 and 32.12) stating that it is good practice, when making decisions about considering whether to discharge or extend the period of a CTO, for the wider multidisciplinary team (MDT) to be consulted, including, where appropriate, the patient, nearest relative, the independent mental health advocate (IMHA) and/or other representative, family and carers, the local authority and clinical commissioning group responsible for the patient's after-care (chapter 33) and any other key service providers.

10.31 One of the major concerns raised at Winterbourne View[26] was that reviews did not take place and that patients were unlawfully deprived of their liberty (often called 'de-facto

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[26] South Gloucestershire Safeguarding Adults Board. *Winterbourne View Hospital: A Serious Case Review.* 2012. http://hosted.southglos.gov.uk/wv/report.pdf. Department of Health. *Transforming Care: a national response to Winterbourne View Hospital Review.* 2012. https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/213215/final-report.pdf

detained'). We have confirmed that detention should not continue if the authority for detention is not renewed because any such detention would be an unlawful deprivation of liberty, which is a breach of the patient's Article 5 ECHR right to liberty (paragraph 32.10). We have included new guidance on what should happen in the exceptional circumstances where the authority for detention is not reviewed and renewed in time (paragraphs 32.10 and 38.50).

10.32 In addition, we are currently reviewing the forms prescribed under the Mental Health (Hospital, Guardianship and Treatment) (England) Regulations 2008. We intend to make changes e.g. requiring documentation of the reasons for not discharging, which should provide further scrutiny, transparency and accountability to the process for renewing detention and extending CTOs. We intend to lay regulations including the proposed amendments to the forms in Parliament in 2015/16 (Action 8).

What we've not done

10.33 The Winterbourne Hospital Serious Case Review[27] had earlier highlighted a potential conflict of interest in relation to the requirement for the responsible clinician to consult a second professional in decisions about whether to discharge or renew detention or extend the CTO. Feedback during the consultation also raised concerns about this requirement. Some respondents viewed this as not offering sufficient protection because both the responsible clinician and the second professional will often work for the same organisation and there may therefore be incentives other than purely clinical factors for making their decisions. It was felt that this may have the consequence that patients are detained or subject to CTOs longer than necessary. Whilst we consider that the changes to chapters 32 and 38 go some way to addressing the concerns raised in relation to decisions to discharge, to make further changes to the process for discharge decisions (including potentially requiring that the second professional work for a different organisation, and/or that they were not involved in the patient's treatment), would require changes to the Act, which are outside the scope of the Code review. The Department will consider whether further changes are required to the Act at the next suitable opportunity (Action 10).

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[27] South Gloucestershire Safeguarding Adults Board. *Winterbourne View Hospital: A Serious Case Review*. 2012. http://hosted.southglos.gov.uk/wv/report.pdf

Chapter 33: After-care

10.34 Section 117 of the Act requires clinical commissioning groups and local authorities, in co-operation with voluntary agencies, to provide or arrange for the provision of after-care to particular patients detained in hospital for treatment who then cease to be detained. This chapter provides guidance on this duty of after-care and should be read in conjunction with chapter 34 (on the care programme approach). The guidance covers after-care planning and direct payments.

What we heard

10.35 There was no specific consultation question about this chapter and less than 5% of respondents made comments.

What we've done

10.36 No significant changes have been made. We have updated this chapter to now include references to additional Care Act guidance and added new guidance, following the consultation, clarifying that after-care services may be reinstated if it becomes obvious that they have been withdrawn prematurely, for example if a patient's mental condition begins to deteriorate immediately after services are withdrawn. We considered this additional clarification would be beneficial to people who may have had their aftercare withdrawn prematurely.

Chapter 34: Care programme approach

10.37 The care programme approach (CPA) is an overarching system for co-ordinating the care of people with mental disorders. The CPA requires identification of a named care co-ordinator. This chapter provides guidance on the key features of the CPA, when to use it, who should be involved, and on care planning. Guidance is also given on patients from Wales who are placed in England.

10.38 We asked two questions relating to this chapter:

Question 27: What further information in relation to the care programme approach (CPA) in chapter 34 would be helpful to include in the Code?

Question 28: How clear is the drafting on how the provisions of the Measure apply to individuals receiving services across the English/Welsh Border? What further guidance would be helpful and why?

What we heard

10.39 20% of respondents commented on this chapter/questions. We received significant responses that the Code needed additional guidance about planning for people with autistic spectrum disorder or learning disabilities. 80% of respondents who commented on Q28 indicated that the draft Code was clear on the provisions.

What we've done

10.40 Following consideration of consultation responses, we have now amended this chapter so that it now includes additional guidance that professionals with specialist expertise should be involved in planning for people with autistic spectrum disorder or learning disabilities.

10.41 The Welsh Government expects to revise the Welsh Mental Health Act Code of Practice in 2015. This will provide further guidance for Welsh patients who are transferred to healthcare units in England or who receive part of their treatment in England (e.g. from specialised services).

11.0 Professional responsibilities

Chapter 35: Receipt and scrutiny of documents

Chapter 36: Allocating or changing a responsible clinician

Chapter 37: Functions of hospital managers

Chapter 38: Hospital managers' discharge power

Chapter 39: Conflicts of interest

Chapter 40: Information for victims

11.1 This group of chapters provides additional information for professionals who have specific responsibilities under the Act.

11.2 We asked three questions during the consultation which relate to these chapters:

Question 24: Should the Mental Health (Conflicts of Interest) (England) Regulations 2008 be amended so that where a patient is to be admitted and the doctor providing one of the medical recommendations is on the staff of that hospital, the other medical recommendation must be given by a doctor who is not on the staff of that hospital, regardless of whether the hospital is an independent?

Question 29: What additional guidance on the role of hospital managers should be included to assist them fulfil their role under the Act?

Question 30: What are your views on how to ensure victims do not miss out on their entitlements to receive statutory victim contact, particularly where the responsibility for this lies with hospitals, and that victims' concerns and views are given appropriate weight and consideration when managing patients subject to a hospital order?

Question 25 also relates to chapter 38.

Chapter 35: Receipt and scrutiny of documents

11.3 This chapter provides guidance on the receipt and scrutiny of documents under the Act. This chapter distinguishes between receiving documents and scrutinising them, and provides guidance on delegation by hospital mangers.

What we heard

11.4 There was no specific consultation question about this chapter and less than 5% of respondents made comments. Some comments concerned how patients are informed about discharge by hospital managers.

What we've done

11.5 In response to the consultation comment, we have included new guidance that patients should be informed of their discharge by hospital managers under section 23, both orally and in writing, and in an accessible format for the patient.

Chapter 36: Allocating or changing a responsible clinician

11.6 This chapter deals with the identification of responsible clinicians for patients being assessed and treated under the Act, including on change of responsible clinician.

What we heard

11.7 There was no specific consultation question about this chapter and less than 5% of respondents made comments. Some comments were that it would be desirable to include guidance for patients on how to request a change in the responsible clinician.

What we've done

11.8 We have included new guidance that, if the patient requests a change in responsible clinician, their reasons for requesting this change should be established so as to inform an appropriate response.

Chapter 37: Functions of hospital managers

11.9 This chapter gives guidance on the responsibilities of hospital managers under the Act, and on specific powers and duties not addressed in other chapters.

11.10 It provides guidance on the identification of hospital managers, the exercise of hospital managers' functions and on specific powers and duties of hospital managers, including admission, transfer between hospitals, transfers to guardianship, transfer and assignment of responsibility for CTO patients, information for patients and relatives, duties in respect of victims of crime, patients' correspondence and the duty to refer cases to tribunals. It also provides guidance on the Secretary of State for Health's power to refer cases to a tribunal, and hospital accommodation for children and young people.

11.11 One question relates to this chapter (this question also relates to chapter 38):

Question 29: What additional guidance on the role of hospital managers should be included to assist them fulfil their role under the Act?

What we heard

11.12 13% of respondents commented on this chapter or question during the consultation. We heard that: we needed to strengthen the chapter on patient involvement; for the judgements of managers' panels to be based on all the evidence; communicating information relating to Part 3 patients who have committed violent or sexual crimes; hospital managers having access to the AMHP report; and, withholding post from patients.

What we've done

11.13 We have made three significant changes to the chapter after considering these responses:

- there is now revised guidance advising on communication of information relating to Part 3 patients who have committed sexual or violent crimes;
- new guidance is included advising that hospital managers should obtain a copy of the AMHP report; and
- we have included further information about giving patients notice of decisions to withhold post from patients and their right to ask the Care Quality Commission to review such decisions.

Chapter 38: Hospital managers' discharge power

11.14 Hospital managers have the power to discharge most detained patients and all patients subject to a community treatment order (CTO). This chapter provides guidance on the exercise of these powers. It includes matters relating to when to review detention or a CTO, the criteria to be applied, the procedure for reviewing detention or a CTO, how to conduct reviews where the detention or CTO is contested, uncontested renewals and recording the reasons for a decision.

11.15 Two questions relate to this chapter (Q25 and 29). Changes to chapter 32 are also related to Chapter 38.

What we heard

11.16 Almost a third of respondents commented on this chapter during the consultation. Almost half of respondents to Q25 agreed with the options proposed in the consultation document, although a significant number of responses suggested, enhancing the role of families, carers, advocates and the police in the discharge process and adapting this to suit individual needs. Some provider organisations also criticised the potential burden of such changes.

What we've done

11.17 We have made a number of significant changes to the chapter after considering these responses. These are aligned with the changes to chapter 32, 27 and 21, about the need to improve transparency and accountability in discharge decisions, ensure that reviews happen when they should, and that the patient and any representatives can be fully involved in discharge decisions. We see the hospital manager or manager's panel as being a key check in ensuring that responsible clinicians are making appropriate decisions in relation to discharge, or renewing detention or extending CTOs.

11.18 Changes to strengthen safeguards for patients to increase transparency, accountability and scrutiny in discharge decisions have been included:

- we have included guidance about involving the patient's nearest relative or carer (if different) in the hospital managers' hearing, being fully supported in order to participate effectively, on sharing the formal record of the decision and reasons for the decision with the patient, and on offering patients an opportunity to discuss the outcome;
- we have included guidance that patients should be informed of their rights to be considered for discharge by the Tribunal;
- we have provided additional guidance on the procedure to be followed in uncontested cases;
- we have clarified that hospital managers' panel members should have appropriate training to understand the law, work with patients and professionals, reach sound judgements and properly record their decisions, including that members are appropriately trained or have the appropriate skills to support patents they will meet, e.g. being able to support an individual with a learning disability, or who does not speak English, or has a sensory impairment; and
- set out what a hospital manager's panel should do if they become aware of a review not having taken place (see also chapter 32).

Chapter 39: Conflicts of interest

11.19 Conflicts of interest may arise which prevent an approved mental health professional from making an application for a patient's detention or guardianship, and a doctor from making a recommendation supporting the application. This chapter provides guidance on the circumstances that constitute a conflict of interest. These may be financial, business, professional or personal.

11.20 Question 24 specifically relates to this chapter.

Question 24: Should the Mental Health (Conflicts of Interest) (England) Regulations 2008 be amended so that where a patient is to be admitted and the doctor providing one of the medical recommendations is on the staff of that hospital, the other medical recommendation must be given by a doctor who is not on the staff of that hospital, regardless of whether the hospital is an independent hospital or an NHS hospital?

What we heard

11.21 20% of respondents made comments on this question/chapter. 60% of responses indicated that the regulations should be amended as suggested in the draft Code, although many acknowledged this may be difficult in practice. 39% of respondents (these were mainly NHS trust and NHS foundation trust provider organisations) did not think the regulations should be amended at all, or amended only in respect of specific circumstances. This meant that there was majority support for additional safeguards to prevent conflicts of interest or doctors making decisions for reasons other than in the best interests of the patient.

What we've done

11.22 We gave guidance in the consultation draft chapter that it is good practice for doctors on the staff of NHS trusts and foundation trusts to ensure that one of the medical recommendations to support an application for detention is given by a doctor not on the staff of that trust (this is the requirement that already applies to independent sector hospitals). We intend to amend the Mental Health (Conflicts of Interest) (England) Regulations 2008 to make this a statutory requirement and to ensure consistency between providers regardless of the type of provider. This should improve transparency and accountability (Action 9).

11.23 On balance, we did not think that the concerns raised by some NHS trusts and foundation trusts outweighed the benefits of the new guidance, as these requirements already relate to the independent sector. To address concerns from providers about how this might work in practice, we have included new guidance stating that it may be beneficial for providers (e.g. NHS trusts, foundation trusts and the independent sector) operating in close proximity to create and maintain a list of second opinion doctors as a pooled resource. By working together providers should ensure that safeguards at admission are enhanced and also that there is no untimely delay or impact on the patient.

Chapter 40: Information for victims

11.24 Under the Domestic Violence, Crime and Victims Act 2004 victims of serious violent and sexual offences have the right to engage with the Victims Contact Scheme (VCS). This chapter provides guidance on the statutory rights of victims to information about mentally disordered offenders (in the Code called Part 3 patients). It outlines the relevant offences for which the police should send details of victims to the VCS, and the support provided by the VCS. It also provides guidance on the Victims' Code.[28]

11.25 We asked one question relating to this chapter during the consultation:

Question 30: What are your views on how to ensure victims do not miss out on their entitlements to receive statutory victim contact, particularly where the responsibility for this lies with hospitals, and that victims' concerns and views are given appropriate weight and consideration when managing patients subject to a hospital order?

What we heard

11.26 12% of responses commented on this chapter or question, with suggestions made that the Code should be clarified in respect of the Victim Contact Scheme, support for victims of unrestricted patients and support for victims where the offender is also a family member, carer or friend.

What we've done

11.27 We have made three significant changes following the consultation:

- we have clarified information about the Victim Contact Scheme, especially in relation to non-statutory victims;
- we have also clarified information about support for victims of unrestricted patients; and
- additional guidance has been added to support victims who are also family, carers or friends.

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[28] Ministry of Justice. *The Code of Practice for Victims of Crime*. 2013. https://www.gov.uk/government/publications/the-code-of-practice-for-victims-of-crime

12.0 General changes

12.1 Questions 1-30 sought feedback on the main proposed changes to the Code. In addition, we requested responses on other, smaller changes to the Code. These included changes in terminology, policy, case law and professional practice. We welcomed respondents' thoughts on these further changes and on anything further which it would be helpful for the Code to include, in particular supporting the delivery of commitments in ***Closing the Gap*** or ***Transforming Care***.

12.2 The following six questions refer to this part of the consultation:

Question 31: What specific issues would you like to see addressed within the Code, which are not covered in the proposed draft? What are your views on the new chapters that are proposed in this revision of the Code?

What we heard

12.3 17% of responses commented about this question or related content. Responses were mostly favourable about being involved in redeveloping the Code, and stakeholder organisations wanted to continue to be involved in this work in future. In general, the responses welcomed the new chapters in the revised Code.

12.4 The CQC, which has the power to make proposals as to the contents of the Code under section 118 of the Act, suggested that consideration should be given as to how the Code will continue to be reviewed and updated so that it remains "***up to date, relevant and responsive to our reports and intelligence on the quality and safety of services***."

What we've done

12.5 Points related to specific chapters have been included under the relevant chapters.

What we've not done

12.6 We noted the CQC's comments with particular interest, given that the CQC has statutory duties to review (and, where appropriate, investigate) the exercise of powers and discharge of duties under the Act. We agree that it should not require significant failings to be identified, such as those at Winterbourne View, to prompt a review of the Code.

12.7 On balance, however we do not agree that future Code or Act reviews should follow a set timetable, although we agree with the CQC and others that it would be helpful to explore ways of making reviews more systematic. This is because changes in guidance take time to implement and embed for professionals, patients and carers and it is not possible to commit a future Government to undertake a review of the Code or Act.

Question 32: Do you believe that the proposed changes to the Code address the concerns about access to safeguards, raised at Winterbourne View and other places? Is there any other guidance, within the parameters of the Act, you think the Code should include? If so, please give details.

What we heard

12.8 14% of the responses commented on this question or related content and of these, half suggested that the proposed changes to the Code addressed concerns. Around a fifth of responses did not think that the Code addressed these concerns, with the remaining responses offering neutral views but making suggestions for improvement.

What we've done

12.9 A number of the changes across the Code are particularly relevant to addressing issues raised at Winterbourne View. These are a major part of the Government's approach to addressing these concerns for individuals subject to the Act, including those who have a learning disability. Combined we think they will make a significant difference in promoting good practice and improving the quality of care. Further detail is available under specific chapters, including where a comment has not been taken forward. Changes include:

- updating the specific guidance on supporting individuals with learning disabilities and autism and on the learning disability qualification;
- five new Guiding Principles, which focus on ensuring that people are placed in the least restrictive setting, that care and treatment is focused on recovery and is therapeutic, and that patients and their families are involved in decisions about their care and treatment and are treated with dignity and respect;
- throughout the Code, have clarified guidance to assist professionals to be compliant with the Code;
- explained CQC's role in the introduction;
- given guidance on what individuals can do if they feel the Code is not being applied appropriately and complaints processes;
- ensuring patients can be more involved in decisions that affect them, including having information in formats that they understand (e.g. easy read), having access to independent mental health advocates (IMHAs);
- ensuring staff, including IMHAs, those on tribunals and on hospital managers panels are trained in supporting individuals with a learning disability, autism or behaviour that can be considered challenging;
- enabling patients and their families to have input in the decision about where they are locating e.g. close to home or family;
- clarified when the Act should be used and when the Mental Capacity Act should be used;
- confirmed that blanket restrictions should be avoided unless these can be justified as being necessary and proportionate;
- promoted the maintenance of family and carer relationships e.g. through visits and use of mobile phones, electronic devices and the internet;
- included a new chapter and additional guidance throughout the Code to promote human rights and equality;
- updating guidance on the use of restraint, seclusion and long term segregation, including supporting the approach in ***Positive and Proactive Care***[29] to promote the use of positive behaviour support and de-escalation techniques, and reconfirming that any form of restraint should only be last resort, not involve pain and be for the shortest possible period;

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[29] Department of Health. *Positive and Proactive Care: reducing the need for restrictive interventions*. 2014. www.gov.uk/government/publications/positive-and-proactive-care-reducing-restrictive-interventions

- Providing additional guidance on the involvement of patients, their families, carers and advocates in reviews and decisions about discharge, continued detention or community treatment, including in ‘uncontested cases’;
- Including additional safeguards in relation to decisions about discharge to promote greater transparency and accountability and to enable greater scrutiny by hospital managers of clinical decisions; and
- Making it clear that reviews must take place and that not having these in the required time frame and continuing to detain a person without authority is an unlawful deprivation of liberty (often called ‘de facto detention’).

Question 33: How far does the proposed structure and order help you navigate the proposed Code? Do you have any suggestions on how the grouping or ordering of chapters could be improved?

What we heard

12.10 21% of responses commented on this question or related content, with more than half of these indicating that the proposed structure and order was clear. Many responses believed that the Code should use the term ‘service user’ rather than ‘patient’ throughout to reflect that the Code applies to contexts outside healthcare.

12.11 We received suggestions to make the Code available in multiple formats, including an easy read version. Responses also suggested that the Code should be edited for consistency of writing style as it appears that different people have written different chapters.

12.12 We also heard suggestions that, because the Code has been expanded (e.g. by the new chapters), it risks being impractical for use as a clinical reference guide. A frequent suggestion – not just during the consultation – was that the Code is too long and in parts is ‘excessively prescriptive’, thus limiting clinical discretion. Suggestions were made that it would be useful if the Code is to remain functional as a clinical reference guide for clinicians that it includes an index to make the document more practical for use.

What we’ve done

12.13 We have included an executive summary and new introductory section at the start of each group of chapters setting out what information is included in that group. This is to improve usability and highlight information in each group. We have increased the number of cross-references between chapters, included additional annexes, including details of related material that may be relevant, and an updated index. This should make it easier to navigate throughout the document. We intend to publish a web resource which will enable users to select key terms.

What we’ve not done

12.14 As the term patient is used in the Act we have remained consistent with that terminology. The Introduction to the Code provides a description of terminology used in the document.

12.15 Whilst we appreciate concerns about the length of the Code, given the wide audiences and uses, and that few respondents were able to identify areas where guidance could be reduced we have not been able to shorten the length of the Code. However, the work to improve navigability, especially the web resource, should ensure that people can find the relevant information required, and in a timely fashion.

Question 34: Are there any ways in which, the flowcharts or case study examples used in the proposed Code can be further improved? Are there additional places where they would help?

What we heard

12.16 8% of responses commented about this question or related content. Responses were generally in favour of more flowcharts, tables and case studies, although few responses provided examples of these that could be included.

What we've done

12.17 We intend to develop a range of case studies to accompany the Code giving further examples of good practice and how to apply the Guiding Principles – these will be shared on the electronic resource to support the Code. We consider that this is more useful as these can be 'real life' situations and can give guidance that is not so theoretical or high level that it is not beneficial. This also means that they can be more easily added to and updated in line with emerging good practice or case law. This would not be possible if included within the Code itself, given the Parliamentary procedure required by section 118 of the Act to issue a revised Code. We would welcome suggestions of good practice to support us to do this or details of issues that people have difficulties with. Please send these to mentalhealthcode@dh.gsi.gov.uk by Friday 27 February 2015.

12.18 From the consultation, we received a number of useful flowcharts that we will consider incorporating into the accompanying reference guide. Due to the technical nature of the information contained, we thought that some of these were better placed in the reference guide. They will also be included on the new electronic resource bringing together materials to support the Code.

Impact Assessment

12.19 Two questions (Q35 and Q36) related to the consultation stage impact assessment and Q6 also considered the consultation stage equality analysis (section 7 of the consultation stage impact assessment).[30] The consultation stage impact assessment provides analysis of the costs and benefits of the revised Code, and the equality analysis the equality impacts. The consultation stage impact assessment relates to the costs and benefits identified in relation to the specific revisions and enhancements proposed to the Code.

Question 35: How far does the consultation stage impact assessment reflect the potential impact of the changes that will be introduced as a result of the proposed changes to the Code?

Question 36: Are there any further impacts that you feel should be considered? Please provide evidence to help us assess and quantify this impact.

What we heard

12.20 Fewer than 5% of responses commented on Questions 35 or 36. For Q35, more than half of the responses received indicated that the impact assessment was sufficient, and responses were generally supportive that the right impacts had been identified and quantified accurately. For Q36, respondents thought that the impact assessment should also include consideration of: rate of detention and treatment of BME patients; local access to care and treatment by community mental health services; and, impact on staff training.

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[30] Department of Health. *Consultation Stage Impact Assessment, section 7 Equality Analysis*. 2014. www.gov.uk/government/uploads/system/uploads/attachment_data/file/330710/MHA_CoP_Impact__Equality_Assessment.pdf

What we've done

12.21 We will update our consultation stage impact assessment to reflect the further changes to the Code. We will publish the revised impact assessment to coincide with the new Code, subject to Parliamentary approval, coming into force on 1 April 2015. This will enable us to take account of wider changes, including updating the reference guide, our accessibility and awareness project and the new supporting web resource.

12.22 The revised Equality Analysis considers the impact of rates of detention and BME experiences, plus other equality impacts.[31]

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[31] Department of Health. *Equality for all: Mental Health Act 1983: Code of Practice: Equality Analysis*. 2015. https://www.gov.uk/government/consultations/changes-to-mental-health-act-1983-code-of-practice

13.0 Action Plan

13.1 Figure 3 provides a list of all additional actions committed to in the Consultation Response. Further actions are included within the Equality Analysis.

Figure 3: Actions to further support implementation of the revised Code of Practice

Action No.	Actions	Target Date	Responsible Organisation	Related Chapter/s
1	The Department of Health will work with system partners to identify examples and case studies of good practice and what should happen in specific situations to aid compliance. By providing these outside the Code we can ensure they are regularly updated, can be relevant to real life situations and fit for purpose.	April 2015	DH	Introduction Chapter 1
2	The Department of Health will promote awareness of the principles among patients, their families, carers and professionals through implementation of the revised Code, including through our Accessibility and Awareness Project	Spring 2015	DH	Chapter 1
3	The Department of Health's Accessibility and Awareness project will develop a range of materials in different formats that will support greater awareness of the Code. It will include materials on how to involve patients in discussions about care and treatment when they are well and wishes expressed in advance statements.	Spring 2015	DH	Chapter 9
4	The Department of Health intends to work with NHS England to develop additional guidance for commissioners, including in relation to challenges to decisions about where a patient is placed.	April 2016	DH and NHS England	Chapter 14

Action No.	Actions	Target Date	Responsible Organisation	Related Chapter/s
5	The Department of Health will discuss care for individuals in immigration removal centres (IRCs) with the Home Office and NHS England, including whether further joint guidance on IRCs is necessary.	TBC	DH, Home Office and NHS England	Chapter 14 Chapter 22
6	Ministry of Justice officials will ensure that conditional discharge reports for patients convicted of serious crimes are subject to additional scrutiny, including, where necessary, thorough dialogue with the responsible clinician.	April 2015	MoJ	Chapter 22
7	The Department of Health and Ministry of Justice will work on refresher training for responsible clinicians, in conjunction with the Royal College of Psychiatrists, focusing particularly on the need to manage restricted patients within the MAPPA (multi-agency public protection arrangements) framework.	2015/16	DH/MoJ	Chapter 22
8	The Department of Health is currently reviewing the forms prescribed under the Mental Health (Hospital, Guardianship and Treatment (England) Regulations 2008. We intend to make changes e.g. requiring documentation of the reasons for not discharging, which should provide further scrutiny, transparency and accountability to the process for renewing detention and extending CTOs. We intend to lay regulations, including the proposed amendments to the forms, in Parliament in 2015/16.	2015/16	DH	Chapter 32

Action No.	Actions	Target Date	Responsible Organisation	Related Chapter/s
9	The Department of Health intends to amend the Mental Health (Conflicts of Interest) (England) Regulations 2008 to make the requirements in relation to financial conflicts of interest equivalent irrespective of types of provider.	2015/16	DH	Chapter 39
10	DH will consider potential changes to primary legislation at the next suitable opportunity.	TBC	DH	Including chapters 1, 2, 5, 6, 29 and 32

14.0 Summary of key themes

14.1 Figure 4 lists the number of responses pertaining to each of the consultation questions. In addition to this, responses also commented on other sections of the draft Code.

14.2 Figure 5 lists the specific wording of the consultation questions and quantifies the proportion of responses that agreed or disagreed, where applicable.

Figure 4: Number of responses commenting on each of the consultation questions

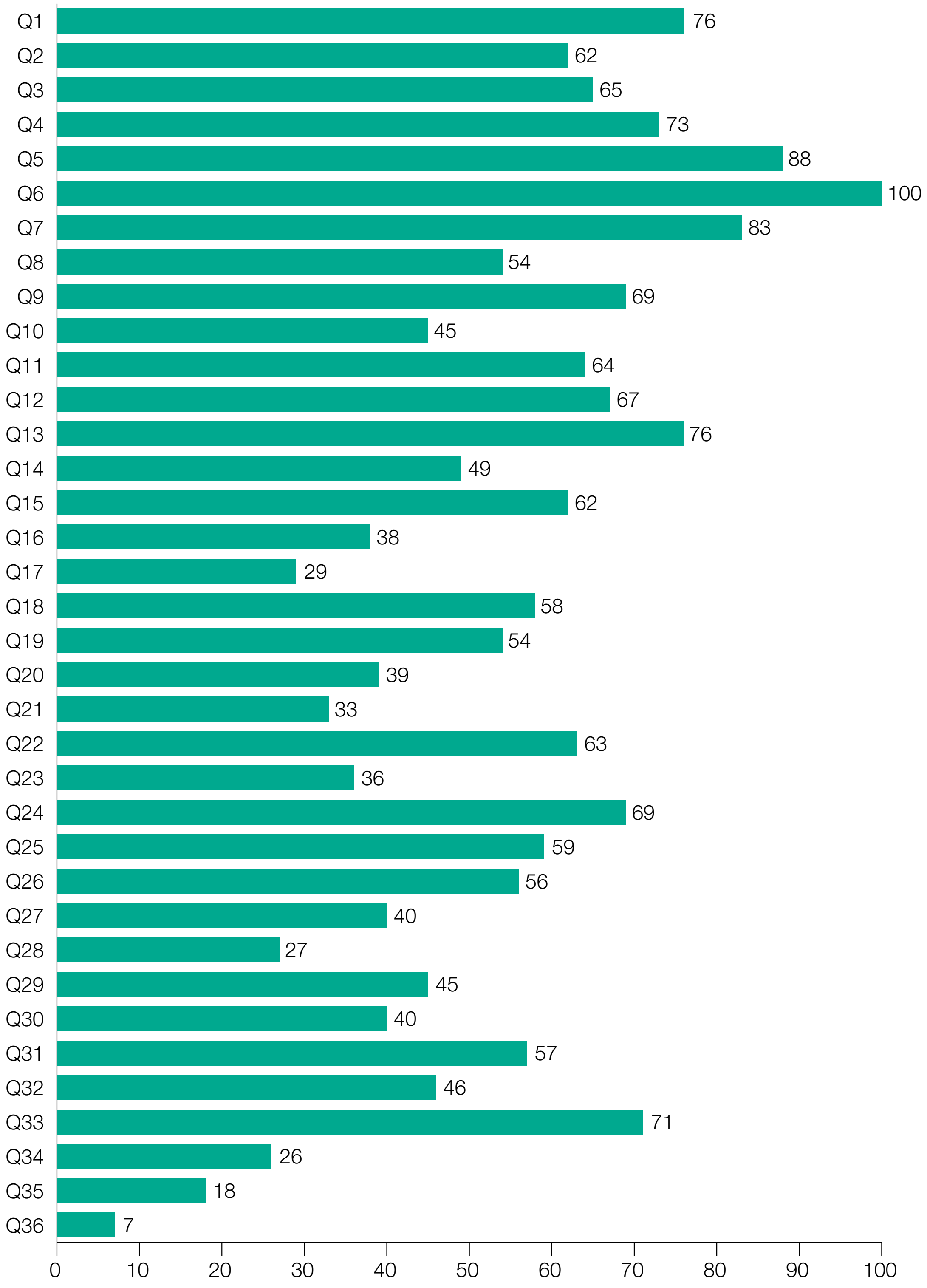

Figure 5: Consultation question wording and number of responses

Consultation questions	Number of responses	Agreed	Disagreed	Unknown
Q1. Do you believe that the additions to the Code provide sufficient assurance that all commissioners, local authorities and health and care professionals will understand what is expected of them? If not, what more should be included in the Code?	76	12 responses (16%)	47 responses (61%)	17 responses (22%)
Q2. Should the proposed Code provide more guidance about appropriate governance arrangements for monitoring duties and powers under the Act? If so, what guidance should be included?	62	44 responses (71%)	12 responses (19%)	6 responses (10%)
Q3. Should any parts of the Code be more specific to determine what 'good' service looks like? If so, please indicate which parts should be more specific and how.	65	53 responses (82%)	11 responses (17%)	1 response (<1%)
Q4. Does the proposed Code provide adequate guidance on local complaints and resolution procedures, specific to the Act? If it does not, please indicate any additional guidance that should be provided.	73	26 responses (35%)	38 responses (52%)	9 responses (12%)
Q5. To what extent do the proposed guiding principles set the correct framework for care, support and treatment under the Act? Are there any additional principles which may be beneficial?	88	58 responses (65%)	14 responses (16%)	15 responses (17%)
Q6. Does the proposed Code of Practice ensure that equality and human rights are adequately protected in the use of the Act? Do you have suggestions on where and how the Code could be further strengthened in this regard? Can you provide evidence or examples of the equality impact of the Act?	100	Analysed in another report		
Q7. In what ways could the Code say more to ensure that people have a say in their own care and that their wishes and feelings are taken into account?	83	Not applicable		
Q8. What additional information in relation to the provision of independent mental health advocates would it be helpful to include?	54	Not applicable		
Q9. How should the Code be updated to reflect the use of electronic media in a patient's correspondence and communications under section 134?	69	Not applicable		
Q10. How can the Code be more specific about aspects relating to the right to have visitors and access to family and friends?	45	Not applicable		

Consultation questions	Number of responses	Agreed	Disagreed	Unknown
Q11. Is any further guidance required to ensure the avoidance of blanket restrictions? If so what guidance is needed?	64	44 responses (69%)	20 responses (31%)	–
Q12. What additional guidance is required in relation to the rights and roles of families and carers?	67		Not applicable	
Q13. Is there any other guidance on the interface that you think would be helpful and if so, what? Do you think that this is sufficiently user friendly to help your professional practice?	76	24 said guidance is user-friendly (32%) 57 said further guidance would be helpful (75%)	33 did not think guidance was user friendly (43%) 5 said no further guidance was needed (7%)	13 did not comment on user-friendliness (17%) 12 did not comment on other guidance (19%)
Q14. What further guidance could the Code give professionals to support their decision making between the choice of adopting section 2 or section 3 for individual patients?	49	18 responses (37%)	32 responses (65%)	–
Q15. What further guidance should be included in relation to where individuals should be geographically located, when detained, within the remit of the current legislative framework?	62	10 responses (16%)	52 responses (84%)	
Q16. What guidance could the Code give to local governance systems to ensure that AHMPs are not put in the position of not being able to find a bed?	38		Not applicable	
Q17. To what extent do the changes to Chapter 16 on police powers address concerns around the use of sections 135 and 136? What further changes are required?	29	–	13 responses (44%)	16 responses (56%)
Q18. In relation to the 'zone of parental control', do you think that this is a helpful term? If not, do you have any suggestions for an alternative term or is it sufficient to explain that there are limits to decisions that parents can take for their children?	58	28 responses partly or fully agreed (48%)	22 responses (38%)	7 responses (12%)
Q19. Further guidance has been provided on when a young person who has capacity might not be able to consent, but the term 'overwhelmed' has been removed as this was thought to be confusing. Are the relevant sections clearer?	54	45 responses (83%)	2 responses (4%)	7 responses (13%)

Consultation questions	Number of responses	Agreed	Disagreed	Unknown
Q20. Does the Code provide sufficient information in relation to individuals where additional safeguards or considerations may be required, eg due to age, or disability? Please note any instances where information is not sufficient.	39	22 responses (56%)	17 responses (43%)	–
Q21. What are your views on how the process for transferring restricted patients under Section 19 of the Act 1983, between secure hospitals could be improved?	33		Not applicable	
Q22. Does the Code adequately address the issues surrounding restrictive practices to ensure their minimisation and safe application? If not, what further guidance do you recommend?	63	30 responses (47%)	33 responses (53%)	–
Q23. In your opinion do the proposed review requirements relating to mechanical restraint, seclusion and long term segregation adequately help safeguard patients? If not, what further guidance do you recommend?	36	17 responses (47%)	19 responses (53%)	–
Q24. Should the Mental Health (Conflicts of Interest) (England) Regulations (2008) be amended so that where a patient is to be admitted and the doctor providing one of the medical recommendations is on the staff of that hospital, the other medical recommendation must be given by a doctor who is not on the staff of that hospital, regardless of whether the hospital is an independent hospital or an NHS hospital?	69	42 responses (61%)	26 responses (39%)	–
Q25. What are your views on the options proposed as a means of increasing and improving the transparency of decision-making for discharge and reviews?	59	26 responses (44%)	–	33 responses (56%)
Q26. Does the revised chapter provide as much guidance as possible, within the current legislative framework, to ensure that CTOs are used effectively and appropriately to support patients to maintain stable mental health outside hospital and to promote recovery, in line with the principle of least restrictive option and autonomy? If not, what further guidance do you suggest?	56	16 responses (28%)	40 responses (72%)	–
Q27. What further information in relation to the care programme approach (CPA) in chapter 34 would be helpful to include in the Code?	40		Not applicable	

Consultation questions	Number of responses	Agreed	Disagreed	Unknown
Q28. How clear is the drafting on how the provisions of the Measure apply to individuals receiving services across the English/Welsh Border? What further guidance would be helpful and why?	27	22 responses (79%)	2 responses (8%)	3 responses (13%)
Q29. What additional guidance on the role of hospital managers should be included to assist them fulfil their role under the Act?	45		Not applicable	
Q30. What are your views on how to ensure victims do not miss out on their entitlements to receive statutory victim contact, particularly where the responsibility for this lies with hospitals, and that victims' concerns and views are given appropriate weight and consideration when managing patients subject to a hospital order?	40		Not applicable	
Q31. What specific issues would you like to see addressed within the Code, which are not covered in the proposed draft?	57		Not applicable	
Q32. Do you believe that the proposed changes to the Code address the concerns about access to safeguards, raised at Winterbourne View and other places? Is there any other guidance, within the parameters of the Act, you think the Code should include? If so, please give details.	46	23 responses (50%)	9 responses (20%)	14 responses (30%)
Q33. How far does the proposed structure and order help you navigate the proposed Code? Do you have any suggestions on how the grouping or ordering of chapters could be improved?	71	37 responses (52%)	–	34 responses (48%)
Q34. Are there any ways in which the flowcharts or case study examples used in the proposed Code can be further improved? Are there additional places where they would help?	26		Not applicable	
Q35. How far does the consultation stage impact assessment reflect the potential impact of the changes that will be introduced as a result of the proposed changes to the Code?	18	11 responses (61%)	3 responses (17%)	4 responses (22%)
Q36. Are there any further impacts that you feel should be considered? Please provide evidence to help us assess and quantify this impact.	7		Not applicable	

15.0 List of organisations who responded

- Action Against Medical Accidents
- Advocacy for Mental Health and Dementia
- African Health Policy Network
- Alzheimer’s Society
- Association of Directors of Adult Social Services (ADASS) and the Local Government Association (LGA)
- Association of Police and Crime Commissioner
- Avon and Wiltshire Partnership NHS Trust
- Birmingham and Solihull Mental Health NHS Foundation Trust
- Black Country Partnership NHS Foundation Trust
- Black Mental Health UK
- British Medical Association (BMA)
- British Psychological Society
- Broadmoor Hospital multi-disciplinary working group
- Calderdale Council AMPHS
- Care Quality Commission (CQC official response, non-formal response appendix and pre-consultation)
- Central and North West London NHS Foundation Trust
- Cheshire and Wirral Partnership NHS Foundation Trust
- Cheshire East Council
- Cheshire Police
- Cheshire West and Chester Council
- Children’s Rights Alliance for England
- College of Social Work
- Coram Voice
- Cornwall NHS Foundation Trust
- Cumbria Independent Custody Visiting Scheme
- Darlington Borough Council
- Dorset Healthcare University Foundation Trust
- Durham City Council

- Dyfed-Powys Deputy Police and Crime Commissioner
- Essex Police
- Gateshead Council
- General Medical Council
- Greater Manchester Police
- Greater Manchester West Mental Health NHS Foundation Trust
- Group from Leicestershire Partnership NHS Trust
- Halton Borough Council
- Hampshire County Council
- Healthwatch England
- Helplines Partnership
- Hundredfamilies
- Huntercombe Group
- Improving Lives, NHS England
- Independent Police Complaints Commission Wales
- Kent and Medway NHS and SC Partnership Trust
- Kent County Council
- Kent Panel of Associate Hospital Managers
- Law Society
- Lay members of the Royal College of Anaesthetists
- Leeds Advocacy Group
- Lincolnshire Partnership NHS Foundation Trust
- London Mental Health Act Network
- Mencap
- Mencap and The Challenging Behaviour Foundation's joint response
- Mental Health Alliance
- Mental Health Foundation
- Mental Health in Immigration Detention Working Group
- Mental Health Law Steering Group of St Andrew's
- Mental Health Lawyers Association
- Metropolitan Police
- MHA and MCA Law

- Mind
- Ministry of Justice, Victims Policy team
- Nacro
- National Autistic Society
- National Secure Forensic Mental Health Service for Young People
- Network for Mental Health
- NHS Confederation
- NHS High Weald Lewes, NHS Hastings and Rother and NHS Eastbourne, Seaford and Hailsham CCGs
- NHS Protect
- North East London NHS Foundation (NEFLT)
- North East London NHS Foundation (NEFLT) - Associate Managers
- North Somerset Council AMHP Panel
- Northamptonshire NHS Foundation Trust
- Northumberland, Tyne and Wear NHS Foundation Trust
- Nottinghamshire Healthcare Foundation Trust
- NPS Bristol and South Gloucestershire LDU and Victims Services
- Office of the Victims' Commissioner
- Police Federation of England and Wales
- Priory Group
- Prison Reform Trust
- Psychiatric Rights Scotland
- Rotherham Doncaster and South Humber NHS Foundation Trust
- Revolving Doors
- Royal Association for Deaf People
- Royal College of Nursing
- Royal College of Psychiatry
- Shropshire Council group of approved mental health professionals
- Social Perspectives Network
- Solent NHS Trust
- South Essex Partnership University NHS Foundation Trust (SEPT)
- South West Yorkshire Partnership NHS Foundation Trust
- Standing Commission on Carers

- Suffolk County Council (Adult Community Services)
- Surrey CCG Collaborative
- Sussex Partnership NHS Foundation Trust
- Tees, Esk and Wear Valley NHS Foundation Trust
- The April Centre
- The British Association of Social Workers
- The Carers Trust
- The Children's Society
- Victim's Policy Team, Offender Management and Public Protection Group, NOMS
- Warrington based AMHPs
- West London and St George's Mental Health Trust
- West London Mental Health NHS Trust
- West Midlands LA DoLS Leads Group
- West Sussex County Council
- Wolverhampton City Council
- Young People's Health Partnership
- YoungMinds

Note: Responses from Healthwatch Hertfordshire and Rescare were also received by the Department but were not available for inclusion in the independent themes analysis by the Evidence Centre. They were considered by Department of Health and other Government department officials.

Department
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2902943 Produced by Williams Lea for the Department of Health