Good Practice in Action 029
Legal Resource

Mental health law within the counselling professions in England and Wales

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Context

This resource is one of a suite prepared by BACP to enable members to engage with the current BACP *Ethical Framework for the Counselling Professions* (BACP 2018) in respect of mental health law in England and Wales.

Purpose

The purpose of this resource is to provide information for therapists and counselling service providers in respect of legal issues relating to mental health law in the context of therapeutic work in England and Wales. Some references are included for UK-wide resources to assist readers working across jurisdictions. The law in Scotland is different and will be the subject of a separate publication.

Using the Legal Resources

The *Ethical Framework for the Counselling Professions* establishes a contractual commitment between BACP members and BACP. These Legal Resources are not contractually binding on members but support good practice by offering general information on principles and policy applicable at the time of publication.

The Legal Resources should not be used to constitute legal advice in specific cases, nor are they sufficient on their own to resolve legal issues arising in practice. As practice issues and dilemmas arising from work with clients are often complex, we strongly recommend consulting your supervisor, and also, wherever necessary, a suitably qualified practitioner or lawyer. Some professional insurers will provide legal advice as part of their service.

Specific issues in practice will vary depending on clients, particular models of working, the context of the work and the kind of therapeutic intervention provided. Please be alert for changes that may affect your practice, as organisations and agencies may change their practice and policies.

References were up to date at the time of writing but there may be changes to the law, government departments, websites and web addresses, and it is important for you to keep informed of any changes that may affect your practice.

In these resources, the word 'therapist' is used to mean specifically counsellors and psychotherapists and 'therapy' to mean specifically counselling and psychotherapy. The terms 'practitioner' and 'counselling related services' are used generically in a wider sense, to include the practice of counselling, psychotherapy, coaching and pastoral care.

Counselling professionals may refer to those with whom we work as 'clients', but in this resource, an individual under the care of the mental health services may also be referred to as a 'patient,' or 'cared-for person', reflecting the terms used in current legislation.

Introduction

This resource refers to mental health law in relation to counselling as it applies in England and Wales. Although some mental health law provisions apply to other jurisdictions, additional statutory provisions and regulations are made for other regions in the UK. In England and Wales, mental health law and practice were radically reformed – the Mental Health Act 1983 was amended by the *Mental Capacity Act 2005, the Mental Capacity Act 2005 Code of Practice*, the Mental Health Act 2007, and the United Nations Convention on the Rights of Persons with Disabilities, which came into effect in 2008. Now, once again, mental health law and practice have been under critical review. Following the Law Commission review of the Deprivation of Liberty Safeguards (DoLs), the Department of Health (DH) issued a new *Mental Health Act 1983 Code of Practice* (DH 2015).

In March 2015, the NHS set up the Mental Health Taskforce, chaired by Paul Farmer (Mind's Chief Executive) seeking the views of mental health service users, their families and professionals to develop a new five-year strategy for mental health, focusing on prevention, access, integration and attitudes, with the goal of full implementation by 2020, but was delayed by the impact of the COVID-19 health pandemic. It was followed by a Department of Health consultation 'No voice unheard, no right ignored.'

In October 2017, the then Prime Minister announced an independent review of the Mental Health Act 1983, chaired by Sir Simon Wessely, to make improvements following rising detention rates, racial disparities in detention and concerns that the Act was out of step with a modern mental health system. The review team was also asked to consider how to improve practice within the existing legislation.

On 8 December 2018, the Government announced new legislation in the form of a Mental Health Bill, following publication of the final report of the Independent Review of the Mental Health Act 1983, (accessible at: www.gov.uk/government/publications/modernising-the-mental-health-act-final-report-from-the-independent-review).

Currently the guidance remains the *Mental Capacity Act 2005 Code of Practice* (available from the Stationery Office (TSO)).

Various members of the government have commented on the need for reform including

> '...better legislation to underpin the service improvements needed for the most severely mentally ill people while also tackling health inequalities in our society. '
>
> and
>
> 'High-quality support in the community before a person reaches crisis point, coupled with improved crisis services when they are needed' and for the best care in hospital during and after their stay.

It is hoped that these proposed changes in attitude, practice and funding, are reflected in the new law and guidance.

In 2019, the Mental Capacity (Amendment) Act 2019 was passed, amending the deprivation of liberty (DOLS) provisions and creating new Liberty Protection Safeguards (LPS). Spring 2020 was nominated for the implementation of this Act, but the COVID-19 pandemic and other events have so far caused delay, and it was scheduled to come into force on 1 April 2022. For details of its planned implementation, please see the Research Briefing *Implementing the Mental Capacity (Amendment) Act 2019* and the link to download the full report from the House of Commons Library at: https://commonslibrary.parliament.uk/research-briefings/cbp-9341.

A draft Mental Health Bill is anticipated this year. The proposed reforms are summarised in part 2 of this resource.

The Mental Capacity (2016 Act) (Commencement No. 1) (Amendment) Order (Northern Ireland) 2019, makes similar provisions. As the implementation of the 2019 Act is imminent, it is included in this resource.

Terminology

Psychiatry and the law do not always sit comfortably together, in that their respective perceptions of 'mental illness' may differ.

The language of psychiatry was described by Foucault (1965:10-11) as 'a monologue of reason *about* madness' (sic) and lawyers might say that the centrality of a medical model of insanity imposes a scientific order into the profoundly unordered world of the mad, and that the law tries to impose reason and rationality onto the irrational – for an interesting discussion of these perspectives see Bartlett and Sandland (2014:1-11).

Attempts to define insanity in the context of the law may sometimes seem to identify the person as their illness, and sometimes the law may perceive a relationship between the person and their condition – these different perspectives were explored in a court case involving the treatment of a person diagnosed with a personality disorder, not anorexia, who was refusing food to the point of near starvation; see *B v Croydon District Health Authority [1995] 4 22 BMLR 13 (HC)* in Bartlett and Sandland (2014:7).

The ethical provision of counselling and psychotherapy in the context of current mental health law is complex. There are many issues to consider, and counselling in the arena of mental health law and guidance may present a complex range of legal and ethical considerations for practitioners.

This resource addresses a number of commonly raised practice issues, and in situations where the answer is not crystal clear, it suggests topics for discussion in supervision and ways of thinking through ethical and legal dilemmas. At the end of this resource are lists of relevant legislation, references and sources of further information, advice and practical help.

The resource list is not exhaustive – there may be other local services available, and it may be helpful to consult the legal department of your local authority or health authority, to seek legal advice through your insurers, or your local health service may hold lists of resources available in your area.

The current main statutory provisions in this field are the Mental Health Act 1983 (MHA 1983) as amended by further subsidiary legislation, along with relevant guidance, the Mental Health Act 2007 (MHA 2007), Mental Capacity Act 2005 (MCA 2005), the Mental Capacity (Amendment) Act 2019, and the current Care Standards legislation. The Mental Capacity (Amendment) Act 2019 was scheduled to come into force on 1 April 2022. For details of its planned implementation, please see the Research Briefing *Implementing the Mental Capacity (Amendment) Act 2019* and the link to download the full report from the House of Commons Library at: https://commonslibrary.parliament.uk/research-briefings/cbp-9341. Watch the government websites listed in this resource to see further practical details of the implementation of the new law as they are published.

Other statutes are relevant to specific care issues, police matters, criminal offences, and procedures, and are mentioned in this resource where relevant.

Note: For ease of reference in this resource, the MHA 1983 as amended by the MHA 2007 is referred to throughout simply as the 'MHA'; and the Mental Capacity Act 2005 as amended by the Mental Capacity (Amendment) Act 2019 is referred to as the 'MCA'.

1 Glossary of legal terms relevant to mental health

This section is a glossary of basic legal terms related to mental health which are used in this resource. More complex legal terms and concepts are explained in the body of the text.

Appropriate medical treatment and detention: Detention means keeping a patient in hospital or other place where care appropriate to their condition is provided. Detention is subject to the 'appropriate medical treatment' test which applies to all the longer-term powers of detention.

In the MHA, 'appropriate medical treatment' is defined, in relation to a person suffering from mental disorder as 'medical treatment which is appropriate in his case, taking into account the nature and degree of the mental disorder and all other circumstances of his case.'

As a result, it is not possible for patients to be detained compulsorily or their detention continued unless medical treatment which is appropriate to the patient's mental disorder and all other circumstances of the case is available to that patient (s.4, MHA 2007).

The changes in the MCA provide for new revised procedures to authorise the deprivation of liberty of a person resident in a hospital or care home who lacks capacity to consent to the arrangements.

The principles of supporting a person to make a decision when possible and acting at all times in the person's best interests and in the least restrictive manner, apply to all decision-making in operating the procedures affecting the liberty of a cared-for person.

Approved doctor: Except in cases of emergency when, under s4 MHA 1983, one recommendation is sufficient, two medical recommendations are necessary to support the application of an approved mental health professional (AMHP) or nearest relative for compulsory admission to hospital. One of these must be by an 's.12 approved doctor'.

This means a doctor approved for the purpose in England by the Secretary of State and in Wales by the Welsh Ministers (who have delegated the power to the local health boards. The approved doctor will usually be a psychiatrist but may also be a suitably qualified and experienced GP. The second recommendation can be made by any physician.

One of the two doctors should have previous acquaintance with the patient and both practitioners should have personally examined the patient either together or separately, but where they have examined the patient separately not more than five days must have elapsed between the days on which the separate examinations took place.

Approved Mental Capacity Professional (AMCP): A new specialist role created under Schedule 1, Part 4 of the Mental Capacity (Amendment) Act 2019 to 'provide oversight for those who need it most.' Most AMCPs will be independent, trained, and registered professionals and will normally be employed by a local authority, NHS Trust, local health board or clinical commissioning group.

To provide a balance (and perhaps, too, a creative tension) between medical and other social perspectives, doctors are in law specifically excluded from this particular role (s.114(2), MHA 1983). AMCPs now include approved social workers, nurses and community health nurses, psychologists and occupational therapists, see Schedule 1 of *The Mental Health (Approved Mental Health Professionals) (Approval) England Regulations 2008 SI* 2008/1206.

Appropriate Person: The Government envisages that the role will usually be fulfilled by a family member or a volunteer from a third-sector organisation. The appropriate person will be able to apply to the Court of Protection to challenge the authorisation and may need to provide support to the cared-for person during the court process.

Deprivation of liberty: There is no statutory definition of a deprivation of liberty in the 2019 Act. Consequently, using case law definitions, a deprivation of liberty occurs when a person is objectively 'not free to leave' and 'under continuous supervision and control'.

Independent Mental Capacity Advocate: IMCAs were introduced in the MCA to support patients who are unable to make decisions for themselves. IMCAs are trained and experienced to provide support to the cared-for person throughout the LPS process. There is a presumption that an IMCA will be appointed by the responsible body to represent and support the cared-for person, unless it would not be in the person's best interests.

Learning disability: Under s.1 (4) of the MHA, 'learning disability' means 'a state of arrested or incomplete development of the mind which includes significant impairment of intelligence and social functioning'. Please note, however, that under s.1 (2A) MHA, a person with learning disability is not considered to be suffering from mental disorder for many purposes of mental health law, including hospital treatment, 'unless that disability is associated with abnormally aggressive or seriously irresponsible conduct on his part'.

Medical treatment: This is defined in s.145 (1) of the MHA as including nursing, psychological intervention and specialist mental health habilitation, rehabilitation and care, provided that (as per s.145 (4)) 'Any reference in this Act to medical treatment, in relation to mental disorder, shall be construed as a reference to medical treatment the purpose of which is to alleviate, or prevent a worsening of, the disorder or one or more of its symptoms or manifestations.'

The explanatory note in the MHA 2007 states:

Practical examples of psychological interventions include cognitive therapy, behaviour therapy and counselling. 'Habilitation' and 'rehabilitation' are used in practice to describe the use of specialised services provided by professional staff, including nurses, psychologists, therapists and social workers, which are designed to improve or modify patients' physical and mental abilities and social functioning. Such services can, for example, include helping patients learn to eat by themselves or to communicate for the first time, or preparing them for a return to normal community living. The distinction between habilitation and rehabilitation depends in practice on the extent of patients' existing abilities – 'rehabilitation' is appropriate only where the patients are relearning skills or abilities they have had before.

Mental disorder: The MHA 1983 states that this act governs 'the reception, care and treatment of mentally disordered patients, the management of their property and other related matters' (s.1(1)).

'Mental disorder' is the gateway provision for the operation of many parts of mental health legislation, for example, compulsory admission to hospital, detention in hospital, confinement, and warrants to search for and remove individuals believed to be ill-treated.

There is now a unified definition of mental disorder, so that a single definition now applies throughout the MHA and complements the changes to the criteria for detention. Under s.1(2) of the MHA, '"mental disorder" means any disorder or disability of the mind; and "mentally disordered" shall be construed accordingly.'

Under s.1 (2A) of the MHA, in relation to certain specified purposes:

'a person with learning disability shall not be considered by reason of that disability to be –

(a) suffering from mental disorder... or (b) requiring treatment in hospital for mental disorder... unless that disability is associated with abnormally aggressive or seriously irresponsible conduct on his part.'

So, care should be taken when working with someone with a learning disability to assess whether s.1(2a)–(2b) of the MHA applies to your work.

Under s.1(4), *'"learning disability" means a state of arrested or incomplete development of the mind which includes significant impairment of intelligence and social functioning.'*

Note that under s.1(3) of the MHA, 'Dependence on alcohol or drugs is not considered a disorder or disability of the mind...'

Bear in mind, though, that in some cases, a person may have comorbid conditions additional to their alcohol or drug dependence, which could then fall within the definition of mental disorder under the MHA.

For further consideration of the range of this definition, see Sections 2.4-2.13 of the Mental Health Act 1983 Code of Practice (DH 2015: pp26-27).

Mental Health Review Tribunal (MHRT): The MHA 2007 and the Tribunals, Courts and Enforcement Act 2007 overhauled the tribunal system, and introduced a single, two-tier, tribunal for England; the one in Wales remaining in being. Each tier of the tribunal has specialist chambers headed by a president.

The MHRT is part of the Health Education and Social Care chamber of the First Tier Tribunal (FTT). The second tier – the Upper Tribunal (UT), acts as an appellate system to review decisions of the FTTs.

The role of the MHRT was transferred to the FTT and UT system by article 3 and Schedule 1 of the *Transfer of Tribunal Functions Order 2008*, and mental health cases are heard within the Health Education and Social Care chamber of the FTT. The mental health tribunal has its own Mental Health Administrative Support Centre in Leicester, and uses specialist judges and other tribunal members, and rules of procedure.

Mental illness: Mental illness was not defined as a specific term in the MHA, because there was, and still remains, a general reliance on case law and medical and psychiatric practice for a definition of mental illness on a case-by-case basis. Since the psychiatric manuals of mental disorder are constantly being updated and definitions of mental illness will change over time, this makes perfect sense, and provided that the patient's condition is defined as a category of mental illness in one of the commonly used psychiatric manuals, application of the law should follow appropriately.

For an example of such a manual, see the *Diagnostic and Statistical Manual of Mental Disorders, 5th edition DSM-V-TM*, (American Psychiatric Association 2013; updated annually each October, see http://psychiatryonline.org), and *ICD-10 Classification of Mental and Behavioural Disorders: Clinical descriptions and diagnostic guidelines* (10th revision, effective from 1 October 2015, and updated each 10 years).

Relative and nearest relative: The terms 'relative' and 'nearest relative' are defined in s. 26 MHA and ranked as 'nearest' in the order of the list.

They include:

1. husband or wife or civil partner;
2. son or daughter;
3. father or mother;
4. brother or sister;
5. grandparent;
6. grandchild;
7. uncle or aunt;
8. nephew or niece.

The person with whom the patient is living or had been living before admission to hospital may also be regarded as a relative or nearest relative, provided they comply with the circumstances specified in s. 26 and s.27 of the MHA.

If the patient '...ordinarily resides with or is cared for by...' one of the people on the list, they will take precedence over the others, under s 26(4) MHA.

Section 29 of the MHA gives patients the right to make an application to displace their nearest relative and enables county courts to displace a nearest relative where there are reasonable grounds for doing so.

Under s.26(2) MHA, in deducing relationships for the purposes of this section, any relationship of the half-blood shall be treated as a relationship of the whole blood, and an illegitimate person shall be treated as the legitimate child of:

a. his mother, and

b. if his father has parental responsibility for him within the meaning of section 3 of the Children Act 1989, his father.

Supervised community treatment: Chapter 4 of the MHA 2007 introduced supervised community treatment for patients following a period of detention in hospital. It was expected that this would allow a small number of patients with a mental disorder to live in the community whilst subject to certain conditions under the 1983 Act, to ensure they continued with the medical treatment that they needed. Currently some patients leave hospital and do not continue with their treatment, their health deteriorates and they require detention again – the so-called 'revolving door'.

2 Summary of the proposed reforms to the mental health legislation

On 13 January 2021 a press release was circulated by the Department of Health. It is available at www.gov.uk/government/news/landmark-reform-of-mental-health-laws. In it, the major reform of the Mental Health Act is welcomed. The package of reforms is now set out in a White Paper 'Reforming the Mental health Act'. See also the report of the consultation outcome at www.gov.uk/government/consultations/reforming-the-mental-health-act/reforming-the-mental-health-act.

The press release confirms that 'the Government will consult on a number of proposed changes, including:

- introducing statutory 'advance choice documents' to enable people to express their wishes and preferences on their care when they are well, before the need arises for them to go into hospital
- implementing the right for an individual to choose a nominated person who is best placed to look after their interests under the act if they aren't able to do so themselves
- expanding the role of independent mental health advocates to offer a greater level of support and representation to every patient detained under the act
- piloting culturally appropriate advocates so patients from all ethnic backgrounds can be better supported to voice their individual needs
- ensuring mental illness is the reason for detention under the act, and that neither autism nor a learning disability are grounds for detention for treatment of themselves
- improving access to community-based mental health support, including crisis care, to prevent avoidable detentions under the Act – this is already underway backed by £2.3 billion a year as part of the NHS Long Term Plan.

The White Paper sets out the path towards the Government's commitment to introduce the first new Mental Health Bill for 30 years, and end the stigma of mental illness once and for all.'

The press release continues:

'Decisive action will be taken to help tackle the disproportionate number of people from black, Asian and minority ethnic communities detained under the Mental Health Act. Black people are over four times more likely to be detained under the Act and over 10 times more likely to be subject to a Community Treatment Order.

A national organisational competency framework for NHS mental health trusts will be introduced, referred to as the 'Patient and Carers Race Equality Framework' (PCREF). The PCREF will be a practical tool which enables mental health trusts to understand what steps it needs to take to improve black, Asian and minority ethnic communities' mental health outcomes.

Improved culturally appropriate advocacy services will be piloted where needed, so people from BAME backgrounds can be better supported by people who understand their needs.

The reforms will also change the way people with a learning disability and autistic people are treated in law by recognising a mental health inpatient setting is often not the best place to meet their specific needs. The proposal sets out that neither learning disability nor autism should be considered a mental disorder for which someone can be detained for treatment under section 3 of the Act. Instead, people with a learning disability or autistic people could only be detained for treatment if a co-occurring mental health condition is identified by clinicians.

Significant investment in community support has led to a 29% reduction since 2015 in the number of people with a learning disability and autistic people in a mental health inpatient setting. The Government has established the £62 million Community Discharge Grant to make further progress on discharging people with learning disabilities and autism from inpatient care. The proposed changes in the legislation will help to further reduce reliance on inpatient care.

The White Paper also takes steps to ensure parity between mental health and physical health services. The Government is already investing over £400 million to eradicate dormitories in mental health facilities as part of its response to Sir Simon's recommendations and its commitment to level up access to mental health services and rebuild better than before, so people admitted to hospital can receive care in a modern and genuinely therapeutic environment.

High impact changes are already under way – including vital capital spend on the mental health estate, and work to pilot and develop the Patient and Carer Race Equality Framework.

A 28-day time limit is being proposed to speed up the transfer of prisoners to hospital, ending unnecessary delays and ensuring they get the right treatment at the right time.

The Government also commits to ending the outdated practice of using prisons as 'places of safety' for defendants with acute mental illness. Instead, judges will work with medical professionals to ensure defendants can always be taken directly to a healthcare setting from court.

Victims of all mentally disordered offenders will now have the option of being assigned a dedicated victim liaison officer to keep them informed of key developments in the offender's case, including when the patient is discharged.

Claire Murdoch, Mental Health Director for NHS England, said:

'The proposed reforms are a welcome step towards ensuring that people with mental health needs, a learning disability or autism, remain at the centre of decisions about their care, and that longstanding inequalities in experience and outcomes are addressed.'

The NHS is delivering a package of important measures set out in our NHS Long Term Plan to transform mental health, learning disability and autism services, which will ensure everyone can access the right treatment for their needs, when they need it most, which will improve lives and help to implement the Mental Health Act reforms effectively.

Four principles, developed by the review and in partnership with people with lived experience, will guide and shape the approach to reforming legislation, policy and practice. These are:

1. Choice and autonomy – ensuring service users' views and choices are respected

2. Least restriction – ensuring the Act's powers are used in the least restrictive way

3. Therapeutic benefit – ensuring patients are supported to get better, so they can be discharged from the Act

4. The person as an individual – ensuring patients are viewed and treated as rounded individuals.

Consultations on changes requiring further legislation continued until early spring 2021 to listen to current concerns, and proposals for reforming mental health arrangements are reported at: www.gov.uk/government/consultations/reforming-the-mental-health-act/reforming-the-mental-health-act. A draft Mental Health Bill will hopefully be offered for parliamentary consideration next year.

3 Compulsory detention for mental health assessment and treatment

For a guide to good practice in the process of admissions, see the *Mental Health Act 1983 Code of Practice* (DH 2015). This is guidance and not compulsory, but it is a significant help to understanding definitions and also an indication of what is expected in best practice.

3.1 Admission under Section 2 of the MHA for assessment

Applications for admission under the MHA s.2 or s.3 should be made by the nearest relative of the individual or (subject to s.11 of the MHA) an 'approved mental health professional'.

A compulsory admission for assessment may last for up to 28 days, subject to the provision of certificates by two doctors (except in cases of emergency – see below) in the prescribed form. One should be a medical practitioner (usually the patient's GP) and the other a specialist in mental disorders (usually a consultant psychiatrist).

The period of 28 days is not renewable, and should be followed by discharge, continued admission as an informal patient or a formal compulsory admission under s.3 MHA (see the section on compulsory admission under s.3 MHA in section 2.3).

Text of MHA 1983 Section 2

1. A patient may be admitted to a hospital and detained there for the period allowed by subsection (4) below in pursuance of an application (in this Act referred to as 'an application for admission for assessment') made in accordance with subsections (2) and (3) below.

2. An application for admission for assessment may be made in respect of a patient on the grounds that –

    a. he is suffering from mental disorder of a nature or degree which warrants the detention of the patient in a hospital for assessment (or for assessment followed by medical treatment) for at least a limited period; and

    b. he ought to be so detained in the interests of his own health or safety or with a view to the protection of other persons.

3. An application for admission for assessment shall be founded on the written recommendations in the prescribed form of two registered medical practitioners, including in each case a statement that in the opinion of the practitioner the conditions set out in subsection (2) above are complied with.

4. Subject to the provisions of s. 29(4) below, a patient admitted to hospital in pursuance of an application for admission for assessment may be detained for a period not exceeding 28 days beginning with the day on which he is admitted, but shall not be detained after the expiration of that period unless before it has expired he has become liable to be detained by virtue of a subsequent application, order or direction under the following provisions of this Act.

3.2 Emergency admissions for assessment and/or treatment under Section 4 of the MHA

Section 4 MHA reorders the operation of s. 2 for cases requiring an emergency response. In urgent cases, on the application of a nearest relative or AMHP, a patient may be admitted and detained for up to 72 hours by one doctor (rather than the two doctors required under ss. 2-3 MHA), or when immediacy is required, for up to six hours by a nurse (s. 5 MHA).

One medical certificate will suffice for an emergency application for detention under s. 2 MHA for assessment, provided the second certificate is provided within 72 hours (s.4 MHA).

A Justice of the Peace may authorise detention for up to 72 hours under s.135 MHA, on application by an approved social worker, if the person is being ill-treated, neglected, or not kept under proper control, or living alone and unable to care for themselves (s. 135 MHA).

Police officers may remove a mentally disordered individual who is 'in need of care and control' from a place to which the public have access and take them to a place of safety for up to 72 hours (s. 136 MHA).

Assessments should be made on both medical and social factors, and as will be seen from the wording of s.3 in section s.3.3 of this resource, it is based on the criteria of the patient '...suffering from a mental disorder of a nature or degree, which warrants the detention of the patient in hospital for assessment (or for assessment and treatment)...' and 'he ought to be detained in the interests of his own health and safety, or with a view to the protection of other persons.'

Note: S.2 does not require that an appropriate treatment is available – in fact, some mental disorders may be assessed as inappropriate for inpatient hospital treatment. For other patients, the formulation of a treatment plan will be an integral part of their assessment.

Text of MHA 1983 Section 4

1. In any case of urgent necessity, an application for admission for assessment may be made in respect of a patient in accordance with the following provisions of this section, and any application so made is in this Act referred to as 'an emergency application'.

2. An emergency application may be made either by an [approved mental health professional] or by the nearest relative of the patient; and every such application shall include a statement that it is of urgent necessity for the patient to be admitted and detained under MHA section 2 above, and that compliance with the provisions of this part of this Act relating to applications under that section would involve undesirable delay.

3. An emergency application shall be sufficient in the first instance if founded on one of the medical recommendations required by MHA section 2 above, given, if practicable, by a practitioner who has previous acquaintance with the patient and otherwise complying with the requirements of section 12 below so far as applicable to a single recommendation, and verifying the statement referred to in subsection (2) above.

4. An emergency application shall cease to have effect on the expiration of a period of 72 hours from the time when the patient is admitted to the hospital unless:

    a. the second medical recommendation required by section 2 above is given and received by the managers within that period; and

    b. that recommendation and the recommendation referred to in subsection (3) above together comply with all the requirements of section 12 below (other than the requirement as to the time of signature of the second recommendation).

5. In relation to an emergency application, section 11 below shall have effect as if in subsection (5) of that section for the words 'the period of 14 days ending with the date of the application' there were substituted the words 'the previous 24 hours'.

Note: In these short-term detentions, the provisions of s.63 and s.58 of the MHA 1983 regarding treatment without consent do not apply, and so the patient may refuse treatment if competent to do so.

3.3 Admission under Section 3 of the MHA for treatment

The wording of this section is similar to that relating to admissions for assessment (3.1 of this resource), with the difference that for section 3 to operate, the patient must be:

- suffering from a mental disorder (as defined in s.1 MHA), and
- the mental disorder must be 'of a nature or degree' that makes it appropriate for her or him to receive treatment in hospital, and
- it is necessary for the health and safety of the patient or for the protection of other persons that he should receive such treatment, and
- it cannot be provided unless he is detained, and
- appropriate medical treatment is available for her or him.

All five factors have to be in place for the section to operate. Some disorders may not be appropriate for hospital treatment (e.g. they may depend on clinical and social factors) and so then this section will not apply.

If the patient has a learning disability then s.3 can only operate if the learning disability results in 'abnormally aggressive or seriously irresponsible conduct on the part of the person detained' (MHA s. 1(2B)(a)).

The way that this section is worded means that detention can only be used on therapeutic grounds, and it could also be interpreted to mean that it cannot be operated if either the necessary treatment is available in the community and the patient is willing to accept treatment in the community; or if the patient is willing to accept the necessary treatment in hospital as an informal patient.

For a longer discussion of these principles, and the process of admission, see (Bartlett and Sandland 2014: Chapter 6).

Text of MHA 1983 Section 3 (as amended by the MHA 2007)

1. A patient may be admitted to a hospital and detained there for the period allowed by the following provisions of this Act in pursuance of an application (in this Act referred to as 'an application for admission for treatment') made in accordance with this section.

2. An application for admission for treatment may be made in respect of a patient on the grounds that –

a. he is suffering from mental disorder of a nature or degree which makes it appropriate for him to receive medical treatment in a hospital; and

b. *(Para (b) was removed by subsequent legislation)*

c. it is necessary for the health or safety of the patient or for the protection of other persons that he should receive such treatment and it cannot be provided unless he is detained under this section; and

d. appropriate medical treatment is available for him.

3. An application for admission for treatment shall be founded on the written recommendations in the prescribed form of two registered medical practitioners, including in each case a statement that in the opinion of the practitioner the conditions set out in subsection (2) above are complied with; and each such recommendation shall include –

a. such particulars as may be prescribed of the grounds for that opinion so far as it relates to the conditions set out in paragraphs (a) and [(d)] of that subsection; and

b. a statement of the reasons for that opinion so far as it relates to the conditions set out in paragraph (c) of that subsection, specifying whether other methods of dealing with the patient are available and, if so, why they are not appropriate.

4. In this Act, references to appropriate medical treatment, in relation to a person suffering from mental disorder, are references to medical treatment which is appropriate in his case, taking into account the nature and degree of the mental disorder and all other circumstances of his case.

3.4 The process of admission

The process for emergency admissions is addressed in section 3.2 of this resource.

Under s.3 MHA, (except in cases of emergency when, under s.4 MHA 1983, one recommendation is sufficient) two medical recommendations are necessary to support the application of an 'approved mental health professional' (AMHP) or nearest relative (for definitions, see section 1 of this resource) for compulsory admission to hospital. One of these must be by an 's.12 approved doctor'. The second recommendation can be given by any physician. One of the two doctors should, if practicable, have previous acquaintance with the patient.

Both doctors must have personally examined the patient either together or separately, but where they have examined the patient separately not more than five days must have elapsed between the days on which the separate examinations took place.

An 'approved doctor' means a doctor approved for the purpose in England by the Secretary of State, and in Wales by the Welsh Ministers (who have delegated the power to the local health boards).

The approved doctor will usually be a psychiatrist but may also be a suitably qualified and experienced GP.

Prior acquaintance with the patient might comply with the legislation, even if it is short – in the case of *Ann R (By her Litigation Friend Joan T) v The Bronglais Hospital Pembrokeshire and Derwent NHS Trust [2001] EWHC Admin 792*, the GP had only just taken on this patient – he scanned her medical record and visited her for about five minutes. He did have some prior knowledge of her from a case conference and the court held that this satisfied the law. The GP later made a second visit at which he conducted his assessment.

If the doctor does not have previous acquaintance with the patient, the Mental Health Act 1983 Code of Practice (DH 2015) recommends that the doctor should be s. 12 approved (see AMHP in section 1 of this resource).

3.5 Safeguarding the restriction of liberty of a patient or cared-for person

The Mental Capacity (Amendment) Act 2019 was scheduled to come into force on 1 April 2022. For details of its planned implementation, please see the Research Briefing *Implementing the Mental Capacity (Amendment) Act 2019* and the link to download the full report from the House of Commons Library at https://commonslibrary.parliament.uk/research-briefings/cbp-9341. Watch the government websites listed in this resource to see further practical details of the implementation of the new law as they are published.

The Mental Capacity (Amendment) Act 2019 makes new provisions for safeguarding the rights of persons who need care and treatment in a variety of settings where their liberty may be restricted. These new provisions are commonly referred to as the **Liberty Protection Safeguards (LPS)**, although this term is not actually used in the new Act. The new process for authorising a deprivation of liberty is set out in a new Schedule AA1 inserted into the MCA. (see 3.6. below). The citations are taken from 'Implementing the Mental Capacity (Amendment) Act 2019 available from the House of Commons Library, see PDF Mental Health Act 2019 CBP-9341.pdf.

New LPS changes:

- These safeguards will now include a wider range of people – for example those with conditions such as autism, dementia, or learning disability who lack the relevant decision-making capacity, as well as people with diagnosed mental disorders.
- They will also apply to young people over 16 years of age.
- The new provisions are 'setting neutral' and apply to a wide variety of care settings, including hospitals, care homes, domestic settings, and supported living as well as in the family home.
- Deprivations will be authorised for an initial maximum period of 12 months, and then may be renewed up to a maximum of three years, and will be reviewed annually in that period.

3.6. Conditions and process for the restriction or deprivation of liberty

The Mental Capacity (Amendment) Act 2019 includes a 'code of practice' set of clauses amending the present Mental Capacity Act 2005 Code of Practice currently in force. A new wider Code of Practice to accompany the 2019 Act may be drafted in the future.

The 'responsible body' will usually be the Local Authority or NHS trust (or a local Health Board in Wales).

For the responsible body to authorise any deprivation of liberty, it must be clear that all the 'authorisation conditions' listed below are met:

- The person lacks the capacity to consent to the care arrangements; and Implementing the Mental Capacity (Amendment) Act 2019
- The person has a mental disorder, within the meaning of section 1(2) of the Mental Health Act 1983; and
- The arrangements are necessary to prevent harm to the cared-for person and proportionate to the likelihood and seriousness of that harm.

The responsible body must authorise three assessments required for the authorisation, which are:

- The capacity assessment and determination; and
- The medical assessment and determination; and
- The necessary and proportionate assessment and determination.

The assessment process must involve the responsible body consulting with the person and others (such as a family member or someone else close to that person, including any attorney,19 court-appointed deputy or Independent Mental Capacity Advocate, as far as is practicable and appropriate, to understand what the person's feelings and wishes are.

Once the consultation and assessments have been carried out, a pre-authorisation review will be completed to enable the responsible body to decide whether to authorise the arrangements. If, having reviewed all the evidence, the responsible body decides to make an authorisation, it can take effect immediately or within 28 days of being issued.

Exceptional cases: where urgent action is required, it may be necessary to take steps which deprive a person of their liberty before a formal authorisation decision has been made by a responsible body or court. Exceptional circumstances are defined in the Act as those when it is necessary to carry out life-sustaining treatment or a 'vital act'. A vital act is where there is a reasonable belief that it is necessary to prevent a serious deterioration in the person's condition. In these circumstances, there are four conditions to be met (set out in a new section 4B inserted in the MCA) to deprive the person of their liberty:

1. The steps consist of, or are for the purpose of, giving life-sustaining treatment to the person or for doing any vital act;

2. The steps are necessary to give the life-sustaining treatment or carry out the vital act;

3. There is a reasonable belief that the person lacks capacity to consent to the steps;

4. An authorisation to deprive someone of their liberty is being sought from the responsible body under the LPS, or a relevant decision is being sought from the court, or there is an emergency.

The authorisation must be reviewed regularly by the responsible body with access provided to an IMCA or appropriate person to represent and support the cared-for person throughout the authorisation period.

The responsible body can renew an authorisation at any time, but it must consult with the cared-for person and other relevant individuals (including an IMCA) before doing so, to ascertain whether the person's wishes for their care and treatment have changed. The authorisation can end at any time if the responsible body determines that it should, or if the responsible body believes, or ought reasonably to suspect, that any of the authorisation conditions are not met. That means it will end one if one of the following conditions is met:

- the cared-for person has capacity, or has regained capacity, to consent to the arrangements; or

- the cared-for person no longer has a mental disorder; or

- the arrangements are no longer necessary and proportionate

Oversight by the Court of Protection

The new LPS authorisation process will be overseen by the Court of Protection which has jurisdiction over these matters to hear appeals and disputes. Where an LPS authorisation is in place, the cared-for person, their appropriate person or IMCA, or anyone else can apply to challenge the arrangements at the Court of Protection under section 21ZA of the MCA.

The Court of Protection has power to uphold, vary or terminate the authorisation. Non-means-tested Legal Aid will be available for cases brought to the Court of Protection in these circumstances. In some cases, the responsible body may need to make an application to the Court of Protection, for example, if for some reason the cared-for person should have taken their case to court but it did not happen.

3.7 Therapy and mental capacity

In the NHS, therapy may be provided as part of the local community healthcare services.

In private therapy, if a person lacks the necessary mental capacity to understand and enter into some or all of the formal terms of a contract for private therapy, the question then arises as to whether and how it might be appropriate to provide therapeutic services for that person.

There is an ethical and legal issue about responding to an identified need by the provision of an appropriate level of therapy to a person who requests it and who can make sufficient psychological connection to make use of therapy, in a situation where that person may permanently or temporarily lack capacity to enter into the financial details of a business contract but understands enough to engage with the work of therapy. A person in a residential home, or an elderly or infirm client, may be in this position.

If the client can make and maintain psychological contact with the therapist, then ethically and professionally therapy may be appropriate in conjunction with any necessary safeguards.

Therapy may then perhaps be offered to that client with the consent of a person who has the legal authority to make decisions and enter into contracts 'in their best interest' (e.g. a legal guardian or an attorney).

That person could then deal with the formalities of the therapeutic contract (e.g. formalities of payment, etc.) and the client may then perhaps hold a 'working alliance' with the therapist in which they might agree the basic practical boundaries of the therapeutic relationship, such as length and frequency of sessions, venue, mutual expectations, and so on.

4 Community care and mental health treatment

Only a small proportion of people with mental disorders are treated in hospital or are subject to coercion under the provisions of the MHA. The remainder are usually treated in primary care by their GP and/or others, and through other community-based services.

In England and Wales, the legislation governing community care services is listed in s. 46(3) of the National Health Services Care Commissioning Act 1990 (NHSCCA 1990) as:

- Part I of the National Assistance Act 1948
- S.45 of the Health Services and Public Health Act 1968
- S.254 and Schedule 2 of the National Health Service Act 2006
- S.117 of the Mental Health Act 1983.

The Health and Social Care Act 2012 and the Health and Social Care Act 2008 govern aspects of assessment, responsibility, payments, and care standards. For details, see (Bartlett and Sandland 2014: Chapter 3).

On 14 May 2014, the Care Act 2014 received royal assent. It makes wide-ranging reforms, consolidating the current mental health legislation relevant to the safeguarding of adults from abuse or neglect, sets care standards, creates a framework for support for carers, and makes reforms for health education and health research.

There is insufficient space here to go into detail about the provisions of the Care Act 2014, but the guidance published is helpful, see the *Care and Support Statutory Guidance* (available at www.gov.uk/government/publications/care-act-statutory-guidance/care-and-support-statutory-guidance).

The Care Act 2014 came into effect in April 2015, and at the same time, draft regulations and guidance for implementation were published (www.gov.uk/government/publications/care-act-2014-part-1-factsheets/care-and-support-statutory-guidance-changes-in-march-2016).

The present regulations made under the Care Act 2014 are listed in the statutes and subsidiary legislation at the end of this resource. Watch out for the new regulations as they are rolled out in the coming months, see www.legislation.gov.uk for all UK legislation in force.

4.1 Community treatment orders (CTOs)

Introduced under the Mental Health Act 2007 (s.23 of which introduced sections 17A-G into the MHA 1983), CTOs may be made in respect of patients who live in the community and apply to patients who were detained in hospital under s.3, s.37 or s.47 of the MHA (with or without restrictions) and are now discharged. The effect of the CTO is to discharge the patient but make him/her subject to recall to the hospital; that is, it continues the effect of the MHA order with the patient living in the community. A CTO will not permit treatment without the patient's consent.

A CTO may be made for an initial six months and can then be renewed for a further six months. Thereafter, it is renewable annually unless or until discharged. On each renewal the criteria must be met.

4.2 After-care under Section 117 of the MHA

Under s.117(2) MHA, after-care should be provided to those MHA patients who need it, following discharge from detention under ss.3, 37, 45A, 47 or 48 of the MHA. See Mental Health Act 1983: Code of Practice (DH 2015: Chapter 33).

For patients detained under ss.3 or 37, discharge must be made into the community, but for those transferred to hospital from prison under ss.47 or 48, or made subject to a hospital direction under s.45A following conviction, discharge from hospital might be back to prison to finish serving a sentence, and they, too, should have after-care under s.117.

For community patients, after-care services must be available throughout the duration of their CTO.

After-care may include health and social care, regaining or enhancing existing skills, or learning new skills in order to cope with life outside hospital. The areas in which after-care could be provided also include commissioned payments to help with welfare benefits, employment, daytime activity and meeting social, cultural or spiritual needs.

5 Therapists and private mental healthcare

Therapists in private practice may be employed by the NHS (under a contract of service) or they may be commissioned to work on a self-employed basis (under a contract for services) as part of an NHS team for the holistic healthcare of a patient. The contract in either case will usually bind the therapist to work within the boundaries relevant to the NHS, and their actions will then be subject to the appropriate regulations and government guidance. The therapist will be expected to share information with the healthcare team on a need-to-know basis in accordance with the Caldicott guidelines (DH 2013) (www.gov.uk/government/publications/the-information-governance-review).

Therapists in private practice may work with a client who is in private mental healthcare (e.g. a private residential care home); the client will be referred to them by local medical practitioners or psychiatrists, but the therapy will be under a private contract with the client.

In this case, the therapist should discuss and enter into a contractual agreement with the client about the agreed conditions of work, including confidentiality, records, referrals and information sharing.

In the case of private practice work, if there is concern about the safety or welfare of the client or others, apart from making an appropriate referral where necessary, the therapist is less likely to be involved in any subsequent mental health decision-making process concerning the client, unless invited to do so by the national mental health services.

6 Outline of the NHS mental health system and mental health pathway in England and Wales

There is insufficient space here to give more than a brief outline and the web links to the NHS 'mental health pathways' available in England and Wales, as the options are complex and may vary in each local area. The information in this section is derived from the NHS websites relevant for England and Wales. Further contacts and resources are available at the end of this resource.

6.1 England

Readers can find links to the NHS pathways for mental and physical illness at www.nhs.uk. The pathways specific to mental health can be found at: www.nhs.uk/using-the-nhs/nhs-services/mental-health-services.

Sometimes web pages change, and if this is the case a search for 'NHS mental health pathways' should locate the required information.

The provision of publicly funded mental health services in England and Wales form part of the physical and mental health services in these areas and are governed by the National Health Service Act 2006, the Health and Social Care Act 2012, and other subsidiary legislation. These services should be provided free of charge unless charging is specifically permitted in the legislation.

Mental health services may be provided in hospitals or residential services, or as outpatient or community care provided by a range of government and non-government organisations and agencies. Such services may be commissioned by the NHS Commissioning Board, or local clinical commissioning groups formed under the Health and Social Care Act 2012.

Many people with mental disorders are cared for by their family or in private facilities, (for example, adults with developmental disabilities and vulnerable senior citizens living in private care homes), and the NHS may provide little more than a GP service, and inspection and licensing of the residential care homes to provide NHS services.

Mental health services in England are generally run in the following categories:

- adult services
- child and adolescent mental health services (CAMHS)
- forensic services
- learning disability services
- older adults' services
- substance misuse services.

These services may be organised differently in each local area.

This means some may not cover all mental health conditions, or only deal with people of a certain age. For example, some areas offer services for young people between the ages of 16 and 25 to help with transitions from children to adult services. Local GPs, mental healthcare provider or relevant clinical commissioning group (CCG) should be able to provide information about services available in the area.

6.2 Wales

For services in Wales, see the NHS website 'Health in Wales' at www.wales.nhs.uk. For mental health issues, see www.wales.nhs.uk/healthtopics/populations/peoplewithmentalhealthproblems. There is also a mental health helpline specifically for Wales, call Freephone 0800 132737 or text 'help' to 81066.

In Wales, *Raising the Standard – The Revised National Service Framework for Adult Mental Health Services in Wales*, published in 2005 updates the original National Service Framework (NSF) published in 2002. It can be found at: www.wales.nhs.uk/documents/websiteenglishnsfandactionplan.pdf.

7 Mental capacity and consent for adults

For adults, law relating to mental capacity is now governed by the Mental Health Act 2007, the Mental Capacity Act 2005, the Mental Capacity (Amendment) Act 2019, and the relevant Regulations. In this resource, these are collectively referred to as the MCA. Relevant publications and websites are listed at the end of this resource.

The MCA empowers individuals to make their own decisions where possible and protects the rights of those who lack capacity.

Where an individual lacks capacity to make a specific decision at a particular time, the MCA provides a legal framework for others to act and make that decision on their behalf, in their best interests, including where the decision is about care and/or treatment. (Mental Health Act 1983: Code of Practice, DH 2015: 96)

See also the Mental Capacity Act 2005 Code of Practice (MoJ 2007) and the Reference Guide to Consent for Examination or Treatment (second edition) (Department of Health 2009) available at: www.gov.uk/government/uploads/system/uploads/attachment_data/file/138296/dh_103653__1_.pdf. The MCA should be '*central to the approach professionals take to patients who lack capacity in all health and care settings (including psychiatric and general hospitals). The starting point should always be that the MCA should be applied wherever possible to individuals who lack capacity and are detained under the Act' (Mental Health Act 1983 Code of Practice*, Department of Health 2015:98, para 13.11).

There are some decisions to which the MCA does not apply, for example decisions that, under Sections 27–29 MCA 2005, cannot be made by others for a person who does not have mental capacity:

- voting
- consent to marriage or civil partnership
- consent to sexual relations
- consent to reproductive technology governed by the Human Fertilisation and Embryology Act 1990
- consent to divorce or dissolution of civil partnership based on two years' separation
- consent to placement of a child for adoption, or the making of an adoption order.

In these situations, if the person cannot make the decision themselves, then that is the end of the matter, except for divorce and adoption where, in the absence of consent, an order may be made by a court.

Note that neither mental disorder nor any form of disability should be automatically linked with an assumed lack of mental capacity. Mental capacity is situation specific, see below, and also part 8 of this resource. The 2015 guidance clearly provides that:

'It is important for professionals to be aware that those with a mental disorder, including those liable to be detained under the Act, do not necessarily lack capacity. The assumption should always be that a patient subject to the Act has capacity, unless it is established otherwise in accordance with the MCA.' (Mental Health Act 1983: Code of Practice DH 2015: 99, para 13.15).

Under article 12(2) of the United Nations Convention on the Rights of Persons with Disabilities (UNCRPD), there is a requirement that 'persons with disabilities enjoy legal capacity on an equal basis with others in all respects of life.' This seems to mean that people with mental disabilities are generally expected to exercise choice in their ordinary day-to-day decision making.

Article 12(3) requires states to provide people with disabilities all reasonable support in their decision making. Article 12(4) requires that the support systems 'respect the rights, will and preferences of the person.'

Under the MCA 2005, mental capacity is a legal concept, according to which a person's ability to make rational, informed decisions is assessed. There is no single, definitive test for mental capacity to consent; however, s.2(1) of the MCA 2005 sets out the criteria for deciding when a person doesn't have capacity in relation to the Act:

'For the purposes of this Act, a person lacks capacity in relation to a matter if at the material time he is unable to make a decision for himself in relation to the matter because of an impairment of, or a disturbance in the functioning of, the mind or brain.'

This means that there is a two-tier test of capacity:

- Does the person have an impairment of, or a disturbance in the functioning of, the mind or brain?

- Does the impairment or disturbance mean that the person is unable to make the specific decision at the time that it needs to be made?

This test for capacity takes a 'function-specific' or situation-specific approach that means it looks to assess a person's understanding in relation to each decision that has to be made and recognises that, while a person may have capacity to make some decisions, they may not have capacity to make other decisions.

It is not a question of whether a person has capacity to make particular types of decisions generally.

The assessment of mental capacity is based on a set of principles in which it is situation-specific and depends upon criteria set out in s.3(1) MCA 2005.

'A person is unable to make a decision for himself if he is unable:

a. To understand the information relevant to the decision

b. To retain that information

c. To use or weigh that information as part of the process of making the decision; or

d. To communicate his decision (whether by talking, using sign language or any other means).'

The quality of the decision-making process is dependent on the quality of the information given to the person, and the manner in which relevant information is provided. The person only needs to retain the information long enough to make the decision, so short-term memory will suffice. Ability to evaluate the potential consequences of making the decision (or not) is important. If the person fulfils the criteria for capacity, they may not then be assumed to lack capacity, just because they wish to make a decision that is regarded by others as unwise.

The five statutory principles of the MCA (*Mental Health Act 1983: Code of Practice*, DH 2015: 98-99, para 13.14) are:

- **Principle one:** A person must be assumed to have capacity unless it is established that they lack capacity.

- **Principle two:** A person is not to be treated as unable to make a decision unless all practicable steps to help them to do so have been taken without success.

- **Principle three:** A person is not to be treated as unable to make a decision merely because they make an unwise decision.

- **Principle four:** An act done, or decision made, on behalf of a person who lacks capacity, must be done, or made, in their best interests.

- **Principle five:** Before the act is done, or the decision is made, regard must be had to whether the purpose of the act or the decision can be as effectively achieved in a way that is less restrictive of the person's rights and freedom of action.

It is presumed in law that adults and children over the age of 16 have the legal power to give or withhold consent in medical and healthcare matters, provided that they have mental capacity. This presumption is rebuttable (e.g. an assumption that is taken to be true unless someone comes forward to contest it, or proves it to be otherwise), for example in the case of mental illness.

Currently, the legislation regarding the mental capacity of adults is now mainly embodied in the comprehensive MCA 2005, the MHA 2007, subsidiary legislation and government guidance.

There is no single test for mental capacity to consent. Assessment of mental capacity is not on a theoretical ability to make decisions generally, but is situation-specific and depends upon the ability of the person to:

- take in and understand information including the risks and benefits of the decision to be made
- retain the information long enough to weigh up the factors to make the decision, and
- communicate their wishes in an appropriate form (e.g. writing, braille or sign language).

Part 1 of the MCA 2005 defines 'persons who lack capacity' and sets out the principles underpinning actions taken under the Act, including a checklist to be used in ascertaining their best interests.

In particular, it requires that a person is not to be treated as lacking capacity simply because they may be making an unwise decision.

A person may be mentally incapacitated on a temporary basis (i.e. unconscious in hospital after an accident), or on a longer-term or permanent basis (i.e. those who suffer from severe long-term mental illness or other impairments of mental functioning). In this case, their capacity to make medical decisions is likely to be assessed by a medical doctor or psychiatrist. The assessment of a person's mental capacity for other tasks may be made by others; for example, a decision on their capacity to make a will may be made by a lawyer or a decision on whether they can engage in therapy may be made by the therapist. If there is any doubt, advice from an appropriate registered medical practitioner, psychiatrist or psychologist should be sought.

Relevance of capacity to therapy

A person's capacity is relevant in therapy when dealing with issues of consent, especially when considering whether someone can give valid consent to receive therapy or agree the terms on which therapy is being provided – including their wishes about the management of confidentiality and privacy. Capacity to give valid consent may depend upon a number of factors, notably:

- For what action is consent being sought?
- Have all the potential benefits, risks and consequences of taking or not taking that action been fully explained and understood?
- Has the person retained the information long enough to properly evaluate it when making their decision?
- Can the person clearly communicate their decision (with help as appropriate) once it is made?
- Is the consent sought for the individual concerned, or is it for the treatment of another person?
- If consent is sought for another person, is that person an adult or a child?
- If consent is sought for a child, does the person giving consent have parental responsibility for the child? (For mental capacity in relation to children and young people under the age of 18, see part 8 of this resource.)

On some occasions, therapists may be in doubt as to whether a client can give valid consent for the therapeutic contract, or therapists may need to determine issues regarding confidentiality and disclosure of information. For example, consent from another person may be necessary before engaging in therapeutic work with vulnerable adults.

Therapists may be asked to work with vulnerable adults and assist them to consider all the relevant issues in making difficult decisions, for example in family relationships or when considering treatment or long-term planning for their future care.

The therapist may need to work alongside or in co-operation with healthcare staff and others. Some adults will have intermittent mental capacity to make specific decisions.

7.1 The Court of Protection, guardianship and lasting powers of attorney

Adults who do not have the mental capacity to make their own decisions may need others to give consent to the sharing of information or medical or psychological treatment, or for the day-to-day running of their affairs. The Court of Protection protects and manages the property and financial affairs of people with impaired mental capacity. The Public Guardianship Office provides administrative support for the Court of Protection, and for updates, see Office of the Public Guardian (blog.gov.uk).

An adult with mental capacity (the donor) can appoint another person to act as their attorney to run their affairs.

These appointments may be made with immediate effect, or contingent upon a future loss of the donor's mental capacity. The MCA 2005 creates new forms of *Lasting Power of Attorney (LPA)*. These forms of LPA carry new powers, replacing the earlier single form of *Enduring Power of Attorney (EPA)*. EPAs can no longer be made, but those still in existence remain valid in relation to a donor but are more limited in scope than the two new LPAs.

The major change is that under one of the new LPAs (financial decisions), a donor is able to appoint an attorney to carry out duties relating to property and financial affairs, but in addition, under the second LPA (health and care) an attorney can be empowered to make decisions on the health and welfare of the donor. Whichever type of LPA is granted, it must be registered under the Court of Protection Rules 2007 before it can be used. There is a legal four-week wait before the Office of the Public Guardian can register an LPA.

Note: Information, forms and guidance from the Government on creating these powers of attorney are available on the websites and addresses listed at the end of this resource.

The powers of an attorney holding a health and care LPA may potentially include giving or refusing consent for medical treatment or entering into a formal contract for therapy in circumstances where the donor has lost the mental capacity to enter into the business contract of therapy for himself but can make sufficient psychological connection to benefit from therapy and can form a working alliance with the therapist. There are legal provisions in the MCA to limit the types of decision that can be made by an attorney, to safeguard against misuse of advance decisions, to appoint mental capacity advocates and visitors, and to prevent the neglect or mistreatment of people without mental capacity.

7.2 Advance decisions, advance directives, advance statements and living wills

Therapists may be asked to assist clients in developing plans or expressing their wishes for present or future healthcare arrangements.

While they have mental capacity, some clients may wish to make an 'advance directive' (otherwise known as an 'advance statement' or 'living will') about the forms of medical treatment to which they may (or may not) consent if they should subsequently lose the capacity to decide for themselves.

Advance directives refusing treatment are legally binding, provided that they are made while the person has capacity, without duress and the circumstances to be applied are clear. Sections 24–26 of the MCA empower those who wish to do so to make 'advance decisions' concerning their wish to refuse specified treatment.

There are conditions under the new MCA:

An advance decision is not applicable to life-sustaining treatment unless:

1. the decision is verified by a statement to the effect that it is to apply to that treatment even if life is at risk, and

2. the decision and statement comply with these rules:

    a. it is in writing,

    b. it is signed by the person or by another in their presence and by their direction, the signature is made or acknowledged by the person in the presence of a witness, and

    c. the witness signs it, or acknowledges his signature, in the person's presence.

7.3 Guardianship

Guardianship is not very widely used, perhaps because MHA and DoLS orders are available, and perhaps because most guardians will be local authorities, which may be reluctant to take on this responsibility.

Guardianship of a person over the age of 16 (see s.7(1) MHA 1983), enables that person to receive care outside a hospital, in the community, in a place where it cannot be provided without the use of compulsory powers. See (Mental Health Act 1983: Code of Practice DH 2015: 342-348, Chapter 30) for guidance on the operation of the system. Guardianship is useful for aftercare, or for a person leaving compulsory detention as an alternative to a Community Treatment Order (CTO).

A guardian may be a local social services' authority, or a private guardian approved by the local social services' authority and is appointed under s.7 of the MHA. The guardian may make decisions about where the person should live, and the guardian's decisions will take priority over others. However, the guardian cannot make decisions that effectively deprive a person of their liberty; in that case a DoLS order is more appropriate.

Guardians have the following powers:

- The exclusive right to decide where a patient should live (taking precedence over a power of attorney, or deputy appointed under the MCA). The Court of Protection does not have jurisdiction to determine the place of residence of a patient whilst under guardianship with a residence requirement in effect.

- The guardian can require a patient to attend for treatment, work, training or education at specific times and places (but cannot use force to get them there).

- The guardian can demand that a doctor, approved mental health professional or other relevant person attends the patient at the place where they live.

A patient who is subject to a guardianship order may still become an informal patient in a hospital or psychiatric facility, but this should not be a requirement imposed by the guardian.

Guardianship is appropriate where the patient is suffering from a mental disorder of a nature or degree that warrants their reception into guardianship, and it is necessary for the welfare of the patient or for the protection of others that the patient should be so received (*Mental Health Act 1983: Code of Practice*, DH 2015: 343, para 30.08).

An application for a guardianship order is made under the civil powers of Part II of the MHA 1983, and is made on similar grounds to applications under ss.2 and 3 of the MHA, usually by an approved mental health professional or the patient's nearest relative. The order will be founded on the written recommendation of two doctors in the prescribed form, stating that the criteria for guardianship are met.

8 Mental capacity and consent for children and young people under the age of 18

Section 105 of the Children Act 1989 defines a child as 'a person under the age of 18'.

A young person with mental illness, disability or psychiatric disturbance may also be subject to other legislation, including the provisions of the Children and Young Persons Act 1989, the Mental Health Act 1983, the Mental Capacity Act 2005 and Mental Health Act 2007. Mental health decisions regarding children and young persons should also be subject to the provisions of the Human Rights Act 1998 and the UN Convention on the Rights of the Child.

Children and young people under the age of 18 are also collectively referred to in many areas of law (including contract law) as 'minors'. People over the age of 18 are said to have reached the age of 'majority'. Section 1 of the Family Law Reform Act 1969 lowered the former age of majority of 21 to the current age of 18. A minor may make a valid contract for 'necessary' goods and services, including therapy and medical services, for which, in the event of a dispute over the contract, they should pay a reasonable price.

The law on children's capacity to make decisions, and other people making decisions for children, is vitally important for all practitioners who work with children and young people.

Whether children can enter into a formal contract for therapy will depend upon whether they have the legal capacity to make their own decisions. It may be that a younger child who does not have capacity can form a therapeutic alliance (e.g. agree a mode of working with a school counsellor), and the legal boundaries of the contract for their therapy may be made with those who have parental responsibility for the child.

Note: A child's (or adult's) mental capacity to make any particular decision is not only situation-specific but may also be affected temporarily or permanently by illness, ability, substance use or abuse, medications, and psychological response to stressful or traumatic life events.

8.1 Mental capacity: young people aged 16–18

Under s.8 of the Family Law Reform Act 1969, at the age of 16, a young person with mental capacity gains the right to give their informed consent to (or refusal of) medical or dental treatment, which includes psychological treatment and therapy. The consent of the young person aged 16-18 is as valid as that of an adult. Note that the MCA applies to all persons over the age of 16, and so under the MCA, the test which will be applied for mental capacity in relation to a person aged 16 years or more is exactly the same as that for an adult.

Under s.8 of the Family Law Reform Act 1969, if a young person aged between 16-18 with capacity consents to recommended medical or dental treatment, (even if those with parental responsibility for them disagree for any reason), the medical practitioner would be protected from a claim for damages for trespass to the person.

8.2 Where a 16–18 year old has capacity, but refuses consent

If a young person aged 16-18 has capacity, but refuses recommended mental health treatment, the High Court may in some circumstances overrule the wishes of the young person and make an appropriate order for the welfare of the child, or an order may be made under the MHA.

In the event of a dispute between the young person and healthcare staff about admission to hospital or other consent for essential medical or psychological assessment or treatment for a mental disorder, for those aged 16 years or older, the issue may now be resolved under the MCA using the liberty safeguards as it would be for an adult (see sections 2 and 3 of this resource).

Although in the past, there have been court decisions indicating that those with parental responsibility could technically give their consent for treatment despite the clear refusal of their child, since the inception of the Human Rights Act 1998, in the case of a child aged 16-18 who has capacity, medical and other authorities are unlikely to rely on this, and court cases reflect the right of the child or young person with capacity to have their views respected. See the case of *R (on the application of Axon) v Secretary of State for Health and the Family Planning Association [2006] EWHC 37 (Admin).*

In some circumstances, and with the MCA safeguards in place, it may still be possible for young people aged 16-18 lacking capacity to be admitted to hospital and/or treated in residential care etc on the basis of consent of those with parental responsibility for them (see Mental Health Act 1983 Code of Practice, DH 2015: 182–5, paragraphs 19.53 – 19.70). However, the courts have made it clear that there are limits to the types of decisions that those with parental responsibility can make on behalf of their child, and the circumstances in which such decisions can be made. If the decision is unsuitable for those with parental responsibility to make, then the matter may need to be referred to the responsible bodies under the MCA and/or a court.

The issue may be brought before the High Court, either under the High Court's inherent jurisdiction or under s. 8 of the Children Act 1989 for a specific issue order. In the case of *Re W (A Minor) (Consent to Medical Treatment) [1993] 1 FLR 1*, the Court of Appeal gave a direction for the treatment of a girl aged 16 who had anorexia nervosa, despite her refusal. The refusal of the young person and the reasons for it are important considerations for the court, but the health and welfare of the young person will be the paramount consideration in any court decision.

Capacity can be a complex issue for consideration where a young person may be in the process of assessment or diagnosis of mental disorder or mental illness.

Under changes made to s.131 of the Mental Health Act 1983 by s.43 of the MHA 2007, when a young person aged 16 or 17 has capacity (as defined in the MCA 2005) and does **not** consent to admission for treatment for mental disorder (whether because they are overwhelmed, they do not want to consent or they refuse to consent), they cannot then be admitted *informally* on the basis of the consent of a person with parental responsibility (see s 131 (4) MHA and Mental Health Act 1983: Code of Practice, DH 2015: Chapter 19). Formal procedures for admission would have to be followed (see section 2.3 on compulsory admission for mental health assessment and treatment).

8.3 Where a 16–18 year old lacks capacity

Where the young person aged 16-18 is assessed under the MCA and does **not** have capacity, those who have parental responsibility for them should be identified and consulted about the proposed decision (subject to the young person's right to confidentiality), see s.4 of the MCA. For the scope of parental responsibility and situations where those with parental responsibility for a young person may give consent for treatment, see 8.8 of this resource.

8.4 Mental capacity in children under the age of 16

The capacity of children under the age of 16 to make decisions depends on the concept of 'Gillick competence' as set out in the case of *Gillick v West Norfolk and Wisbech Area Health Authority 1986*. The steps for assessment of competence are set out in Mental Health Act 1983 Code of Practice (DH 2015: 174 at para 19.25):

Practitioners should consider the following three questions, which should be read in conjunction with the examples in the paragraphs below:

1. Has the child or young person been given the relevant information in an appropriate manner (such as age-appropriate language)?
2. Have all practicable steps been taken to help the child or young person make the decision? The kind of support that might help the decision-making will vary, depending on the child or young person's circumstances. Examples include:
    - steps to help the child or young person feel at ease
    - ensuring that those with parental responsibility are available to support their child (if that is what the child or young person would like)
    - giving the child or young person time to absorb information at their own pace, and
    - considering whether the child or young person has any specific communication needs (and if so, adapting accordingly).
3. Can the child or young person decide whether to consent, or not to consent, to the proposed intervention? The Mental Health Act 1983 Code of Practice (DH 2015: 177, para 19.37) states: '

    'A child may lack the competence to make the decision in question either because they have not as yet developed the necessary intelligence and understanding to make that particular decision; or for another reason, such as because their mental disorder adversely affects their ability to make the decision. In either case, the child will be considered to lack Gillick competence.'

8.5 Where a child under the age of 16 has competence, but refuses consent

Those with parental responsibility could technically give their consent for medical or psychiatric treatment despite the clear refusal of their child.

Since the inception of the Human Rights Act 1998, however, in the case of a child under the age of 16 who is competent to make their own decisions in accordance with the principles in the *Gillick* case, medical and other authorities are less likely to rely on parental consent, and more recent court cases reflect the right of the child or young person with capacity or *Gillick competence* to have their views respected. See, for example the case of *R (on the application of Axon) v Secretary of State for Health and the Family Planning Association [2006] EWHC 37 (Admin)* (available at: www.bailii.org/ew/cases/EWHC/Admin/2006/37.html), in which the court expressed doubt as to why a parent should retain the right to parental authority relating to a medical decision when the child concerned understood the advice provided by the medical profession and its implications. For the scope of parental responsibility and situations where those with parental responsibility for a child may give consent for treatment, see 8.8. of this resource.

8.6 Where a child under the age of 16 lacks competence to consent

Where the young person under the age of 16 does **not** have capacity to make the necessary decision, as assessed in the context of the principles in the Gillick case, those who have parental responsibility for them should be identified and consulted about the proposed decision (subject to the young person's right to confidentiality; see s.4 of the MCA). Again, for the scope of parental responsibility and situations where those with parental responsibility for a child may give consent for treatment, see 8.8 of this resource.

8.7 When can those with parental responsibility give consent for treatment for a child or young person?

If the child or young person lacks competence or capacity, or resists or has refused treatment, and the issue to be decided is one which falls within the scope of parental responsibility to decide, then those with parental responsibility may make the decision.

However, if the matter does not fall within this scope, then the professional will either have to use their powers under the MCA (if the intervention is for assessment or treatment of a mental disorder) or seek legal advice as to whether the matter should be put before a court, see (Mental Health Act 1983 Code of Practice, DH 2015: 178-9, para 19.42).

In some circumstances, it will be possible for children under 16 lacking competence and young people aged 16-18 lacking capacity to be admitted to hospital and/or treated on the basis of consent of those with parental responsibility (see Mental Health Act 1983 Code of Practice, DH 2015: 182-5, paras 19.53-19.70). However, the courts have made it clear that there are limits to the types of decisions that those with parental responsibility can make on behalf of their child, and the circumstances in which such decisions can be made. If the decision is unsuitable for those with parental responsibility to make, then the matter may need to be referred to a court.

In terms of assessing whether the issue is one appropriate for those with parental responsibility to decide, the guidance identifies these factors:

- When making decisions for a child, those with parental responsibility must act in the child's best interests (Mental Health Act 1983 Code of Practice, DH 2015: 178, para 19.40).

- Is the decision one that a parent should reasonably be expected to make? (Mental Health Act 1983 Code of Practice, DH 2015: 178, para 19.41). Factors may include: invasive or controversial nature of the proposed treatment, resistance of the child, use of electro-convulsive therapy, and the child's expressed views.

- Are there factors that might undermine the validity of parental consent? Factors may include the parent's own mental state or capacity, parental bias or inability to focus on the child's best interests, parental conflict or distress, parental disagreement about the decision to be made (see Mental Health Act 1983 Code of Practice, DH 2015: 178, para 19.41).

- Does the matter involve a deprivation of liberty? Until the case of P v Cheshire West and Chester Council and another and *P and Q v Surrey County Council ('Cheshire West')* [2014] AC 896, it was fairly clear that those with parental responsibility could not authorise a deprivation of liberty for their child. However, 'Cheshire West' opened the door a little. It defined the elements that established a deprivation of liberty but did not go so far as to expressly decide whether those with parental responsibility could consent to restrictions that would amount to deprivation of liberty without their consent, and if so in what circumstances that consent might be given. So, practitioners are still left to assess matters on a case-by-case basis and watch for future case law to clarify the situation.

(See also RK (*by her litigation friend and the official solicitor*) v BCC, YK and AK [2011] EWCA Civ 1305.) Factors to consider are: the child's right to liberty under the European Convention for Human Rights (ECHR) (Article 5), and Article 37 of the United Nations Convention of the Rights of the Child (UNCRC); the parent's right to respect for family life and the concept of parental responsibility for the care and custody of minor children (UNCRC Article 8).

Again, professionals making difficult decisions here should seek legal advice (see Mental Health Act 1983 Code of Practice, DH 2015: 180-1, para 19.48).

- Does the matter involve informal admission for assessment or treatment? Where a child or young person lacks competence or capacity, in specified circumstances they may be admitted informally with either consent of those with parental responsibility or the provisions of the MCA.

If the specified circumstances do not apply, then unless it is a life-threatening emergency (see Mental Health Act 1983 Code of Practice, DH 2015: 185, paras 19.71-72), they should be admitted under the formal criteria in the MCA or by an order of the High Court (either a declaration of lawfulness or an order under s 8 of the Children Act 1989), or an order by the Court of Protection for a person aged 16 and 17.

8.8 Parental responsibility

People may assume that all parents have the power to make decisions for their children. This is not so. The ability of a parent, or anyone else, to make a decision for their child depends on whether they have 'parental responsibility', which is the legal basis for making decisions about a child, including giving valid consent for therapy, and for certain actions under the MCA in relation to children and young people requiring the consent of a person with parental responsibility.

Parental responsibility is a legal concept created by the Children Act 1989 and defined in s. 3(1) as 'all the rights, duties, powers, responsibilities and authority which by law the parent of a child has in relation to a child and his property'. There may be new legislation that will further define the concept of parental responsibility, so watch for changes in the law.

More than one person can have parental responsibility for a child at the same time. Parental responsibility cannot be transferred or surrendered, but elements may be delegated; see s. 2(9) of the Children Act 1989.

For a detailed, informed and very readable explanation of who has parental responsibility, and how it may be acquired or lost, see Mahmood and Doughty (2019). Here is a brief summary:

'Parental responsibility is a legal concept created by the Children Act 1989 and defined in s.3(1) as "all the rights, duties, powers, responsibilities and authority which by law the parent of a child has in relation to a child and his property."'

Mothers and married fathers: Every mother (whether she is married or not) has parental responsibility for each child born to her; and every father who is married to the child's mother at the time of, or subsequent to, the conception of their child, which may be shared with others but will cease only on death or adoption.

Unmarried fathers: Unmarried fathers may acquire parental responsibility for their biological child in one of several ways, the first three of which can only be removed by order of the court:

- From 1 December 2003, in England and Wales (earlier in Northern Ireland) an unmarried father automatically acquires parental responsibility for his child if, with his consent, he is named as the child's father on the registration of the child's birth. This law does not operate retrospectively.

- By formal Parental Responsibility Agreement signed by the mother and father, witnessed by an officer at court, then registered. Copies may be obtained for a fee, in a similar way to obtaining a birth certificate (see Parental Responsibility Agreement Regulations SI.1991 1478).

- The court can make an order under s. 4(1)(a) of the Children Act 1989 on application from the father, awarding parental responsibility to the father, consistent with the interests of the child.

Parental responsibility can also be acquired by a child's biological father where:

- a residence order is made under s. 8 of the Children Act 1989, directing the child to live with the father, and parental responsibility is awarded along with it

- appointment as the child's guardian is made under s. 5 of the Children Act 1989

- the father marries the child's mother

- certain placement or adoption orders are made under the Adoption and Children Act 2002.

Acquisition of parental responsibility by others: parental responsibility may be acquired by others (including relatives, partners and guardians) in a variety of ways, for example by the appointment of a testamentary guardian, or (subject to the agreement with the others who also hold parental responsibility for that child) by marriage to, or civil partnership with, a parent who has parental responsibility for the child. It may also be acquired by local authorities in care proceedings and by others by means of various court orders. Parental responsibility may then be shared with others who also hold it, and the exercise of parental responsibility may be limited by the court in certain cases.

Note: For the parental responsibility agreement regulations, please see the list of statutory instruments at the end of this resource. For the necessary forms, such as *Parental responsibility Agreement* C (PRA 1), please see www.gov.uk/government/publications/form-cpra1-parental-responsibility-agreement or ask at any family court office.

What if there is no one with parental responsibility for a child? Some children (for example, a child whose biological father is unknown and whose single mother dies without appointing a guardian) may have nobody with legal parental responsibility for them. Relatives or others wishing to care for the child will then have to apply for parental responsibility under one of the applications listed above or, failing that, the local authority has a responsibility to assume the care of the child and can seek an appropriate order.

There is an additional provision in s.3(5) of the Children Act 1989 that those without parental responsibility may 'do what is reasonable in all the circumstances to safeguard and promote the welfare' of a child in their care. This provision is useful in day-to-day situations, for example allowing a babysitter, neighbour or relative who is temporarily looking after a child to take that child for medical help in an emergency. This provision is unlikely to apply to counselling, unless in an emergency.

9 Assessment and management of risk and the therapist's duty of care

Working with risk is always a concern for a therapist. We have to consider any area of potential risk to the health and welfare of the client to whom we have a duty of care in the context of the therapeutic work. Also, as part of our duty of self-care, we need to be aware of any potential risk to ourselves as practitioners – whether the risk arises from the client's actions, or from any other aspect of the therapeutic work.

Sometimes, the client may live in an environment or social context that could pose a specific or generalised risk to the client or others, and this too may need to be taken into account. This might include, for example, clients (or their families) involved with violent gangs or criminal activities, living in violent or highly oppressive situations, involved in a culture of illegal dangerous substance abuse.

Reeves and Bond pay attention to both areas of risk in *Standards and Ethics for Counselling in Action* 5th Edition (2021).

All clients may potentially pose a level of risk. Unless clients are referred to us by a medical practitioner or other professional, or we have some information about them through a previous assessment, we may know little about our new clients. When we work with clients who have a mental disorder or who suffer from mental illness, the element of risk may be increased.

Some mental conditions may carry with them an increased risk of suicidality or other forms of self-harm, while other mental conditions may carry a degree of risk of violence to others, which may put the therapist and/or others at risk.

For practitioners who work from home, careful attention should be paid to risk assessment. The choice of venue for therapy is important when there is a risk to the therapist or others.

The therapist's duty of care both to the client and to the public may involve having an appropriate level of safety mechanisms in place for emergency use, back-up by colleagues and support staff, and safety equipment and routines for the protection of the client and others. Staff should be familiar with all of this and be well-rehearsed in it.

For example, in organisations and waiting rooms there may be fire drills, emergency 'panic' buttons, emergency exits, toughened safety glass in windows and doors. Some practitioners working with high-risk clients will need to pay attention to safety concerns such as: the accessibility of hot liquids, items which could be thrown or used as weapons, storage of personal belongings that may contain medicines belonging to staff or practitioners, accessibility of confidential information, seating arrangements, placement of furniture, having a colleague or member of staff nearby, and so on.

9.1 Suicidality – where the client is at risk of self-harm

Under the Suicide Act 1961, suicide or attempted suicide is not a criminal offence. In *Regina (Pretty) v. Director of Public Prosecutions* the court referred to section 3(1) of the Human Rights Act 1998 and articles 2 and 3 of the European Convention on Human Rights – the right to life and the right to decide what to do with one's own body. Although these articles protect life and preserve the dignity of life, they do not protect the right to procure one's own death or confer a right to die. See GPiA 057 (Suicide) and 058 (Assisted death) for more detailed discussion of these issues.

Clients have a general right to expect confidentiality within a professional relationship, but this is not an absolute legal right, since confidentiality is always subject to the requirements of the law. For example, in certain situations like terrorism, statute requires that compulsory disclosures must be made, and therapists must comply with orders of the courts.

There is also legal protection for disclosure made by a practitioner without client consent, provided that the disclosure is justifiable in the public interest.

In the case of a risk of serious harm to the client or to others, confidentiality may therefore be breached in the public interest (see Reeves and Bond (2021); Mitchels and Bond (2021); Reeves (2015, 2010), and GPiA 014). The proposed method of an intended suicide may well cause harm to others, and so may justify a breach of the client's confidentiality in the public interest if the therapist holds a reasonable belief that the risk is real, serious and imminent. In this event, disclosure should be made on a 'need-to-know' basis to the people (or organisations) who can act effectively to prevent the intended harm, providing as much information as is necessary in order to prevent the harm. The disclosure should be properly recorded. Disclosures are best made with the client's knowledge and consent, and in a manner appropriate for the client, so confidentiality should always be negotiated as part of the contract between therapist and client.

The client should also be informed of any limitations on confidentiality before counselling commences, and the counsellor should ensure wherever possible that the client understands and agrees to these limitations. See the *Caldicott Review* (DH 2013) for guidance on disclosures within the NHS, and the online GMC guidance *Good Medical Practice* which embodies confidentiality and consent.

Further information can be found within Good Practice in Action 042 Fact Sheet: *Working with suicidal clients in the context of the counselling professions*, which can be downloaded at: www.bacp.co.uk/gpia.

9.2 Risk assessment in the context of mental illness and mental disorder

Risk assessment is very much a matter of good practice.

See Reeves and Bond (2021); Reeves 2015, 2010, and Good Practice in Action 030 *Safeguarding vulnerable adults* and 031 *Safeguarding children and young people* for help in good and effective risk assessment in therapy practice. The legal position is that the courts will expect the practitioner to take reasonable care of each client taking into account their circumstances and their specific situation. Where there is a formal diagnosis of mental illness or a mental disorder, it is therefore advisable for the practitioner to seek guidance on the appropriate management of risk in relation to that specific client (or group of clients) from the relevant professionals responsible for the client's health and welfare. For example, where appropriate, it is advisable to consult with those responsible for the client's medical, social and physical care, within the bounds of client confidentiality and client consent.

We have a duty under the *Ethical Framework for the Counselling Professions* (Commitment 2a) to 'work within our competence'. The courts would regard it as an unacceptable risk to a client for a therapist to work with a client who presents material, issues or behaviours that may challenge the therapist beyond the remit of their competence, or whose circumstances (for example, their age, ethnicity, social circumstance, personal qualities, or a diagnosis of specific mental illness or disorder) may similarly challenge the therapist.

Therefore, we as therapists should be cautious and take advice in supervision or from a relevant experienced professional, when thinking about working with any client or circumstances in which our competence may be questioned or in any way in doubt.

When undertaking group work, the practitioner will need to be aware of the safety issues presented by the group as a whole, and the individuals within the group. There is a duty of care to each client in the group and also to the group as a whole, in addition to self-care. The practitioner's insurer may be able to assist with information and guidance about the practitioner's public liability duties and responsibilities.

10 Referrals and the therapist's duty of care

We have a duty of care to work within our own personal area of expertise and competence. It is a failure of our duty of care to provide an inadequate service. We should therefore refer a client on – with the client's knowledge and consent if we feel unable to provide the level or type of therapy that the client needs.

If mental disorder or mental illness is as yet undiagnosed but is suspected by the therapist in the course of working with a client, the issue of an appropriate referral should be considered and discussed in supervision. Consultation with the therapist's professional organisation or an experienced colleague may also be helpful. Referrals should be made with the explicit knowledge and consent of the client and will usually go to the client's GP or mental health practitioner.

A referral will usually take the form of advising clients to consult their GP but if a client required emergency assistance, referral may have to be made by the practitioner. It is good practice to discuss confidentiality with clients at the outset of the therapeutic alliance, and, in advance of starting therapy, to obtain from the client a general formal consent for making appropriate referrals if necessary, and to agree how this will be done. For more detailed exploration of confidentiality and disclosures of information see *Confidentiality and Record Keeping in Counselling and Psychotherapy 3rd edition*, Mitchels and Bond (2021); Reeves and Bond (2021) and Good Practice in Action 014 *Managing confidentiality*.

Referral letters form part of a client's clinical record, and so should be carefully considered and accurately worded. Not only is there a duty of care regarding accuracy in referral, but there is also a legal liability (slander and libel) in the law of tort for making a verbal or written statement, that is untrue and may damage the reputation of another person. Practitioners could be legally liable for inaccurate information disclosed about a client.

For practice guidance, please refer to BACP's *Ethical Framework for the Counselling Professions* (BACP 2018) and the relevant Good Practice in Action resources, which can be downloaded at: www.bacp.co.uk/gpia.

11 National Institute for Health and Care Excellence (NICE) pathways and guidance

NICE produces quality standards, technology appraisals, guidance and pathways in order to maintain standards of good practice. The NICE guidance (available at www.nice.org.uk/guidance/lifestyle-and-wellbeing/mental-health-and-wellbeing) claims to be based on evaluations of evidence-based practice.

People receiving a referral to mental health services should be given a copy of their referral letter and offered a face-to-face appointment within three weeks. They should be greeted and engaged in a 'warm, friendly, empathic, respectful and professional manner', and not be kept waiting at that appointment for longer than 20 minutes. Crisis resolution and home treatment teams should be accessible 24 hours a day, seven days a week, and 'available to service users in crisis, regardless of their diagnosis.' If detention is necessary under the mental health legislation, this should happen only after all alternatives have been fully considered in conjunction with the service user if possible, and with the family or carer if the service user agrees.

Alternatives may include:

- medicines' review
- respite care
- acute day facilities
- home treatment
- crisis houses.

Shortly after service users arrive in hospital for hospital care, they should be made welcome and shown around the ward, introduced to the health and social care team as soon as possible (within the first 12 hours if the admission is at night).

They should have a named healthcare professional who will be involved throughout their hospital stay. Formal assessment and admission processes should start within two hours of arrival.

In hospital, the staff should:
Give verbal and written information to service users, and their families or carers where agreed by the service user, about:

- the hospital and the ward in which the service user will stay
- treatments, activities and services available
- expected contact from health and social care professionals
- rules of the ward (including substance misuse policy)
- service users' rights, responsibilities and freedom to move around the ward and outside
- meal times
- visiting arrangements.

Make sure there is enough time for the service user to ask questions.

11.1 The Improving Access to Psychological Therapies (IAPT) programme

For details of how the IAPT programme works, see the IAPT website (www.england.nhs.uk/mental-health/adults/iapt). Briefly, the programme supports the frontline NHS in implementing NICE guidelines on the provision of evidence-based psychological therapies for people suffering from depression and anxiety disorders. It is available to adults of all ages.

The plans for a nationwide rollout of psychological therapy services, a stand-alone programme for children and young people, and models of care for people with long-term physical conditions, medically unexplained symptoms and severe mental illness are in place. It is not clear how far this plan has been fulfilled nationally, at the time of writing.

The Improving Access to Psychological Therapies for Severe Mental Illness (IAPT for SMI) project aims to increase public access to a range of NICE-approved psychological therapies for psychosis, bipolar disorder and personality disorders.

For how the IAPT pathway works in practice, see: www.england.nhs.uk/publication/the-improving-access-to-psychological-therapies-iapt-pathway-for-people-with-long-term-physical-health-conditions-and-medically-unexplained-symptoms. If you are an IAPT service provider, please check the NHS website www.nhs.uk/service-search/other-services to ensure that your service is registered and the details are fully up to date. A range of helplines and other support resources can be found at the Helplines Partnership website (www.helplines.org).

12 Complaints and Mental Health Review Tribunals (MHRTs)

MHRTs have significant legal powers in relation to the continued detention and the discharge of patients. All detained patients have the right to have their detention reviewed at regular intervals by a tribunal that has the power and duty to discharge them if the necessary criteria are met. There are similar rights for all patients subject to Guardianship and Community Treatment Orders, and those patients with restrictions imposed who have been conditionally discharged by a tribunal or with the agreement of the Justice Secretary.

The Tribunals, Courts and Enforcement Act 2007 (TCEA) overhauled the tribunal system and covers tribunals in all areas including the MHRT. Section 3 of the TCEA created a two-tier system of First Tier Tribunals (FTTs), and a second tier, the Upper Tribunal (UT), which acts as an appellate system to review decisions of the FTTs. Each tier of the tribunal has specialist chambers headed by a president.

The role of the MHRT was transferred to the FTT and UT system by article 3 and schedule 1 of the *Transfer of Tribunal Functions Order 2008*, and mental health cases are heard within the 'Health Education and Social Care' chamber. The mental health tribunal has its own 'Mental Health Administrative Support Centre' in Leicester, and uses specialist judges and other tribunal members, and rules of procedure.

The rules for making applications to the mental health tribunal are complex. For details please refer to Chapter 12 of Mental Health Act 1983 Code of Practice (DH 2015: 87-94). Patients (or their nearest relatives) are entitled to be informed about their legal rights, and are entitled to free legal advice and representation, and also to private visits from an independent doctor or clinician, who may also see that patient's records.

In some situations, hospital managers should either refer patients to the Tribunal, see the helpful flowchart at Mental Health Act 1983 Code of Practice (DH 2015: 381-383, paras 37.39-43) or consider requesting the Secretary of State to refer a patient (Mental Health Act 1983 Code of Practice DH 2015: 383-384 paras 37, 44-46). For children and young people, see Mental Health Act 1983 Code of Practice (DH 2015: 193, paras 19:107-110).

Tribunals may request reports and medical examinations. If the patient has not appointed a representative, the tribunal can, if necessary, appoint a person to represent the patient. This may be a family member, carer or advocate.

Patients will normally be present throughout a hearing. They do not have to attend but are encouraged and supported to be there unless it would adversely affect their health and wellbeing. Often a nurse will accompany them.

The clinician and those who have submitted reports should attend the hearing, to provide up-to-date information, especially about after-care available if the tribunal decides to discharge the patient.

The decisions of the tribunal are communicated verbally to the patient and all parties at the end of the hearing. If feasible, and if the patient wishes it, the tribunal will speak to the patient personally; otherwise the representative will be informed. A written copy of the reasons for the decision should be provided as soon as possible.

Information about applications to the mental health tribunal and complaints regarding the tribunal procedure is available at www.gov.uk/mental-health-tribunal.

See also The Tribunal Procedure (First-tier Tribunal) (Health, Education and Social Care Chamber) Rules. 2008 (as amended), available at: www.legislation.gov.uk/uksi/2008/2699/contents/made.

For further information, see the lists at the end of this resource.

About the author

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References and further reading

- UK Government publications are available from: The Stationery Office (TSO), PO Box 29, Norwich NR3 1GN; Tel: 0870 600 5522; Email: customer.services@tso.co.uk; www.tsoshop.co.uk

- The Department for Education (www.education.gov.uk), formerly Department for Children Schools and Families, publishes policy regarding children's services in England.

- The Ministry of Justice (www.justice.gov.uk) publishes policy regarding the courts in England and Wales.

- Northern Ireland Government publications are available from the Department of Health, Social Services and Public Safety (www.dhsspsni.gov.uk).

- The Welsh Government publications, see (https://gov.wales/publications)

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Resources, information, guidance and reference works

Cases

Ann R (By her Litigation Friend Joan T) v The Bronglais Hospital Pembrokeshire and Derwen NHS Trust [2001] EWHC Admin 792

B v Croydon District Health Authority (1994) 22 BMLR 13 (HC).

Gillick v West Norfolk and Wisbech Area Health Authority 1986 AC 112. (www.bailii.org/uk/cases/UKHL/1985/7.html)

P v Cheshire West and Chester Council and another and P and Q v Surrey County Council 2014 WLR 2 (www.bailii.org/uk/cases/UKSC/2014/19.html)

Regina (Pretty) v. Director of Public Prosecutions, Secretary of State for the Home Department (interested party); Medical Ethics Alliance and others [2001] QBD 18 October 2001

R (Purdy) v. Director of Public Prosecutions (Society for the Protection of Unborn Children intervening) [2009] WLR (D) 271; [2009] UKHL 45 House of Lords(E)

Pretty v United Kingdom (2002) 35 EHRR 1 and R (Pretty) v Director of Public Prosecutions (Secretary of State for the Home Department intervening) [2002] 1 AC 800

R (on the application of Axon) v Secretary of State for Health and the Family Planning Association [2006] EWHC 37 (Admin)

RK (by her litigation friend and the official Solicitor) v BCC, YK and AK 2011 EWCA Civ 1305 (www.bailii.org/ew/cases/EWCA/Civ/2011/1305.html)

Contacts

Improving Access to Psychological Therapies (IAPT)
www.england.nhs.uk/mental-health/adults/iapt. Alternatively, a range of helplines and other support resources can be found at the Helplines Partnership website at: https://helplines.org

Mental Health Practice Guidance
www.rcni.com

Mental Health Tribunal
www.gov.uk/mental-health-tribunal/overview

MIND
https://youngminds.org.uk and https://mind.org.uk

NICE
www.nice.org.uk and www.nice.org.uk/guidance

Quality Standards
www.nice.org.uk/guidance/lifestyle-and-wellbeing/mental-health-and-wellbeing

Royal College of Psychiatrists Publications
www.rcpsych.ac.uk › Useful Resources › Publications

Disclosure and barring services (DBS)

England and Wales
Disclosure and Barring Service (DBS) customer services, PO Box 110, Liverpool, L69 3JD; Tel: 0870 90 90 811; Minicom: 0870 90 90 344; Email: customerservices@dbs.gsi.gov.uk; Transgender applications: sensitive@dbs.gsi.gov.uk; www.gov.uk/dbs-update-service

Welsh language scheme: www.gov.uk/government/organisations/disclosure-and-barring-service/about/welsh-language-scheme

Northern Ireland
Information on the application process: www.nidirect.gov.uk/accessni; information on the disclosure and barring programme in Northern Ireland: www.dojni.gov.uk/accessni.

Legal contacts

England
For a list of the courts and links to regional courts' contact details, see www.justice.gov.uk/contacts/hmcts/courts

CAFCASS (*Children and Family Court Advisory and Support Service*): National Office, 3rd Floor, 21 Bloomsbury Street, London WC1B 3HF; Tel: 0300 456 4000; Fax: 0175 323 5249; www.cafcass.gov.uk Local offices are listed on the website or available from National Office.

NAGALRO (*The Professional Association for Children's Guardians, Family Court Advisers and Independent Social Workers*): PO Box 264, Esher, Surrey KT10 0WA; Tel: 01372 818504; Fax: 01372 818505; Email: nagalro@globalnet.co.uk; www.nagalro.com

Northern Ireland
See www.courtsni.gov.uk for contact details of all courts, publications, judicial decisions, tribunals and services.

Northern Ireland Guardian Ad Litem Agency: Email: admin@nigala.hscni.net

Wales
Children and Family Court Advisory and Support Service (CAFCASS) Cymru: National Office, Llys y Delyn, 107–111 Cowbridge Road East, Cardiff, CF11 9AG; Tel: 02920 647979; Fax: 02920 398540; Email: Cafcasscymru@Wales.gsi.gov.uk; Email for children and young people: MyVoiceCafcassCymru@Wales.gsi.gov.uk; http://new.wales.gov.uk/cafcasscymru

Republic of Ireland (Eire)
An Roinn Slainte: Republic of Ireland Department of Health: Hawkins House, Hawkins Street, Dublin 2, Ireland; main switchboard: 01 635 4000 (dial +353 1 635 4000 from outside Ireland).

Ombudsman for Children's Office: Millennium House, 52–56 Great Strand Street, Dublin 1, Ireland; Tel: 01 865 6800; (dial +353 1 865 6800 from outside Ireland) Email: oco@oco.ie; Fax: 01 874 7333 www.oco.ie

Legal resources

British and Irish Legal Information Institute (www.bailii.org). Publishes all High Court, Court of Appeal and Supreme Court judgments

Statutes

Care Act 2014

Children Act 2004

Children Act 1989

Children and Young Persons Act 1969

Children and Young Persons Act 2008

Data Protection Act 1988

Family Law Act 1969

Family Law Act 1987

Freedom of Information Act 2000

Human Rights Act 1998

Mental Capacity Act 2005

Mental Capacity (Amendment) Act 2019

Mental Health Act 1983

Mental Health Act 2007

Mental Health (Northern Ireland) Order 1986Suicide Act 1961

Tribunals, Courts and Enforcement Act 2007.

Statutory instruments

The Care Act 2014 (Transitional Provision) Order 2015

The Care Act 2014 (Commencement No. 4) Order 2015

The Care Act 2014 and Children and Families Act 2014 (Consequential Amendments) Order 2015

The Care Act 2014 (Consequential Amendments) (Secondary Legislation) Order 2015

The Care Act 2014 (Health Education England and the Health Research Authority) (Consequential Amendments and Revocations) Order 2015

The Care Act 2014 (Commencement No.3) Order 2014

The Care Act 2014 (Commencement No.2) Order 2014

The Care Act 2014 (Commencement No.1) Order 2014

The Mental Health (Approved Mental Health Professionals) (Approval) England Regulations 2008 SI 2008/1206.

Parental Responsibility Agreement Regulations 1991, SI 1991/1478

Parental Responsibility Agreement (Amendment) Regulations 1994, SI 1994/3157

Transfer of Tribunal Functions Order 2008. SI 2008/2833

The Tribunal Procedure: First-tier Tribunal, Health, Education and Social Care Chamber Rules. 2008. SI 2008/2699

Conventions and protocols

- UN Convention on the Rights of the Child
- European Convention for the Protection of Human Rights and Fundamental Freedoms
- Protocols made under the European Convention for the Protection of Human Rights and Fundamental Freedoms
- Care Council for Wales (https://socialcare.wales/learning-and-development/family-justice). Publishes Child law for social workers in Wales in English and Welsh, with regular updates
- Family Law (www.familylaw.co.uk). Access to Jordan Publishing's family law reports
- Family Law Week (www.familylawweek.co.uk)
- Justis (www.justis.com). Online resource
- UK statute law (www.legislation.gov.uk)
- UK statutory instruments (www.opsi.gov.uk/stat.htm).