

ar gyfer pobl
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hafal

for people
with severe
mental illness

CONSULTATION BY THE WELSH ASSEMBLY GOVERNMENT ON THE MENTAL HEALTH ACT CODE OF PRACTICE FOR WALES AND RELATED MATTERS

Hafal's Response

On behalf of:

- 1,000 Hafal Members – people with severe mental illness and their carers.
- Other clients of Hafal's services, both service users and carers.
- Over 450 responses to the "Jo's Blog" consultation on the Code of Practice.

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25 January 2007

1. Introduction

My name is Jo Roberts and I am a service user. I have been working with Hafal on the consultation for the Code of Practice, and have been asked by them to introduce this response.

When the consultation process began I felt very strongly that the opinions of service users like me and their carers should be clearly heard. After all, I have been detained on a number of occasions in my life and I know how it feels to be subject to Sections.

So I decided to start a Blog. My aim was just to get my point of view across and maybe start a bit of discussion. But the response was overwhelming. Over 450 people contacted me offering their input and support – the majority being service users like myself. So considerable was the feedback that Hafal has substantially based this response on comments from Jo's Blog. It represents the real views of people like myself.

From the responses to my Blog there are key messages which I want to summarise here.

First and foremost, the clearest message that came from the responses to the Blog was this: **Don't miss this opportunity to put care planning at the heart of the Code of Practice.**

What everyone agreed on was that care planning must relate not just to aftercare but to the period of detention. My life does not stop when I go to hospital. For example, I still have the same need for a social life, and I will still have educational and employment aspirations. The Code as it currently stands does not adequately ensure that I will receive proper care planning from the moment I am detained. I spent years in Ashworth and I know what it feels like to be institutionalised with no end in sight and no appreciation that my life is what I am living right now. Users and their carers need the Code to **guarantee** that care planning will happen immediately one is detained and that the quality of the planning will be holistic. There are eight key areas that we have identified and all of these areas should be the absolute minimum for what is required of a care plan. **This is such an important and central issue for users and carers that it warrants a chapter of its own in the Code.**

Other concerns were: (i) We need to know that the **principles** will directly improve the quality of the care we receive, and (ii) We need to make the Code of Practice much more accessible. I do realise that the Code is meant to be a working document for professionals; however, as it directly affects my life I need to be able to understand it as well.

I feel like there is an opportunity in this consultation to really improve the quality of the care that I and other users and their carers receive. In my experience as a user of mental health services for nearly 20 years, these opportunities have not come along very often. I hope that the Welsh Assembly Government will use this window of opportunity to make a real difference to our lives. And I ask you to please take this response fully into account when making your decisions, as it represents the views of those people in Wales who will have to live with the Code of Practice.

Jo Roberts
January 2008

2. About us

Hafal is a charity run by its 1000 Members: people with direct experience of severe mental illness. Our Members are those in Wales most directly affected by Code of Practice: those with severe mental illnesses such as schizophrenia and bipolar disorder, and their carers.

This submission represents the views of Hafal's Members and clients, many of whom have been subject to the Mental Health Act. In putting this response together we have gathered feedback from discussions about the 2007 Act and Draft Code at meetings across Wales. This response is also based on comments arising from "Jo's Blog" – a web log started by Hafal Member Jo Roberts that focused specifically on the Draft Code of Practice. Jo continues to be subject to Section 37/41 of the 1983 Mental Health Act and gave evidence to the House of Commons Pre-Legislation Scrutiny Committee and the Welsh Assembly Government on the Draft Mental Health Bill. Jo's aim in writing the Blog was to elicit the opinions of service users and carers – those directly affected by the Code of Practice: over 450 people, the majority users and most of the rest carers, responded to the Blog.

Hafal is the lead organisation in Wales working for people recovering from severe mental illness and their carers: every day our 150 staff and 200 volunteers provide support to over 800 people across the 22 counties of Wales. The charity is founded on the belief that people who have had direct experience of severe mental illness know best how services can be delivered. In practice this means that at every project our clients meet to make decisions about how services will move forward and the charity itself is led by a board of elected Trustees with extensive direct experience of mental illness.

Our mission is to empower people with severe mental illness and their carers to enjoy equal access to health and social care, housing, income, employment, education and to:

- achieve a better quality of life
- fulfil their ambitions for recovery
- fight discrimination.

3. Overview

Hafal, and our Members, of course accept that there will unfortunately be times when, because of severe mental illness, people have to be detained, whether in their own interests or occasionally for the safety of others. At the same time, in line with our mission statement, we believe that people with severe mental illness should have access to good quality services when their illness means they need them. We believe this for every person with a severe mental illness in Wales but, specifically in relation to this context, we very strongly believe that when health and social care services take the exceptional step of depriving a person of their liberty because of psychiatric illness, there is a clear duty on those services to ensure that that person (now “a patient”)...

- is **kept fully informed** as what is happening to them, and why decisions are being made to deprive them of their liberty
- is **fully involved** in the planning of their own treatment and care
- has confidence that **all aspects of their lives** are being considered and safeguarded, and that it is not only their psychiatric symptoms that are being considered
- can expect that there will always be a focus on **promoting their recovery** and that their circumstances, treatment and care will be **regularly reviewed** so that their detention is lifted at the earliest reasonable opportunity.

We also believe that **the relatives and carers who are important to that person** should be kept informed about decisions made about him or her, and are encouraged and allowed to be fully involved in supporting the patient both in the present and the future.

We have made some specific points about issues concerning carers and the Nearest Relative in our notes on those chapters (Chapters 19 and 20). These points are informed by the views of the 222 carers who responded to Jo’s Blog, and on feedback from the All Wales Mental Health Carers Forum – a forum facilitated by Hafal involving over 30 mental health carers groups. The main point that we wish to make with regard to carers is that the opportunity has been missed for the Code to create a step change in understanding and fully valuing the carer’s role. The Code needs to spell out exactly and explicitly the role and rights of the carer in respect of each aspect of the patient’s treatment and care pathway.

Finally we believe that service users and carers want to work **in partnership** with statutory services knowing that, if statutory services listen to their personal experiences, services will be improved for the future.

We want to emphasise that we recognise the work that has already gone into preparing the draft Code and much that is positive within it. However, we believe there are also missed opportunities and key omissions, and so in this response our aim is to offer and suggest changes, amendments and additions which we consider essential in developing a sufficiently robust and fair Code, and which are entirely consistent with the important principles set out in Chapter I of the draft Code. Our suggested changes are also made from the perspective outlined above and, specifically, our amendments seek to clarify and enhance:

- the **information** given to patients who are detained under the Act,
- the **involvement of patients in the planning and implementation of their own care and treatment**, and the involvement of their **relatives and carers** wherever appropriate,
- a **holistic approach** to the care and treatment of patients
- **involvement** of service users and carers in drawing up and reviewing the **policies** required within the draft Code.

How we have ordered our comments

In submitting our comments:

- we first respond to the Consultation questions in the introduction to the draft Code;
- and, second, having considered each chapter of the draft Code in turn, we include detailed comments under that chapter heading where we have such comments.

In our detailed comments:

- where we include paragraph numbers, these refer to the existing paragraphs in the draft Code,
- where we suggest specific additions or changes to the text in the draft Code, we have set out these additions or changes *in italics*.

4. RESPONSES TO THE CONSULTATION QUESTIONS

A. Comments on the structure, style and tone of the draft Code

We acknowledge the work that has gone into writing the draft Code and we commend much of the content. However, it is clear that the chapters have been written by different authors and we suggest considerable editing is required to achieve a uniformity of style in line with the best written chapters. For example, we found the language in chapters **14** and **30** the simplest and easiest to read. We particularly commend the language in **30.5** and **30.6**, and are somewhat disappointed this accessible language is not replicated throughout the Code. In contrast we found the language in chapter **17** relatively inaccessible and difficult to read, one of the problems being the overuse of the passive tense. We are aware of the Mental Capacity Act Code of Practice and hope the draft Code can be edited to achieve the type of style in that document.

Within the code there are a range of phrases used to refer to mental health professionals. For example, just in Chapter 1 there are references to “those who perform functions under the Act” (1.17), “practitioners” (1.19, 1.20, 1.29) “staff” (1.21), and “mental health professionals” (1.18, 1.28). It may be that subtle differences are intended in the use of these differing terms but, if so, those subtleties are not obvious. It would be helpful if, in this regard, consistent language is used throughout the Code.

We believe it would be helpful if significant sections of the 1983 and 2007 Acts could be reproduced in the relevant chapters in the Code.

We wonder how far the Code will be accessible to non-professionals, despite the reference to this in the Introduction, paragraph v, and we suggest that a shortened version specifically for service users, families and informal carers may be necessary.

We anticipate that, however well the Code is written at this point, parts of it will need to be revised and amended in the light of experience. We hope, therefore, that a review and rewriting of the Code will be programmed by the Welsh Assembly Government within one to two years.

B. The guiding principles

We have included detailed comments under our Comments on Chapter 1 below.

C. WAG mental health and related policy

We believe the Code could be more explicit about the interrelationship between its guidance and that around CPA and Unified Assessment, and we refer to this issue in

detail in our response to **F** below. Where we consider the draft Code fails to consider other important aspects of mental health policy, we have included comments under the appropriate chapter below.

D. Equality

Again where we believe equality issues have not been properly considered, we have included comments under the appropriate chapter below.

E. Issues relating to the Welsh Language

We feel that issues relating to the Welsh Language are not adequately covered in the Code of Practice. Welsh Language considerations could be set out more clearly in a separate section as well as being referred to within other chapters where appropriate: this would ensure that professionals, patients and carers have a ready point of reference regarding Welsh Language issues. A separate guide to Welsh Language issues would also be extremely valuable.

F. Issues that may be missing from the draft Code

Throughout the Code there are numerous references to care plans, treatment plans, care plans under CPA and care programmes, which suggest just how important care and treatment planning is for all mental health patients, whether or not they are detained under the Act. Such references include:

1.13 Principle of patient involvement in care and treatment planning

1.27 to 1.30 References to “Care programmes”, “programmes of care” and “care plans”

6.8/6.9 References to “a comprehensive care plan” within Guardianship

10.38 Reference to “care planning/CPA” in relation to MHRTs

11.29 to 11.34 Reference to “treatment plans” within “care programmes”

14.8 Reference to psychological treatments within a “care plan”

15.7/15.9 References to “high quality care planning” in relation to supporting people safely in hospital

17.21 Reference to “care planning (and the CPA)” in relation to Information

20.5 to 20.11/20.12 References to “care plans” in relation to involvement of carers and to Unified Assessment

26.31 References to “CPA/Unified Assessment” in relation to CTOs

28.5/28.11 to 28.19 Reference to “CPA” and “After-care planning”

However, we suspect such references have been included by different authors, and the various terms are often used too loosely and there is a lack of consistency in the terminology. Overall, therefore, the guidance fails to offer a clear framework for practitioners and patients on care and treatment planning.

We believe this is a very important omission. Based on the experience of our members and the many comments we have received in response to “Jo’s Blog”, Hafal believes systematic and holistic care planning is an essential part of the role of statutory agencies if they are to work effectively with patients, to support them towards recovery from their mental illness, and to reduce the risk of further detention under the Act. We, therefore, very much welcome the sentence in **28.5** of the Code which states: “The planning of after-care therefore needs to start when the patient is admitted to hospital and for those patients to whom Care Programme Approach (CPA) applies should continue as part of the CPA planning and review process.”

At the same time, we are concerned that the Code does not state explicitly that the care planning which should begin as soon after admission as possible is important, not just in relation to aftercare, but also in guiding the care and treatment to be given to the patient **at the time he or she is still detained in hospital**. We also believe the Code misses an important opportunity to offer detailed guidance on how care planning should be undertaken with patients, and their relatives and carers. We also believe that while there are frequent references in the Code to CPA (and fewer to Unified Assessment), it fails to offer real clarity around the relationship between this guidance and other statutory guidance around CPA and Unified Assessment.

To resolve this omission, there are two possible options

- either to rename Chapter 28 as “**Care Planning and After-Care**”, and expand it to give much clearer guidance about the whole process of care planning to support the recovery of **all** patients whether in psychiatric hospitals, discharged from hospital, or subject to community orders;
- or include an additional chapter in the Code entitled “**Care and Treatment Planning**” which offers the clearer guidance suggested in the first option but also draws together the differing references to care and treatment planning throughout the Code, and makes clear how guidance in the Code fits with WAG guidance on CPA and Unified Assessment.

Our clear preference is for a separate chapter wholly devoted to care and treatment planning which appears early in the Code and sets the scene for the guidance in a number of later chapters. While we have not attempted to write such a chapter, we offer at the end of this section (after J below) detailed suggestions as to the content to be included in such a chapter. (We would of course be happy to contribute to the writing of such a chapter and/or to contribute to the drawing up of templates to back up such a chapter.)

G. Professional responsibilities and decision making under the Mental Health Act

In response to this question, we refer again to our response to **F** above which we believe could be enormously helpful in increasing consistency across professionals around the whole area of care and treatment planning.

H. Flowcharts

We believe that there would be value in including flow charts to make some of the text more accessible.

I. Material that could be left out of the draft Code

There is material within the draft Code that is somewhat repetitive and which could be reduced. However, we suggest it is more important to accept the Code will be a lengthy document, and that it needs to be laid out in such a way that it is as easy as possible to access the relevant reference sought. An index may be helpful in this regard.

J. Commissioning and managerial responsibilities

In response to this question, we refer again to our response to **F** above which we believe could again be helpful, in particular, in managing service provision.

4. Proposed Chapter on Care and Treatment Planning

General Comments

As stated above, we have not attempted to write a text for this proposed chapter but, based on the comments of service users and carers, we suggest that the following areas should be included in such a chapter.

1. Refer back to the principles in **1.13**, and **1.27 to 1.30**.
2. Refer to WAG guidance on **CPA** and **Unified Assessment**
3. Offer guidance on the relevance of this chapter at critical points in the patient pathway, as set out in the various chapters of the Code, including:
 - following detention under Section 2 or 3
 - as part of treatment planning, including psychological treatments, under Section 3
 - in relation to supporting people safely and therapeutically in hospital
 - in relation to aftercare
 - as part of Guardianship
 - as part of SCT and CTOs
 - in relation to the provision of information
 - in relation to MHRTs
 - in relation to involvement of carers
4. Offer guidance about the **key elements** of care planning as already set out in **28.8**, but also emphasising the key point that the overall aim of care planning is to help, support and empower the patient towards his or her recovery whether he or she is in hospital, about to be discharged from hospital, or subject to a community order (Guardianship or SCT)
5. Offer guidance as to how **risk assessment** and **treatments plans** form part of care planning
6. Offer guidance as to **who should be involved** in the care planning process, including the central involvement of the patient, and their relatives and carers as already set out in **28.13**
7. Offer guidance as to **who should coordinate** the negotiation and delivery of the care plan, whether AMHP, Responsible Clinician, CPA Co-ordinator, or other professional
8. Offer guidance as to the **holistic** nature of “high quality care planning” and about the areas to be included in a care plan in line with **28.17**, and clearly stating that regard should be given both to the period when the patient is detained in hospital and to the period after discharge. We suggest this guidance could more accessible if set out as a table as included here:

Areas for holistic Care and Treatment Planning	Care and Treatment Planning for detention in hospital	Care and Treatment Planning for aftercare and Guardianship/SCT
Medical Treatment	Information for, and discussion with, the patient about any proposed medical treatment	Continuing review of the patient's treatment plan on and after discharge, in partnership with GP
Psychological and other Treatments	Access to appropriate psychological and other treatments in hospital	Continuing access to psychological treatments in the community
Physical Health	Review of all aspects of a patient's general health, including medical issues, dentistry, optician and lifestyle issues and how these will be covered in hospital	Encourage appropriate contact with GP and continuing consideration of all aspects of a patient's general health, including medical issues, dentistry, optician and lifestyle issues
Housing or Accommodation	Consideration of accommodation issues inside hospital Consideration of security/maintenance of the patient's home in their absence	Preparation of the patient's home for discharge Registration of homelessness/referral for supported housing where appropriate
Employment	Occupational therapy and other structured opportunities within hospital. Support to maintain contact with an existing employer or to seek vocational guidance	Support to contact employment agencies, access specialist mental health employment services, seek new job opportunities, or to volunteer
Training and Education	Opportunities for learning in hospital or accessed from hospital	Opportunities to take up training or educational courses in the community

Finance and Money	Support to access benefits or other income, and deal with financial problems/anxieties when in hospital	Support with maximising benefits, budgeting and responding to financial anxieties on discharge and at home
Social Life	Access to social activities within hospital. Support to maintain or build relationships with family or friends when in hospital	Support to maintain or build a social network and leisure activities in the community

It is vital that the Code requires that Care Plans explicitly address the above eight areas as a minimum, systematically and in a written format which both requires and assists the responsible professional to cover each area.

We emphasise this care planning grid or model is built upon the direct experience of service users. We know of many examples, for every aspect of this list, where service users who have been detained have suffered, and their mental health further compromised, because proper attention has not been paid to that aspect.

7. Offer guidance as to the routine points when care plans should be **reviewed** and when the change in circumstances of a patient should trigger a review. Key points will be that a pre-existing care plan should be reviewed when a person is admitted to hospital and on discharge.

6. DETAILED COMMENTS ON CHAPTERS WITHIN THE CODE

Comments on Chapter 1 – The Guiding Principles

General Comments

Hafal continues to regret the opportunity missed in the drafting of the 2007 Act to include a clear set of principles to guide the assessment and treatment of people with severe mental illness, but very much welcomes the comprehensive set of principles included in chapter 1 of the Code. As we consider this to be a very important chapter, setting the tone for the Code, we have looked at it in detail.

In general terms we are happy with **the content** of the chapter, but we do have a major concern that there are some 20 principles set out in paragraphs 1.10 to 1.30, and it is unclear from **the presentation** which of these are of primary importance, and which are more secondary. We also believe the views of service users and carers should be regularly sought so they can comment on the extent to which the care and treatment they receive is congruent with these principles. You may, therefore, wish to consider how SMART these principles are to achieve this aim.

We therefore set out a number of detailed suggested amendments to this chapter, mainly to attempt to improve on the presentation. In our amendments, we:

- suggest there are 10 primary principles which we believe should be highlighted in the text (perhaps using a different colour) and which should be set out in an introductory section,
- some minor rewording to draw out or improve the sense of some paragraphs.

Our amended wording for this chapter is set out in italics as follows:

SUMMARY

This Code establishes ten guiding principles, consistent with the four principles in the strategy “Adult Mental Health Services for Wales”, which should underpin decision making under the Act. They are:

Empowerment

1. *Patient well-being and safety should be at the heart of decision making.*

2. *Retaining the independence, wherever practicable, and promoting the recovery of the patient should be central to all interventions under the Act.*

3. *Patients should be involved in the planning, development and delivery of their care and treatment to the fullest extent possible.*

4. *Those who perform functions under the Act should pay particular attention to ensuring the maintenance of the rights and dignity of patients, their carers and families, while ensuring the safety of patients and that of other people. (Or suggested alternative wording...Practitioners performing functions under the Act should pay particular attention to ensuring the maintenance of the rights and dignity of patients, and their carers and families, while also ensuring their safety and that of others.)*

Equity

5. *Practitioners must respect the diverse needs, values and circumstances of each patient.*

6. *The views, needs and wishes of patient's carers and families should be taken into account in the assessment and delivery of care and treatment.*

7. *Practitioners should ensure that effective communication takes place between themselves, patients and others.*

Effectiveness and Efficiency

8. *Any person made subject to compulsion under the Act should be provided with evidence-based treatment and care, the purpose of which should be to alleviate, or prevent a worsening of, that person's mental disorder, or any of its symptoms or manifestations.*

9. *Practitioners should ensure that the services they provide are in line with the Welsh Assembly Government's strategies for mental health and learning disability.*

10. *Practitioners from the appropriate range of statutory and non-statutory agencies should work in partnership to meet the needs of patients, and their carers, through the delivery of their care programmes.*

BACKGROUND TO THE GUIDING PRINCIPLES

1.5 to 1.9 No suggested changes

GUIDING PRINCIPLES

Empowerment

- 29.29** *Patient well-being and safety should be at the heart of decision-making.* Where relevant, this should also be consistent with ensuring the wellbeing and safety of others. (The wording...“this incorporates ensuring” ...seems particularly clumsy and inaccessible.) *Patients and...*(continue as text)
- 1.11 (as text)
- 1.12 *Retaining the independence, wherever practicable, and promoting the recovery of the patient should be central to all interventions under the Act.* Alternatives to avoid...(continue as text)
- 1.16 (as text – This paragraph seems to follow more logically after 1.12)
- 1.13 *Patients should be involved in the planning, development and delivery of their care and treatment...*(and add)...*to the fullest extent possible.* Alternatives...(continue as text)
- 1.14 (as text)
- 1.15 (as text)
- 1.16 *Those who perform functions under the Act should pay particular attention to ensuring the maintenance of the rights and dignity of patients, their carers and families, while ensuring the safety of patients and that of other people.* (Or suggested alternative wording...*Practitioners performing functions under the Act should pay particular attention to ensuring the maintenance of the rights and dignity of patients, and their carers and families, while also ensuring their safety and that of others.*) This should...(as text)

Equity

- (1.18 We are unclear why this paragraph is included under Equity and suggest it more logically comes immediately before 1.27.)
- 1.19 *Practitioners must respect the diverse needs, values and circumstances of each patient.* They must pay due regard to all the (note typo) legislation relating to equality and non-discrimination, and give due and positive regard to the needs of each patient including consideration of their:
- (bullet points as text)
- (final sentence as text)

- 1.20 **The views, needs and wishes of patient’s carers and families should be taken into account in the assessment and delivery of care and treatment.** *Particular...*(continue as text)
- 1.21 **Practitioners should ensure that effective communication takes place between themselves patients and others.** *All those...*(continue as text)
- 1.22 (as text)
- 1.23 (as text)

Effectiveness and Efficiency

- 1.24 **Any person made subject to compulsion under the Act should be provided with evidence based treatment and care, the purpose of which should be to alleviate, or prevent a worsening of, that person’s mental disorder, or any of its symptoms or manifestations.** *Treatment...*(continue as text)
- 1.25 (as text)
- 1.26 (suggested new wording to improve the sense) *Patients should be offered treatment and care in environments that are safe (for them and for the public) and supportive, and which enable practitioners to deliver a range of therapeutic interventions with a focus on patient recovery, and other positive clinical and personal outcomes. Such environments should also be appropriate to a person’s age and gender, and to their cultural and religious needs, and should allow for a patient’s dignity to be maintained to the fullest possible extent.*
- 1.18 **Practitioners should ensure that the services they provide are in line with the WAG’s strategies for mental health and learning disability.** *This will ensure...*(continue as text)
- 1.27 (Suggested new text) **Practitioners from the appropriate range of statutory and non statutory agencies should work in partnership to meet the needs of patients, and their carers, through the delivery of their care programmes.** *This is particularly...*(continue as text)
- 1.28 (as text)
- 1.29 (as text)
- 1.30 (as text)

Comments on Chapter 2 – Examination and assessment prior to application for admission to hospital and guardianship

- 2.3** We do not understand the inclusion of the wording “It can assist the assessment process for the assessors to see the person” which seems to run contrary to the clear statements in 2.23/2.25/2.26 and 2.43 to 2.46 as to how assessors should see and interview the person carefully. We believe this wording is, therefore, misleading and should be deleted.
- 2.25** We suggest “*professional*” rather than “suitable” in the first line.

We commend the guidance in **2.23 to 2.26** and **2.43 to 2.46** which places important requirements on assessors in interviewing patients. We suggest that in **2.43** there should be a clear reference to the appropriate paragraphs after “provided above”.

Comments on Chapter 4 – Places of Safety and police powers

While acknowledging the guidance in **4.17, 4.18 and 4.19** that police stations should be an option of last resort, Hafal continues to believe that police stations should **never** be used as Places of Safety for people who are significantly unwell and potentially in need of treatment. The Code itself in essence also states this in **29.2**.

Hafal welcomes the guidance on local policies in **4.10** but would like to see additional wording to state:

“Such policies should be subject to local consultation and the comments of service users and carers should be properly considered.”

We note there is no reference to the requirement to ensure the availability of Appropriate Adults in line with PACE legislation and codes of practice, and suggest an appropriate reference is included in this chapter.

Comments on Chapter 6 – Guardianship

- 6.8** We welcome the guidance that “An application for Guardianship should be accompanied by a comprehensive care plan”, but suggest an addition after “advance statements” to read: “*and the patient should be included as fully as possible in its formulation*”.
- 6.9** We have made detailed suggestions above in relation to care planning and, in line with these, we suggest this paragraph should begin: “*The care plan*”

should be drawn up in line with the guidance in chapter (enter number) on care planning and key elements of the plan should include”.

We also suggest a rewording of the third bullet point to read:

- *suitable accommodation appropriate to the person’s needs*

Comments on Chapter 8 – Hospital Holding Powers

8.3 We believe the reference to “a compliant patient” is inappropriate and suggest the alternative wording “...*is considered to be a patient who has come to the ward willingly and who has not acted to resist (verbally or physically) the admission procedure.*”

8.13 We suggest the addition “...*and their nearest relative...*” after “The Patient...”.

Comments on Chapter 10 – Duties of Hospital Managers

29.29 We suggest this amended wording:

“The patient should be given the opportunity to comment on the acceptability of their proposed Responsible Clinician and every effort should be made to accommodate a request for an alternative Responsible Clinician, where appropriate and practical.”

29.29 We suggest amended wording in the first sentence to make this paragraph more positive:

“...Local health Board and LSSA in order to arrange for a section 117 care planning/Care Programme Approach meeting before the MHRT takes place and to compile a report for the MRHT.

Comments on Chapter 11 – Treatment for mental disorder

Hafal welcomes the inclusion of the section on **Treatment Plans in 11.29 to 11.34** and would like to see this section clearly linked to a chapter on Care and Treatment planning referred to above.

Comments on Chapter 12 – Appropriate medical treatment

12.8 While we understand the sort of balance this paragraph may be attempting to achieve, we believe it ought to make a clearer and more positive statement

about the treatment to be given to detained patients. (The word “offered” also seems inappropriate in this paragraph as it refers to compulsory treatment.) The wording we suggest is:

“Any medical treatment given must be an appropriate response to the patient’s condition and situation. Every effort should be made to give the best treatment possible, although this may not always be the most ideal treatment which may be available for that patient. Where a preferred treatment is not available, this should be explained and discussed with the patient, and their relatives.”

- 12.9** As is stands, the sentence that begins “On the other hand..” seems contradictory to the last sentence in this paragraph and to the test set out in 12.2. We suggest that either this sentence is deleted or the “specialist care” referred to needs to be defined much more clearly.
- 12.10** The first sentence in this paragraph is at best unclear and at worst contradicts the principles in Chapter 1, as a patient’s attitude to treatment proposed for them will **always** be relevant. We therefore suggest this sentence needs to be revised.

Finally, we doubt the terminology “**decision-makers**” in 12.9 and 12.12 will be clear to service users and relatives, and we suggest it is revised.

Comments on Chapter 14 – Psychological Treatments

14.2 We suggest the addition after “diagnosis” to read “...and should always be given due weight alongside other treatments.”

Comments on Chapter 15 – Supporting patients safely and therapeutically

We suggest the following amendments/additions in this Chapter

- 15.6** To be added after the existing sentence: “*Decisions about interventions should be discussed with the patient as far as possible and, where appropriate, included in their care and treatment plan.*”
- 15.8** We are concerned that the guidance places no responsibility on managers or staff to minimise or eradicate the factors in this paragraph and suggest that such a responsibility to report and deal with such factors should be clearly stated at the end of the paragraph.

- 15.9** In relation to the point about access to “open space and fresh air”, we have been told by service users of times when they have been denied such access for lengthy periods and we, therefore, suggest the amendment “...have *regular, and preferably daily, access to...*”.
- 15.15** To be added at the end of the paragraph: “*Options should be discussed with the patient wherever possible and included in their care/treatment plan where appropriate.*”
- 15.27** Hafal receives reports of serious incidents of aggression/violence, including rape, on hospital wards where the victim felt the alleged violence was not taken seriously by hospital managers and staff, and where no attempt was made to report such alleged crimes to the police. While we therefore welcome the guidance in 15.27 we do not believe it goes nearly far enough and believe the guidance should be considerably more specific. While we do not have specific wording to suggest, we believe that there should be guidance about the need for hospitals to have clear policies (including where appropriate involvement of the police) for when patients (or others) have suffered serious assaults when in, or detained in, hospital.
- 15.38** We are concerned that the requirement for a practitioner to be “within sight and sound” of a seclusion room does not go nearly far enough and service users have reported to us incidents when, in a frightened and confused state, they have been subjected to seclusion from others with just the most minimal non verbal contact with staff (through an opening in a locked door) for many hours. We therefore consider this guidance should be strengthened to include as much human contact as possible, consistent with the need to seclude a patient for their own safety and that of others. We also suggest that such seclusion should be discussed with the patient’s Responsible Clinician and the person’s AMHP/ relatives/advocate as appropriate.

Comments on Chapter 16 – Personal searches

- 16.12** We suggest the addition after “Patients, staff and visitors should be informed that there is a policy on searching” stating: “*and have the opportunity to comment on and inform such a policy*”.

Comments on Chapter 17 – Information for detained patients, those subject to supervised community treatment of guardianship, and Nearest Relatives

General Comments

Unfortunately we found this chapter, which is all about information for detained patients, to be written in a style that is difficult to read and understand. In particular it seems to include an overuse of the passive voice, which fails to give a real sense of empowering people. We therefore suggest it is significantly revised and we offer some specific suggestions for such a revision.

We suggest, for example, that there is nothing wrong with the phrase “to give information” and wonder why the writer sought to use phrases as “the delivery of” (17.1) and the “imparting” (17.4) of information.

17.6 Suggested rewording of the first sentence:

“The patient should be given clear information explaining why they are being detained, so that they can adequately and effectively challenge their detention should they wish to do so. This information should set out in full the specific reasons for their detention, rather than offering broad reasons why a section may be applied to a person. If the reasons for a patient’s detention then change, the person should be kept informed of such changes as they happen rather than only at the point where they may decide to challenge their detention.”

17.11 Suggested additional first bullet point:

- *how the proposed treatment fits into their treatment and care plan;*

The wording in the following two important paragraphs is particularly difficult to understand and we suggest these alternative wordings:

17.14 *Information about the IMHA service, including information about how to obtain this support, should be given to patients who qualify for this support as soon as practicable. The person who holds the responsibility for giving this information to “qualifying patients” is set out in the table below;*

17.15 *“IMHAs have a significant role in supporting and helping qualifying patients to obtain and understand the type of information set out in this chapter, and in supporting them to exercise any rights they may have under the Act. It is important therefore that protocols are in place to secure the involvement of IMHAs as speedily as possible so that, where appropriate, patients can be*

supported to access information and exercise their rights under the Act. The IMHAs role...

17.23 We suggest the addition of “...and is culturally sensitive...” after “...can be understood...”.

17.42 We suggest an addition in second bullet point to read: “...the requirements of the law, *and of this code of practice*, and at...”

Comments on Chapter 18 – Visiting patients in hospital

General Comments

We have received a number of comments from service users and their relatives as to the importance of this Chapter, especially in relation to those patients who are detained in high secure and medium secure units, often a long way from their homes. We are aware of situations where patients have felt that staff have not been welcoming to appropriate visitors, and we know of one situation when a patient was not visited by his family for 9 years because of practical and financial difficulties. We have sought to reflect these comments in our suggested amendments.

We find the order of this chapter to be rather odd, if not unfortunate, and suggest a better order would be for the section on **Facilitation of visiting, 18.16/18.17/18.18**, which should set the scene, should come before **Grounds for excluding a visitor, 18.6/18.7/18.8**.

18.2 We suggest the second sentence reads “...in a patient’s care, treatment *and recovery*.”

18.9 This paragraph is not easy to understand and fails to offer any guidance about the need for an initial discussion with the patient. We, therefore, suggest the amended wording to the second sentence:

“Where such a concern exists, the Responsible Clinician should discuss this with the patient and should only consider excluding a visitor if a noticeable...”

We suggest there should be a clearer definition of children in the context of **18.15**. The stringent agreements required for children to visit may be right for very young children but seems overzealous for older children. In addition we believe it should be stated that policies should be subject to change based on comments of patients/relatives.

We also suggest some wording in **18.16/18.17** should be clearer, and more positive and definite, for example:

18.16 *Hospital managers should ensure that there are sufficiently flexible arrangements in place to enable patients to receive regular visits, if they wish to. Staff should be welcoming to visitors and, ordinarily,....*

18.17 *Hospital managers should ensure that the facilities...*

18.18 We believe the wording in this paragraph should be clearer and stronger to the effect that hospital managers should offer practical and financial assistance to help relatives to visit.

General Comments on Chapters 19 and 20

Hafal has consulted with a significant number of carers regarding the Draft Code of Practice. A remarkable 222 carers responded to Jo's Blog. This response is also informed by discussion in Hafal's carer groups, and in the Hafal-facilitated All Wales Mental Health Carers' Forum which has members in every county of Wales.

In Wales there has been some progress in listening to carers and acknowledging their important role – for which the Welsh Assembly Government can take credit. But we need a step change in fully understanding and valuing carers' input. The Code offers an opportunity to highlight and address the essential role of the carer. That opportunity has not been taken up sufficiently in the current Draft.

Chapter 20 of the Draft identifies some of the key principles with regard to carers' involvement during the detention and treatment of patients under compulsion and briefly summarises some of the practicalities of engaging carers during crisis. However, we believe that there is a need for a much stronger message in terms of key principles. The Code needs to set out the vital role and rights of carers as the most important providers of care and support – often providing the only continuity of care from the onset of illness to recovery.

The Code needs to spell out exactly the role of the carer with regard to protecting the legal rights and liberty of the patient. It needs to describe in concrete fashion how carers will be engaged in the process of compulsory treatment, with examples of how that engagement can be made to work effectively. Expansion of Chapter 20 may be insufficient to achieve this – the development of a key guide to carers' involvement and rights would, we feel, be advisable.

Furthermore, carers need to be fully taken into account in care planning. Under each area addressed in a patient's Care Plan the role of the carer needs to be clearly stated. The carers' support needs also need to be recorded and addressed as a standard practice.

The Code also needs to convey more firmly to professionals (and to carers themselves) not only the rights of carers, but how supportive they are in providing care.

Other Comments on Chapter 19 – The Nearest Relative

This chapter necessarily addresses the legal aspects surrounding the management of the aspects of the Act concerning the Nearest Relative. However, it is unfortunate that in the Code the opportunity has not been taken to set out the sensitive management issues that surround this difficult area.

The Code needs to give guidance to those managing the process to ensure that it is dealt with sensitively. The Code needs to set out how important relationships can be maintained for patients and the Nearest Relative through any matters of dispute.

It would also be helpful if the definition of the Nearest Relative is included in the chapter.

We also suggest the following amendments:

19.9 Addition of “..., *having regard to any advance statement which may have been made by the patient*” after “...AMHPs should consider proposing this in appropriate circumstances”.

19.16 Addition of “(*including financial support*)” after “Where the applicant is the patient, support”

Other Comments on Chapter 20 – Involvement of Carers

We suggest the following amendments:

20.5 Addition of “...*including risk assessment...*”, after “...care and treatment...”

20.6 “... carers can provide relevant, detailed and *up to date* information *about* the person and *their needs, wishes and lifestyle*, which ...”

20.7 Addition of a bullet point:

- *invitations to appropriate meetings;*
-

20.8 Addition to second bullet point: “...”*accurate information about the patient’s current and proposed care and treatment plans.*”

20.11 Addition of a bullet point:

- *seek to understand and minimise any risks to carers;*

Comments on Chapter 21 – Independent Mental Health Advocacy

We suggest that in **21.11** who the “responsible person” is should be set out in table form (as in 7.3).

More substantially, many service users and carers have commented to us that anyone detained under the Act should qualify for the IMHA service. Since people who become subject to Sections 4, 5, 135 and 136 are clearly liable to be detained under Section 2, Section 3 or another section of the Act, we strongly believe that they should be able to access the IMHA service.

Comments on Chapter 22 – The Mental Health Review Tribunal

22.30 We suggest this should be amended to read: “The MHRT must conduct the hearing in the manner it considers to be most suitable, *and this should involve helping the patient, and any relatives, to understand and contribute to the proceedings as fully as possible.*”

Comments on Chapter 25 – Absence without leave

25.10 We suggest the inclusion of an additional sentence after “absent without leave”:

“This policy should be subject to local consultation and the comments of service users and carers should be properly considered.”

Comments on Chapter 26 – Supervised Community Treatment

General Comments

We welcome the section on **Consultation (26.20/26.21)** and the list of people to be consulted, but we suggest a further paragraph after **26.21** to clarify the sort of information to be discussed with the patient, and their relative and carers. This is, therefore, a suggested form of words for a new 26.22:

“When the Responsible Clinician or AMHP is consulting with the patient, Nearest Relative or carers about a CTO they should give clear information as to how the CTO will help with implementation of all aspects of a patient’s care plan and what other options were considered and discounted.”

Risk Assessment

However, we are concerned at the lack of reference to **risk assessment** in the section on **Conditions** and in the following sections of this chapter. We, therefore, suggest a number of additions to fill this gap.

26.23 The paragraph to start: “*Before setting conditions the Responsible Clinician and AMHP should undertake a thorough evidenced based risk assessment, using recognised risk assessment tools, and must agree...*”

26.25 The paragraph to read: “Conditions should be the minimum necessary to achieve their purpose, be in keeping with the Code’s Guiding principles, *and should be justifiable, appropriate and proportionate in line with the requirements of the Human Rights Act.*”

26.28 We suggest the following additional words:

“... the Responsible Clinician should inform the patient, orally and in written, *clearly and in full*, of the reasons for making a CTO, the conditions to be applied, *the potential sanctions for failure to apply*, and of their right of appeal.....the Nearest Relative *and any other relevant carers* should be ...”

26.32 Amendment to the last sentence: “If the patient is not complying with the conditions, *a further risk assessment should be undertaken and appropriate action may need to follow -...*”

26.41 Addition to the second sentence: “The Responsible Clinician *should undertake a further risk assessment, consulting one or more...*”

Other comments

26.31 We welcome the inclusion of this as an important and positive paragraph.

26.33 to 26.37 We are concerned by the lack of requirement on the Responsible Clinician to consult the patient or any other appropriate people when varying CTO conditions. This may be entirely reasonable for routine, minor or uncontroversial variations, but not for more substantial or controversial variations. We, therefore, suggest there should be a requirement for the Responsible Clinician to consult on, and explain, more substantial variations. We also believe the guidance should include a clear process for the patient to seek and negotiate reasonable variations.

26.41 We do not believe the reference to 2 months is an appropriate one, and suggest a considerably shorter period is substituted.

26.44 to 26.49 Recall There seems to be no requirement for the Responsible Clinician to have to consult or inform the patient/carers orally and/or in writing of the reasons for deciding to recall, and we believe there should be such a requirement.

26.50 This is potentially a very significant paragraph for a person subject to SCT and we do not believe the intention is as clear as it should be. We, therefore, suggest this amended wording:

“Where a patient’s mental health is deteriorating so significantly that the risks to themselves or others can no longer be managed outside hospital, there may be a need for recall to hospital, even where the patient is complying with their CTO conditions. Where practicable, such a decision should be discussed with the AMHP and with their relatives and carers.”

Comments on Chapter 27 – The Hospital Managers’ power of discharge

27.33 We suggest an amendment at the beginning of this paragraph to read:

“At the time their decision is made, the reasons for the decision should be communicated in full, both.... “

Comments on Chapter 28 – After-Care

We welcome the sentence in **28.5** of the Code which states: “The planning of after-care therefore needs to start when the patient is admitted to hospital and for those patients to whom Care Programme Approach (CPA) applies should continue as part of the CPA planning and review process”, and we make detailed suggestions about expanding this guidance earlier in this response.

Comments on Chapter 29 – Assessment, admission and discharge under Part 3 of the Act

General Comments

In the chapter there are references to “restricted patients” and it would, therefore, be helpful if a clear definition of “restricted patients” is included.

In **General Matters** guidance is required on the need for appropriate psychiatric screening and diversion facilities across Wales, in line with the Mental Health NSF. Currently such facilities exist in some areas but are patchy across Wales generally.

- 29.2** We completely agree with the second sentence in this paragraph and suggest this endorses our view that a police cell should never be considered as a Place of Safety for a person requiring medical treatment for a mental disorder (see comments on **Chapter 4**).
- 29.6** We suggest the first line of this paragraph should be amended to read: “*Clear information sharing protocols should be established to enable doctors to identify and access...*”
- 29.15** This paragraph should indicate that there are a range of sentencing options available, aside from prison and hospital. We would like to see guidance that emphasizes the use of the least restrictive options available to the Court.
- 29.24** We believe this paragraph should include a national standard for appropriate transfers between prison and hospital to be achieved within a maximum of 14 days. This would be in line with transfer pilots in England.
- 29.29** We believe this paragraph should also include guidance that the patient’s care team should be informed and given adequate notice of all court hearings.

Comments on Chapter 32 – Victims

We have no specific comments on this chapter, but we do believe it is an important chapter to retain in the Code as it offers professionals, and service users and carers, important information they need to be aware of.

Comments on Chapter 33 – Mental Capacity Act

Again we have no specific comments on this chapter, other than to suggest that there should be some guidance in the section on **Independent Mental Capacity Act Advocates (33.21 – 33.23)** for those situations where a person qualifies for both an IMCA and an IMHA advocate.

7. Other Consultation Issues

Consultation on the Mental Capacity Act 2005: Deprivation of Liberty Safeguards

OUR RESPONSE

Hafal has not sought to consult widely on the DoLS regulations, as we recognise these are likely to apply more to people with a learning disability and people with dementia than to people with a functional mental illness. However, we make these comments:-

Mental Capacity (Deprivation of Liberty: Assessments, Standard Authorisations and Disputes about Residence) (Wales) Regulations 2008

In relation to **Regulations 4, 5 and 6** we believe it is important that assessors undertaking the three differing assessments should not be limited to one professional group, in order to safeguard the interests of the person as fully as possible. Consequently, since we acknowledge that the assessment in **Regulation 4** will in practice be a medical assessment, we believe it is important that the best interests assessment in **Regulation 5** is undertaken by a professional other than a doctor. We are happy, therefore, with the list in (a) to (d). However, we are concerned that, as we understand it, all three assessments in **Regulations 4, 5 and 6** could be undertaken by health care professionals and we believe that it should be stipulated that in any situation at least one of these assessments should be undertaken by a social care professional.

Consultation on the Mental Health Act 1983: Secondary Legislation

Mental Health (Approval of Persons to be Approved Mental Health Professionals) (Wales) Regulations 2008

Schedules 1 and 2 We have received some comments expressing concern at the proposed widening of the professional requirements for AMHPs to include health professionals as Chartered Psychologists, first level Nurses, and registered Occupational Therapists, but this concern was far from universal. The important point, which was more universally made, is that whoever takes the AMHP role must have the training, qualifications, skills, experience, and general authority to offer an appropriate social perspective to balance the medical perspective in a person's treatment and care.

Mental Health Act 1983 Approved Clinicians Directions 2008

Schedules 1 and 2 The comments we have received are generally supportive of the proposed widening of the professional requirements for Approved Clinicians to include Chartered Psychologists, first level Nurses, registered Occupational Therapists, and registered Social Workers.