

Mental health law within the counselling professions in England and Wales

**Good Practice in Action 029
Legal Resource**

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Context

This resource is one of a suite prepared by BACP to enable members to engage with the *Ethical Framework for the Counselling Professions* <https://www.bacp.co.uk/events-and-resources/ethics-and-standards/ethical-framework-for-the-counselling-professions> 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 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

Legal resources support good practice by offering general guidance on principles and policy applicable at the time of publication. These resources should be used in conjunction with the current BACP *Ethical Framework for the Counselling Professions*. They are not intended to be sufficient for resolving specific issues or dilemmas arising from work with clients, which are often complex. In these situations, we recommend consulting a suitably qualified and experienced lawyer or practitioner. 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.

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, individuals under the care of the mental health services are referred to as 'patients,' as this is the term used in the 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, there are additional statutory provisions and regulations for Northern Ireland and Scotland. For this reason, BACP aims to publish additional resources on mental health law in relation to counselling as it applies specifically in Northern Ireland and in Scotland.

In England and Wales, mental health law and practice have been radically reformed in recent years; the Mental Health Act 1983 was amended by the Mental Capacity Act 2005 and the Mental Health Act 2007. Furthermore, the United Nations Convention on the Rights of Persons with Disabilities, which came into effect in 2008, poses far-reaching challenges to our current mental health legislation. In October 2017, the 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 is 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: <https://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)).

The Government website (<https://www.gov.uk/government/news/government-commits-to-reform-the-mental-health-act>); states:

'The Government will issue a formal response to the review's recommendations in the New Year before preparing the new legislation.' And then quotes these comments on the proposals for new legislation...

Prime Minister Theresa May said:

'The disparity in our mental health services is one of the burning injustices this country faces that we must put right.

For decades it has somehow been accepted that if you have a mental illness, you will not receive the same access to treatment as if you have a physical ailment. Well, that is not acceptable.

I commissioned this review because I am determined to make sure those suffering from mental health issues are treated with dignity and respect, with their liberty and autonomy respected.

By bringing forward this historic legislation – the new Mental Health Bill – we can ensure people are in control of their care and are receiving the right treatment and support they need.

I'm grateful to Professor Sir Simon Wessely and his team for their tireless work on this vitally important review.'

Health and Social Care Secretary Matt Hancock said:

With 1 in 4 people being affected by mental ill health at some point in their lives, it is more important than ever that we put mental and physical health on an equal footing.

I am determined to do everything I can to protect people's mental health and get them the help they need. The proposed new Mental Health Bill will give patients more control over their treatment and make sure that our mental health laws are fit for the modern age.'

Claire Murdoch, NHS England's National Director for Mental Health, said:

'We warmly welcome Sir Simon Wessely's report, which makes a compelling case for modernising the Mental Health Act. This timely and important review makes the case for better legislation to underpin the service improvements needed for the most severely mentally ill people while also tackling health inequalities in our society.

High-quality support in the community before a person reaches crisis point, coupled with improved crisis services when they are needed, will both help, but the review is also right to argue that anyone who needs to be in hospital should get the best care during and after their inpatient stay.'

It is hoped that these proposed changes in attitude, practice and funding, are reflected in the new Mental Health Bill and accepted by Parliament... watch out for the new legislation and associated guidance to come this year.

See (<https://www.gov.uk/government/news/government-commits-to-reform-the-mental-health-act>).

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]. 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 (2013:1–11).

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 (2013:7).

The ethical provision of therapy 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 a list 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, the Mental Health Act 2007 (MHA 2007), the Mental Capacity Act 2005 (MCA 2005) and the Care Standards legislation.

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

There have been regular calls to update law and practice in the area of mental health, and with increasing scrutiny of our law under the Human Rights Act 1998 by the European Commission for Human Rights (ECHR), the increasing awareness of disability rights, the impact of the United Nations Convention on the Rights of Persons with Disabilities, which came into effect in 2008, and the recurring disclosures of abuse in care systems, we might anticipate further reforms, so stay alert for changes in law and guidance which are relevant to your therapy practice.

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 subsequent legislation is referred to as the 'MCA'.

1 Legal definitions relevant to mental health

This section is a glossary of basic legal terms related to mental health that 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, that 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 introduced by the MHA 2007 provide for procedures to authorise the deprivation of liberty of a person resident in a hospital or care home who lacks capacity to consent. The principles established in the MCA 2005, 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.

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 (see definitions below) 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 health professional (AMHP): AMHPs make most of the applications for admission, or compulsory admission, for assessment or treatment under s.2 and s.3 of the MHA 1983. 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). AMHPs 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*.

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* (Department of Health 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 remained 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 is 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 *Diagnostic and Statistical Manual of Mental Disorders*, 5th edition (DSM-5) (APA, 2013; updated in 2015, see <http://psychiatryonline.org>), and *The ICD-10 Classification of Mental and Behavioural Disorders: Clinical descriptions and diagnostic guidelines* (10th revision, effective from 1 October 2015).

Mental illnesses are sometimes mistakenly perceived as a range of permanently curable illnesses, in the same way that some physical illnesses can be permanently cured. This perception might be true in some instances, but mental illness can perhaps be more clearly perceived generally as a chronic condition, which may be controlled or contained with appropriate conditions of life and/or appropriate treatments.

When we think of mental health legislation that might enforce treatments or conditions of living on people with certain serious mental illnesses, this means that legislation may affect a person with serious mental illness at various times in their life.

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 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* (Department of Health 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.

2.1 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.

2.2 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 s.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 or neglected, not being 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.2 in section 2.2.1 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.

2.3 Admission under Section 3 of the MHA for treatment

The wording of this section is similar to that relating to admissions for assessment (see section 2.1 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 she or he should receive such treatment, and
- it cannot be provided unless she or 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 in that case this section will not apply.

If the patient has a learning disability and this constitutes the mental disorder, then s.3 can only operate if the disorder 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 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 2013: 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.

2.4 The process of admission

The process for emergency admissions is addressed in section 2.2 of this resource. Under s.3 MHA, (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 definitions, see section 1 of this resource) for compulsory admission to hospital. One of these must be by a 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, and had 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 (Department of Health 2015) recommends that the doctor should be s.12 approved (see AMHP in section 1 of this resource).

2.5 Deprivation of liberty safeguards (DoLS)

A person may be detained for mental health treatment under the MHA (see sections 2.1 to 2.4 of this resource). The MCA provides safeguards in relation to the deprivation of a person's liberty (DoLS), which apply in other situations. Under s.16(2) (a) and Schedule A1 of the MCA 2005, the Court of Protection may make an order to deprive a patient of his liberty, for his personal welfare. Basically, where a person needs physical treatment, and this is the sole reason for their detention in a hospital or other form of residential care, then that person is not within the scope of the Mental Health Act (as the purpose of the deprivation of liberty is not to treat mental disorder) and a DoLS authorisation or Court of Protection order should be sought (Mental Health Act 1983: Code of Practice, Department of Health 2015:p102).

DoLS only apply to individuals who lack the capacity to consent to accommodation in a care home or hospital where their care or treatment is likely to amount to a deprivation of liberty. The scope of the term 'deprivation of liberty' is not fixed but was explored in the case of *P v Cheshire West and Chester Council and another and P and Q v Surrey Country Council (Cheshire West)* 2014 WLR 2.

The Supreme Court clarified that there is a deprivation of liberty in circumstances where a person is under continuous control and supervision, is not free to leave and lacks capacity to consent to these arrangements. The court also clarified that the person's compliance, or lack of objection, and the reason or purpose behind such a placement, or the normality of the placement (whatever comparison is made) are not factors relevant in determining whether there is a deprivation of liberty (Mental Health Act 1983: Code of Practice, Department of Health 2015: p103).

The pathway for the deprivation of liberty under the MCA is set out in a useful flowchart in the Mental Health Act 1983 Code of Practice in Chapter 13 (Department of Health 2015:109). In the rare cases where neither the Act nor a DoLS authorisation nor a Court of Protection order is appropriate, then to avoid an unlawful deprivation of liberty it may be necessary to make an application to the High Court to use its inherent jurisdiction to authorise the deprivation of liberty.

Healthcare providers have a legal duty to care for and treat patients who lack capacity in accordance with the MCA, when it applies. Failure to do so could result in enforcement action being taken by the Care Quality Commission (CQC).

2.6 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 her or his 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) 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.

3 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, 2013: 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 <https://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, see: (<https://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.

3.1 Community treatment orders (CTOs)

Introduced under the Mental Health Act 2007 (s.23 of which introduced sections 17A–G into the MHA 1983), community treatment orders (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 or 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.

3.2 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 s.3, s.37, s.45A, s.47 or s.48 of the MHA. See Chapter 33 of the *Mental Health Act 1983 Code of Practice* (Department of Health 2015). For patients detained under s.3 or s.37, discharge must be made into the community but for those transferred to hospital from prison under s.47 or s.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; 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.

4 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 (Department of Health, 2013) (<https://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.

5 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.

5.1 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: <https://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 the transition 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.

5.2 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 at 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:

<http://www.wales.nhs.uk/sites3/page.cfm?orgid=438&pid=11071>.

6 Mental capacity and consent for adults

For adults, law relating to mental capacity is now governed by the Mental Health Act 2007 and the Mental Capacity Act 2005 (Appropriate Body)

(England) Regulations 2006 S.I. 2006 No. 2810. 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, Department of Health 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: https://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 linked with an assumed lack of mental capacity. 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, Department of Health 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 with all reasonable support in their decision making.

Article 12(4) requires that the support systems 'respect the rights, will and preferences of the person'. This might conflict in part with the provisions of the Mental Capacity Act 2005 (MCA 2005), and has generated a current review of that Act, which might result in revisions.

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' 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, he or she 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, he or she 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*, Department of Health 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
- 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 a 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 7 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.

6.1 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.

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 may be 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; 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.

6.2 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, made without duress and the circumstances to be applied are clear. Sections 24–26 of the MCA empower those wanting 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.

6.3 Guardianship

Guardianship is not very widely used, perhaps because MHA and Deprivation of Liberty Safeguards (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 Chapter 30 of the Mental Health Act 1983 Code of Practice (Department of Health 2015:342–348) for guidance on the operation of the system. Guardianship is useful for after-care, 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 guardian has 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*, Department of Health 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 s.2 and s.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.

7 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.

7.1 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 that 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.

7.2 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, the issue may be resolved under the MCA 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, it will be possible for 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 for them (see *Mental Health Act 1983 Code of Practice*, Department of Health 2015:182–185, paras 19.53–19.70). However, the courts have made it clear that there are limits to the types of decision 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.

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 MHA 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 Chapter 19 of the *Mental Health Act 1983 Code of Practice*, Department of Health 2015). Formal procedures for admission would have to be followed (see the section 2.3 on compulsory admission for mental health assessment and treatment).

7.3 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 in 7.2 and 7.3 above, see section 7.7 of this resource.

7.4 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* (Department of Health 2015: p174, 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
 - 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* (Department of Health 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.'*

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

In the past there have been court decisions indicating that 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 section 7.7 of this resource.

7.6 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).

For the scope of parental responsibility and situations where those with parental responsibility for a child may give consent for treatment, see section 7.7 of this resource.

7.7 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 that 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*, Department of Health 2015:178–179, 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*, Department of Health 2015:182–185, paras 19.53–19.70). However, the courts have made it clear that there are limits to the types of decision 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*, Department of Health 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*, Department of Health 2015:178, para 19.41). Factors may include the 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*, Department of Health 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 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); and the child's right to autonomy (UNCRC Article 8). Again, professionals making difficult decisions of this sort should seek legal advice (see *Mental Health Act 1983 Code of Practice*, Department of Health 2015:180–181, 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*, Department of Health 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 by a deprivation of liberty order by the Court of Protection for a person aged 16 and 17.

7.8 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 explanation of who has parental responsibility, see Hershman and McFarlane (2015); Mitchels (2012), Chapter 3; and Long (2013), Chapter 6 for more detail. 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, automatically has parental responsibility for 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 with some legal exceptions, 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 http://hmctsformfinder.justice.gov.uk/HMCTS/GetForm.do?court_forms_id=48 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.

8 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 lives 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, or involved in a culture of illegal dangerous substance abuse.

Tim Bond pays attention to both areas of risk in *Standards and Ethics for Counselling in Action* (Bond 2015: 77–79, 174, 215–218).

All clients may potentially pose a level of risk. Unless they 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 carry with them an increased risk of suicidality or other forms of self-harm, while other mental conditions carry a degree of risk of violence to others that 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 well rehearsed in it.

For example, in organisations and waiting rooms there may be fire drills, emergency 'panic' buttons, emergency exits and 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 that 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.

8.1 Suicidality

Suicide is never an easy thing to think about, and it is a difficult subject for law making. Suicide affects not only the individual contemplating it, but also their friends, family, work colleagues and social groups. Others may have deep feelings about the loss, and the manner of the person's death. Contemplation of, and preparation for, suicide present challenging issues and emotions for everyone involved and, for this reason, any rules must be flexible enough to cover the wide variety of situations that may present themselves.

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.

The right to the dignity of life has been held by the courts to be not a right to die with dignity but the right to live with as much dignity as can possibly be afforded until that life has reached its natural end.

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 Bond and Mitchels 2014a; 2014b). 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 also 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 to confidentiality before counselling commences, and the counsellor should ensure wherever possible that the client understands and agrees to these limitations. See the Caldicott Review (Department of Health 2013) for guidance on disclosures within the NHS, and the GMC guidance (General Medical Council 2013), which embodies Confidentiality (2009) and Consent (2008).

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: <http://www.bacp.co.uk/gpia>.

8.2 Assisted suicide and the law

In the case of *R (on the application of Purdy) v Director of Public Prosecutions* reported at [2009] UKHL45, which came before the House of Lords (now the Supreme Court), the claimant suffered from primary progressive multiple sclerosis and wanted to know what factors the Director of Public Prosecutions (DPP) would take into consideration in deciding whether a prosecution should be brought under s.2 of the Suicide Act 1961 if her husband helped her to travel to a country, such as Switzerland, where assisted suicide is currently lawful. She proposed that the prohibition of encouraging or assisting suicide in s.2(1) of the Suicide Act 1961 constituted an interference with her right to respect for her private life in article 8(1) of the Convention for the Protection of Human Rights and Fundamental Freedoms that was not 'in accordance with the law' as required by article 8(2) in the absence of an offence-specific policy by the Director setting out the factors that would be taken into account under s.2(4). The term 'assisting' suicide is interpreted as aiding, abetting, counselling or procuring the suicide or attempt to carry out suicide.

Having considered earlier decisions, The House of Lords ruled that the law was insufficiently accessible or precise to enable a person affected by it to understand its scope and foresee the consequences of his actions so that he could regulate his conduct. The case of Purdy (and the earlier case of Pretty) did not change the law but as a result, the DPP was impelled to consider its policy regarding prosecutions in relation to assisted suicide.

DPP Policy

On 25 February 2010 the Director of Public Prosecutions launched the *Policy for Prosecutors in Respect of Cases of Encouraging or Assisting Suicide*.

The policy was updated in October 2014 (Ministry of Justice 2014). It provides guidance to prosecutors on the public interest factors to take into account in reaching decisions in cases of encouraging or assisting suicide. The DPP said that the public can have full confidence in the policy the CPS will follow in deciding whether or not to prosecute cases of assisted suicide. The Director published the policy after taking account of thousands of responses received as part of what is believed to be the most

extensive snapshot of public opinion on assisted suicide since the Suicide Act 1961 was introduced. Nearly 5,000 responses were received by the Crown Prosecution Service (CPS) following the consultation exercise launched in September 2009. The Director said:

The policy is now more focused on the motivation of the suspect rather than the characteristics of the victim. The policy does not change the law on assisted suicide. It does not open the door for euthanasia. It does not override the will of Parliament. What it does is to provide a clear framework for prosecutors to decide which cases should proceed to court and which should not. Assessing whether a case should go to court is not simply a question of adding up the public interest factors for and against prosecution and seeing which has the greater number. It is not a tick box exercise. Each case has to be considered on its own facts and merits. As a result of the consultation exercise there have been changes to the policy. But that does not mean prosecutions are more or less likely. The policy has not been relaxed or tightened but there has been a change of focus.

This quote was taken from the CPS website. For the full text and the full policy, which was updated in 2014, please see: <https://www.cps.gov.uk/legal-guidance/suicide-policy-prosecutors-respect-cases-encouraging-or-assisting-suicide>. Below are extracts from the policy, with the relevant paragraph numbers:

- (1) A person commits an offence under section 2 of the Suicide Act 1961 if he or she does an act capable of encouraging or assisting the suicide or attempted suicide of another person, and that act was intended to encourage or assist suicide or an attempt at suicide. This offence is referred to in this policy as 'encouraging or assisting suicide'. The consent of the Director of Public Prosecutions (DPP) is required before an individual may be prosecuted.
- (3) Committing or attempting to commit suicide is not, however, of itself, a criminal offence.
- (6) This policy does not in any way 'decriminalise' the offence of encouraging or assisting suicide. Nothing in this policy can be taken to amount to an assurance that a person will be immune from prosecution if he or she does an act that encourages or assists the suicide or the attempted suicide of another person.
- (7) For the purposes of this policy, the term 'victim' is used to describe the person who commits or attempts to commit suicide. Not everyone may agree that this is an appropriate description but, in the context of the criminal law, it is the most suitable term to use.

(13) Prosecutors must apply the Full Code Test as set out in the Code for Crown Prosecutors in cases of encouraging or assisting suicide. The Full Code Test has two stages: (i) the evidential stage; and (ii) the public interest stage. The evidential stage must be considered before the public interest stage. A case which does not pass the evidential stage must not proceed, no matter how serious or sensitive it may be. Where there is sufficient evidence to justify a prosecution, prosecutors must go on to consider whether a prosecution is required in the public interest.

(14) The DPP will only consent to a prosecution for an offence of encouraging or assisting suicide in a case where the Full Code Test is met. Referring to cases occurring after 1 February 2010:

(17) In these cases, for the evidential stage of the Full Code Test to be satisfied, the prosecution must prove that:

- the suspect did an act capable of encouraging or assisting the suicide or attempted suicide of another person; and
- the suspect's act was intended to encourage or assist suicide or an attempt at suicide.

Details follow in the policy about the actions that constitute murder or manslaughter, and the public interest factors tending in favour of (paras 43–44) and against (paras 45–48) prosecution. The law on assisted suicide and the DPP policy are complex, and there is insufficient space to address them in detail here.

The law leaves unclear the specific position in each case of a therapist who is working with a client who expresses suicidal feelings or suicidal intent, or who is actively contemplating suicide. The reason for this is that each case has to be decided on its own merits, according to the law and the principles expressed in the DPP policy.

The therapist who works with a client who is discussing suicide would have to consider whether their words or actions in the course of the therapeutic work are in any way encouraging or assisting the client to carry out suicide and, where necessary, to take advice in supervision and/or from another relevant legal or other suitably qualified and experienced professional.

However, in the context of this resource, we can see that it is clear from general mental health law and also the DPP policy that the very high level of duty of care owed to a client under the age of 18, or a client who lacks mental capacity, makes it likely, perhaps inevitable, that any therapy received by the client may be explored in detail if such a client then carries out suicide.

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

Risk assessment is very much a matter of good practice. See Good Practice in Action 030 *Safeguarding vulnerable adults* and 031 *Safeguarding children and young people* (which can be accessed at: <http://www.bacp.co.uk/gpia>) 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 the circumstances of that particular client 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.

9 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 requires 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 a more detailed exploration of confidentiality and disclosures of information, see *Confidentiality and Record Keeping in Counselling and Psychotherapy* (Bond and Mitchels 2014a) 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: <https://www.bacp.co.uk/gpia>.

10 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) claims to be based on evaluations of evidence-based practice.

In the area of mental health, the links available at <http://pathways.nice.org.uk> include:

- mental health services, adult service user experience
- mental health, antenatal and postnatal
- mental wellbeing and independence in older people
- mental wellbeing at work.

The NICE Pathways website <http://pathways.nice.org.uk/> also provides detailed standards and guidance for mental healthcare. Briefly, 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, 7 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 (<http://pathways.nice.org.uk/pathways/service-user-experience-in-adult-mental-health-services#content=view-node%3Anodes-hospital-care>).

10.1 The Improving Access to Psychological Therapies (IAPT) programme

For details of how the Improving Access to Psychological Therapies (IAPT) programme works, see the IAPT website (<https://www.england.nhs.uk/mental-health/adults/iapt/>).

Briefly, the programme supports the frontline NHS in implementing NICE guidelines 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 <https://www.england.nhs.uk/wp-content/uploads/2018/03/improving-access-to-psychological-therapies-long-term-conditions-pathway.pdf>. If you are an IAPT service provider, please check the NHS Choices website NHS Choices 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).

11 Complaints and Mental Health Review Tribunals (MHRTs)

MHRTs have significant legal powers in relation to the continued detention and 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, 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* (Department of Health 2015:87–94). Patients (or their nearest relatives) are entitled to be informed about their legal rights, to free legal advice and representation, and 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 (there is a helpful flowchart in the *Mental Health Act 1983 Code of Practice* (Department of Health 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*, Department of Health 2015:383–384, paras 37.44–46). For children and young people, see *Mental Health Act 1983 Code of Practice* (Department of Health 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 orally 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: <https://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: <http://www.legislation.gov.uk/ukxi/2008/2699/contents/made>.

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

About the author

Dr Barbara Mitchels, PhD, LLB, BACP Registered (Snr Accred), is a Fellow of BACP and the Director of Watershed Counselling Services in Devon. Barbara is also a retired solicitor, providing online consultancy, resources and workshops around the UK for therapists on a variety of of therapy-based topics and on the relationship of law, therapy and the courts, see www.therapylaw.co.uk.

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; Website: 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 (www.wales.gov.uk)

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See also the ICD-10 Classification of Mental and Behavioural Disorders: Clinical descriptions and diagnostic guidelines (10th revision, effective from 1 October 2015).

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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 Derwent 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.
<http://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. <https://www.supremecourt.uk/cases/uksc-2012-0068.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. <http://www.bailii.org/ew/cases/EWCA/Civ/2011/1305.html>

Contacts

Improving Access to Psychological Therapies (IAPT)

<https://www.england.nhs.uk/mental-health/adults/iapt/>. If you are an IAPT service provider, please check the NHS Choices website (www.nhs.uk/Service-Search/Psychological-therapies-%28IAPT%29/LocationSearch/10008) to ensure that your service is registered and the details are fully up to date. 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

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

MIND

<https://youngminds.org.uk> and <https://mind.org.uk>

NICE

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

Quality Standards

<https://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; Website: <https://www.gov.uk/dbs-update-service>

Welsh language scheme: <https://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 <https://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; Website: 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; Website: 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; Website: <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 Website: 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 Reform Act 1969

Family Law Reform Act 1987

Freedom of Information Act 2000

Human Rights Act 1998

Mental Capacity Act 2005

Mental Health Act 1983

Mental Health Act 2007

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

Data Protection (Processing of Sensitive Personal Data) Order 2000

Data Protection (Subject Access Modification) Order 2000

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)