



**RESPONSE TO DEPARTMENT of HEALTH  
CONSULTATION**

**STRONGER CODE: BETTER CARE**

**PROPOSED CHANGES TO THE CODE OF  
PRACTICE: MENTAL HEALTH ACT 1983**

**RESPONSE DUE:  
12 PM, FRIDAY 12<sup>TH</sup> SEPTEMBER 2014**

**DATE SUBMITTED: 12<sup>TH</sup> SEPTEMBER 2014**

## **Introduction**

1. Action against Medical Accidents (AvMA) was established in 1982. It is the UK patient safety charity specialising in advice and support for patients and their families affected by medical accidents. Since its inception AvMA has provided advice and support to over 100,000 people affected by medical accidents throughout the United Kingdom.
2. AvMA offers specialist services to the public, free of charge across the United Kingdom. This includes a helpline and an individual casework service staffed by legal and medical professionals, including a pro bono inquest service with representation for families who have lost a loved one who was receiving medical treatment.
3. AvMA provides specialist support services for legal professionals through our Lawyers Resource Service including the recommendation of expert witnesses. We also provide specialist training courses and conferences for health and legal professionals, advice agencies and members of the public.

## **AvMA's Experience of Mental Health Act and the Code of Practice**

4. AvMA had for a long time recognised the need for specialist support for families that had lost a relative where it was suspected failures in medical treatment may have contributed to the death. In September 2009 AvMA committed resources to providing a specialist pro bono inquest project in England and Wales; the project was officially launched in July 2010. The project aims to find representation for people who have been affected by the death of a loved one where the death occurred in a medical setting.
5. The pro bono inquest service has developed so that it now provides advice on approximately 100 inquest cases per annum, some of these cases have been referred to solicitors where there is a potential civil claim. Through our work, we have developed considerable expertise in providing assistance and representation to members of the public at inquests where the death arose in a healthcare setting.
6. Of the inquest cases we provide representation in, up to one third of them can be deaths related to people who have mental health related problems. We have knowledge of the Mental Health Act and the Code of Practice as it relates to the investigation into the patient's death. Some of the deaths have occurred whilst the patient was detained, others following release from detention (Section 2 and or Section 3 MHA) into the community under a Community Treatment Order (CTO).
7. We have not been involved in any inquests touching the death of individuals with mental health problems who have been minors and or who have had learning difficulties. We have been involved in several cases where the deceased was a young person between the age of 18 – 25 years and who continued to be very much reliant on parental/family support.

8. We have used our experience of the treatment provided to mental health patients both whilst detained and otherwise and in particular in the period leading up to the death of the patient to inform our response to the consultation. Where relevant, the specific cases we have worked on are referred to in the response by way of initials.
9. Our inquest experience has enabled us to identify core issues pertinent to the patient's death and which have arisen during the inquest process. The evidence suggests that if the approach to the deceased's treatment had been different, the outcome for the patient may have been better. These core issues often relate to mental health professionals use and knowledge of the Code, their misunderstandings and or misinterpretation of the guidance the Code aims to give. It is hoped that these illustrations will enable relevant changes to be made to the Code to make it a more accessible, user friendly and clearer to those consulting it.
10. It is our experience that families/carers are rarely aware of the existence of the Code.
11. Those families/carers who are aware of the Code have found the language used difficult and the layout complex, this has put them off referring to the Code at all.
12. It is our view that the families experience is probably shared by many health professionals as well. Some of professionals giving evidence at inquest have said that they were aware of the Code but were unsure of what was in it. Many were unable to name even one of the five guiding principles set out in the current Code, this was common to consultant psychiatrists as well as mental health nurses and care coordinators.
13. In order to make the Code of Practice effective and better understood there has to be a fundamental commitment to adequate spending; funds need to be identified not only in relation to educating relevant professionals and families/carers but also in relation to making the necessary beds and staff available to treat those suffering from mental health conditions. Without adequate funding and spending, nothing will change.

#### **AvMA's Response to the Consultation**

14. In completing our response, AvMA has gone back over evidence given during the course of inquests involving the death of mental health patients. We have confined our responses to questions where we feel able to comment based on our experiences.

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

**Response:**

AvMA recognise that the Code of Practice is a key document which professionals should have recourse to in the first instance when ensuring patients' rights are being protected.

It is our experience that professionals who consult the Code of Practice have varying degrees of expertise and experience of the statutory regulations and provisions affecting mental health care. We have considerable experience of questioning healthcare professionals on their knowledge of the Code of Practice and its application to individual patients within the context of issues arising at inquests where the deceased was or was believed to have been under the care of mental health professionals.

On a number of occasions we have been very disappointed to note that many of the healthcare professionals involved including consultant psychiatrists have been unable to cite any of the guiding principles set out in the Code of Practice. Some of the responses given at inquest candidly admit that clinicians were no more than "broadly aware" of the guiding principles (case of CB). This is despite the fact that those principles appear, on the face of it, to be plainly stated.

Our questioning of health professionals on relevant NICE guidelines, which is by comparison to the Code of Practice, arguably a more user friendly document, has met with responses which suggest that key workers such as community mental health nurses are not aware of its contents. In the case of MH one such worker stated words to the effect that they had read it, "but I couldn't tell you what was in it".

Mental Health legislation is complex. The only way to secure any assurance that the relevant professionals will understand what is expected of them is to ensure that those professionals are duty bound to attend courses on the Code of Practice both as an initial introduction to the Code and its application but also by way of regular updates to remind staff of the key principles and reinforce them. The relevant Hospital Managers need to be under an obligation to commit to the cost providing education and allowing workers the time off necessary to attend relevant courses.

The paragraphs on the CQC make it clear that reference to the Code of Practice on its own is not sufficient and that there is a continuing duty for professionals to have recourse to developments in professional practice. In our experience recourse to developments and awareness will only occur if there is a clear commitment to regular and appropriate training sessions.

We support the newly included reference to the CQC within the Code of Practice, however we would suggest that the CQC's responsibilities are put more simply. There should be an emphasis in the introductory paragraphs which state that the CQC is an independent regulator.

We would also recommend that the introductory paragraphs on the CQC make it clear that part of the CQC's role is to make people aware of the standards of quality and safety patients have the right to expect.

The sheer size and volume of information contained with the Code is off putting for many members of the public trying to access it. In our experience, those families/carers who are aware of the Code have found it difficult to access not least because of the complex language, and as a consequence many are put off using the Code at all as it is too daunting. The effect of this is that families/carers often remain unaware of their rights and/or the standard of care the patient is entitled to expect.

The CQC has the potential to play an important role in monitoring the standards of mental health care, and with this in mind we would urge that the introduction to the part that the CQC play in monitoring services is put in simple and straightforward language. There should be clear direction for families/carers/patients and other non-professional people accessing the Code on how they can contact the CQC with their concerns. The CQC website address would assist both professionals and non-professionals alike.

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

**Response:**

We believe that the Code should provide more guidance about appropriate governance arrangements for monitoring duties and powers under the Act. We consider this to be particularly pertinent given the fact that the serious case review into Winterbourne View Hospital identified that there were instances when personnel acting in a professional capacity were not aware of their role in ensuring that the Act and Code were complied with. We have already identified (Question 1 above) that in our view the key to this is education and training of relevant staff.

We consider that clearer guidance about how duties and powers under the Act are to be monitored would serve to ensure that professionals and/or families consulting the Code of Practice should be aware of what governance arrangements should be in place and that there is a duty to monitor.

Currently, there is reference to a CQC commitment to monitoring the exercise of powers under the Act through its inspections of mental health care but no real substantial detail as to how this ought to be effected. The reference to a regulatory model being planned for October 2014 is insufficient and does not begin to help professionals or other users of the Code of Practice identify what action should be taken to monitor care actually being provided.

The Code of Practice identifies what the CQC intends to do but there is no real guidance about what constitutes appropriate governance arrangements.

The arrangements for monitoring duties and powers under the Act need to be clear and readily identifiable by both professionals and lay people having recourse to the Code of Practice.

Paragraph 3.5 of the consultation paper maintains that the draft Code sets out the types of documents the CQC may ask to see during inspections (paragraphs xvi – xviii of the draft COP). In our view those paragraphs do not make it clear to what documents this actually refers to. The emphasis on paragraphs xvi – xviii is on the fact the professionals and providers should not use the Code of Practice in isolation and should consider other, relevant developments in professional practice including NICE and so forth. There is no suggestion that these documents are the same documents which may be called upon for disclosure by the CQC during inspection.

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

**Response:**

The Code should be more specific about how “good” service will be defined. Currently the reference to what a “good” rating should look like is not referable to anything immediately tangible. Although it is stated that the Code would be the starting point for the CQC’s ratings system, it does not explain in straight forward, practical terms what this means and as a result it does not go any way to informing readers as to what will constitute good care.

It is our view that a member of the public, having recourse to the Code of Practice, would gain little understanding of what amounts to a good rating from the current definition. There needs to be clear, easily referable and identifiable standards which the public as well as professionals can use as a practical gauge for whether care provided amounts to good care in any of the other categories identified under the proposed new rating system.

The current definition is nebulous and academic. It is far from user friendly and does little or nothing to inform the public of the standards which they are entitled to receive.

The fact that the proposed regulatory model has not yet been rolled out only serves to further obfuscate what good service should look like.

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

**Response:**

The Code ought to specify that for patients receiving care through an NHS trust, there is a specified complaints procedure which is open to them, their families or carers.

The Code should then go on to state that assistance with formulating complaints can be provided through the patient advisory liaison system, local Healthwatch, CQC and the PHSO. It is important that patients and/or their families are made

aware of a designated complaints procedure. Our own experience, based on calls to our helpline and written advice is that many patients and/or their families are unaware of the existence of a complaints procedure. It is also our experience that NHS Trusts vary considerably in their willingness to point to the existence of a complaints procedure at all. Some trusts have information about the complaints procedure clearly set out on their website, others are far less obvious about the complaints process.

Under the current organisation it is for local authorities to contract with independent advocacy providers, although many local authorities have chosen to contract with local Healthwatch, some have elected to satisfy their duties by contracting with other groups and this can cause confusion. To ensure consistency, accessibility and effectiveness in addressing concerns, we believe that complaints advocacy services should be embedded within local Healthwatch.

We think that the Code of Practice would benefit by setting out the fact that there is also the potential to involve NHS England as part of the local resolution process as well as clinical commissioning groups.

I would add that patient support organisations such as AvMA, MIND, Rethink, Sane and others also have a key role to play in assisting patients and/or their families with accessing local complaints and resolution procedures. We would urge that the Code of Practice refer to a list of support organisations that exist to provide support to people who have suffered during their contact with the healthcare system. Such an approach was recommended by Robert Francis QC in his **Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry** (See Vol 1, para 3.133 - 3.134, page 280) where Robert Francis QC states that ***“such information ensures that complainants know how to access completely independent sources of support, should that be necessary”***.

We would recommend that lists of such organisations, including AvMA are compiled and that the Code of Practice cross refers to that list.

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

**Response:**

The guiding principles create a framework for the care, support and treatment under the Act. However, greater emphasis needs to be given to involving carers, family members and/or other people who have an interest in the patient's welfare. The current wording is that involvement of carers and others ***“who have an interest in the patient's welfare should be encouraged”*** [paragraph 1.6] “Draft Code of Practice for Consultation”. We would also suggest that a guiding principle on patient's capacity is included.

In several of the inquests we have been involved in there has been a clear failure, reluctance or limitations in the way trusts have encouraged families/carers to become involved in the patient's welfare, this is very common. In many of the cases the patient has been a young person, living at home with their family. Particular problems arise when the patient's mental health condition becomes acute

or goes through an acute phase. At this point, patients often lose insight into their condition and the fact that their family/carer wants to help them, it is not uncommon for patients to decide at this point to withdraw their consent for their family to be involved. In our experience, invariably this has led to disastrous consequences.

In the case of **MH**, a very able man with a working diagnosis of bipolar disorder, the family suspected that there was a failure to be compliant with medication. They were conscious that MH was displaying behaviour which was following a pattern which had previously resulted in the breakdown and/or deterioration of his mental health condition. That pattern was brought to the attention of the trust concerned. The trust largely failed to act on information provided by the family. The patient during an acute phase (he was being detained under MHA) then withdrew his consent and the trust subsequently refused to share information with the family about MH's condition. Despite the family's repeated and persistent calls for their views on MH's presentation to be taken into consideration and acted upon this did not happen.

If the trust had taken into account the concerns raised by family members and responded appropriately to them, the outcome for the patient may well have been very different.

In the case of **CB**, who was a young person detained under MHA at a trust proximate to his parent's home where he had been residing up until the time of admission, the trust took the view that CB ought to be transferred to another trust many miles away. This view was taken on the basis that CB had requested this transfer. The parents of CB wrote to the trust clearly setting out their concerns and resisting any suggestion of transfer.

The background to this case was that it was acknowledged that CB had difficulties in engaging with mental health professionals but had established a relationship with a care co-ordinator over the preceding 12 months. In making the decision to transfer CB, the trust failed to consult with CB's care co-ordinator.

CB's family raised issues about CB's capacity to be involved in decisions to transfer; the trust sought to rely on CB's need for independence and empowerment to make his own decisions. The trust did arrange a meeting with CB's family to discuss the transfer however the meeting was arranged to take place only after the transfer had been carried out. The Code of Practice needs to emphasise the need for trusts to consult with parents and/or other relevant people who have a direct interest in the patient's welfare. The importance of consulting as opposed to merely notifying a family/carer needs to be made clear; the outcome following a consultation is likely to be very different.

In another case, that of **MMD**, the patient had also undergone periods of detention under the MHA, subsequently he was discharged and returned to live at home with his mother. MMD was appointed a care co-ordinator who was expected to identify whether MMD continued to be compliant with medication.

Subsequently MMD's mother suspected that MMD was no longer compliant with medication, a fact MMD later admitted to services. MMD agreed to be monitored by the community mental health services (CMHS). At the inquest, CMHS were unable

to state whether MMD's mother was aware that MMD was in fact known to be no longer compliant with medication. The trust in this instance relied on their duty of confidentiality to the patient as a reason why that information may not have been shared. Whilst it is recognised that there is a need to maintain patient confidentiality, it is also the case that a patient, especially one who resides at home and who refuses to comply with medication should be carefully assessed for their mental capacity when withdrawing their consent to involve their families.

Issues concerning a patient's capacity to make decisions about their own care and sharing information is something we have raised repeatedly at Inquests, and rarely have medical staff been able to refer to a mental capacity assessment which was carried out at the time a patient was attempting to make important decisions.

The Code of Practice would be a better document if it identified the need for a formal assessment to take place when important decisions such as consent or transfer are being made by the patient. Any assessment and the discussion around decisions taken by the patient should be clearly documented to show that a patient's capacity has been considered.

It is also the case that greater emphasis could be put on the need for setting out written evidence in the patient's notes where the Code of Practice has been considered and how the relevant principles may affect the patient's decision.

The examples we have set out above show that although there is a written commitment to involving family members and other people who have an interest in the patient's welfare, very often the practical realities are that families are excluded even where the patient may be residing at home. Not only is this disempowering for the family and disenfranchises them but it also puts the patient at considerable risk.

The failure to listen to a family's concern has proven in these cases to be a missed opportunity. Greater emphasis should be set out in the Code of Practice on the importance of obtaining additional information and taking into account families and carers concerned to identify the relevant issues and to ensure that safeguarding the patient is central to their care.

In light of our comments above, we would recommend that the empowerment and participation principle along with the respect and dignity principle are fleshed out to help families and carers identify their rights to ensure that the patient's capacity has been properly assessed and documented and to ensure that additional information has been considered and taken into account when formulating care plans and/or treatment for the future.

Although these principles are to be expected, the Code of Practice needs to elaborate them further.

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

**Response:**

The Code of Practice does appear to cover the essential issues relating to equality and human rights and its use in protecting the patient. We are particularly pleased to see the emphasis being placed on involving relatives, carers and relevant friends of the patient and the extent to which they can be involved and contacted regarding the patient's care and treatment.

We are pleased to see reference to the Care Act 2014 and the duty to assess adult carers. It is also helpful to see that there is a clear obligation on hospital managers to have policies in place to ensure that amongst other things, correct information is given to patients and their nearest relatives.

We support the reference at paragraph 4.34 to the European Convention on Human Rights and in particular the possible breach of a patient's right to privacy.

We consider that the chapter on equality on Human Rights could be improved by making direct reference to ECHR Article 2, in particular the State's duty to ensure that public authorities (trusts) take appropriate steps to safeguard the lives of those within their jurisdiction. This applies to patients detained under the Mental Health Act or who are subject to a CTO.

It is important to emphasise that a trust has a duty to take reasonable steps to protect patients from avoidable harm, particularly where they have actual or constructive knowledge that there is a real or immediate risk to the patient's life. This is often relevant given that many detained patients will have an associated risk of suicide. The trust must take reasonable measures to avoid the risk to a patient's life.

It is appreciated that Article 2 ECHR arguments are frequently advanced at inquests. However, it is our experience that families rarely, if ever are aware of the duties associated with Article 2 and that this is something which can be raised by a families, carers, other relevant parties acting on behalf of a patient in circumstances where they believe the patient is at risk and where the public authority is failing to take action to avoid the risk to a patient's life.

We would go further and say that it may also be helpful to set out the duty to conduct an effective investigation in circumstances where a patient has died whilst in detention or whilst under a CTO. In practice this duty is usually fulfilled by the inquest process but many families are not aware of this.

Informing a family of their rights under Article 2 may also be pertinent in relation to circumstances where they consider that the patient has not been provided with suitable facilities or adequate staff or appropriate systems of operation.

Paragraph 4.52 refers to the availability of information on complaints; this section would benefit from including advice on the fact that the patient/family can seek independent legal advice and/or be referred to independent agencies such as Action against Medical Accidents (AvMA) who may be able to assist the patients/family member with general information on how to access the complaints procedure, there are other independent specialist organisations which may be able support and assistance with the specific mental health related issue complained of.

We refer to the recommendations made by Robert Francis QC in his report on the Mid Staffordshire NHS Foundation Trust Public Inquiry where at Volume 1, paragraph 3.134 he says:

***“organisations such as AvMA provide much help to people who have suffered in their contact with the healthcare system. While it would be wrong to provide service providers and commissioners to provide information amounting to a recommendation of a particular support organisation, it should be required to provide a list of such resources to all patients in general information about this service and again to those lodging complaints. Such information ensures that complainants know how to access completely independent sources of support, should that be necessary.”***

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

**Response:**

As we have already referred to, identification of whether a patient has capacity to make decisions about their care at various points throughout their life is often not given due consideration and / or poorly documented where capacity is in issue we would like to see an emphasis on the need for the assessment and the conclusion being clearly set out in the patient's medical notes.

We would add that we have also seen examples of where a patient has given consent for a family member to be involved in their care but when they go through an acute phase of their condition, they may withdraw that consent. This can have profoundly damaging effects on the patient's outcome and in some circumstances can mean that the patient returns to live with a family member or carer where the family member or carer only has limited information and is therefore not in a position to properly and/or fully look after the patient.

It would be helpful if there was a section clarifying that where appropriate it is good practice to take a patient's instructions on sharing information with family/carers prior to an acute phase of their condition being apparent. The section could more clearly set out the family's rights in circumstances where the patient seeks to withdraw their consent during an acute phase of their condition.

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

**Response:**

AvMA has already identified that reference to independent agencies should be made and a list of such relevant organisations be identified and easily accessible within the Code of Practice. Organisations such as AvMA can help with navigating the NHS complaints procedure and professional regulation other organisations such as MIND are also key.

We do observe that at paragraph 6.18 the emphasis is on the patient having the right to access the independent mental health advocacy service itself rather than

the services of a particular IMHA. As a general point we comment that although the paragraph acknowledges that it would be good practice for the same IMHA to remain involved while the patient's case stays open we consider there to be real weaknesses in this approach. For example, if an IMHA has helped a particular individual with known and identifiable learning difficulties or sensory impairments or other similar debilitating condition then there should be a commitment to making the same IMHA available to that patient rather than it being merely "good practice".

Individuals who have learning or similar difficulties will naturally struggle to express their views and to communicate their views appropriately and/or accurately. The failure to commit to providing continuity of advocacy service will result in the patient having to repeat information previously provided and this will only serve to exacerbate any feelings of frustration and heighten any anxiety which they may already be experiencing/displaying. We would also suggest that the lack of continuity of IMHA will result in additional time being spent with the patient to obtain details of the previous history and that in itself will only serve as a drain on providers' resources.

We would support a commitment to continuity of IMHA for a patient, particularly a patient with learning difficulties, unless there is a clear breakdown in the relationship between the patient and the IMHA.

Paragraph 6.19 refers to the fact that IMHA's must comply with any "reasonable" request to visit and interview a qualifying patient. It may be useful to provide guidance on what would amount to a reasonable request.

**9. How should the Code be updated to reflect the use of electronic media in the patient's correspondence and communications under Section 134?**

**Response:**

AvMA does not feel that it has sufficient knowledge to respond to this question.

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

**Response:**

AvMA does not feel that it has sufficient knowledge to respond to this question.

**11. Is any further guidance required to ensure the avoidance of blanket restrictions? If so, what guidance is needed?**

**Response:**

AvMA does not feel that it has sufficient knowledge to respond to this question.

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

**Response:**

AvMA is confident from its experience that very few families/carers attending inquests into the death of a former patient are aware of the existence of the Code and/or their rights under the Act.

AvMA believes that more needs to be done to draw the existence of the Code of Practice to the attention of families and carers. AvMA would recommend that a grass roots approach is taken so that, for example reference to the Code of Practice is made openly and obviously on Trust websites. It might also be helpful and appropriate for leaflets to be made available setting out the existence of the Code of Practice and for these leaflets to be readily available at CAB, PALS offices and other relevant agencies.

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

**Response:**

AvMA refers to comments made above in response to question 1.

- 14. What further guidance could the Code give professionals to support their decision making between the choice of adopting Section 2 or Section 3 for individual patients?**

**Response:**

AvMA does not feel that it has sufficient knowledge to respond to this question.

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

**Response:**

In our experience, the case of **CB** in particular illustrates the need for trusts to better appreciate the difference between consulting parents/carers on transfer and simply informing them about transfer.

In CB's case a meeting had been arranged to discuss transfer of the patient. However, an opportunity arose to transfer the patient to X trust which was in a completely different location, many miles from CB's home as a result of X trust confirming they had a bed available. This opportunity arose before the meeting took place. The patient died shortly after arriving at X trust. At the inquest the trust which effected the transfer argued that the parents had been consulted on the transfer which was evidenced by a meeting with them being arranged. This approach fails to take into account that the point of the meeting is to consult with the parent/carer on their views about transfer rather than merely inform them.

The inquest into CB's death also identified that the urgency to transfer was prompted by the fact that the patient has registered with a GP in the locality of X trust. The transferring trust took the view that as CB was registered with the GP in the locality of X trust the responsibility for funding CB's care rested with the X trust and not the trust transferring him.

The facts were that CB had registered with a GP but had never been properly resident in the locality of X. Although CB had rented accommodation in the area of

X it was known and accepted by staff treating CB at the trust transferring him that CB had not lived at the accommodation, further that geographical change was not in CB's interests and was only likely to result in him becoming destabilised.

It was also well known to the transferring trust that CB's parents were heavily involved and interested in CB's care. CB's parents had written to the transferring trust setting out their clear and reasoned views as to why CB should not be transferred.

This experience suggests that the code needs to make clear that transferring a patient, must be in the patient's best interest and following proper consultation with parents/carers. It should set out that proper consultation is likely to require a meeting with the parents/carer prior to the decision to transfer being made and if no meeting takes place, the reasons for this.

The Code of Practice makes reference to NHS Commissioners and their responsibility to involve the family/carers; there needs to be more information about the role of the NHS Commissioner, how they can be contacted and so forth.

**16. What guidance could the Code give to Local Government systems to ensure that AHMPs are not put in this position?**

**Response:**

In light of the above AvMA would suggest that the Code of Practice should make it clear that decisions to transfer should not be triggered by funding considerations alone. The overriding concern must be what is in the patient's best interest taking into account all of the factors but particularly what long term carers/family members think.

Equally important is the obligation to ensure that sufficient funds are available to provide enough beds for those people who require detention under the Mental Health Act.

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

**Response:**

AvMA does not feel that it has sufficient knowledge to respond to this question.

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

**Response:**

Given that it is recognised that the expression "zone of parental control" is vague and unhelpful it follows that it ought to be rephrased. AvMA does not have any experience in assisting families who have minors with learning disabilities and mental health problems. However, in our experience as a patient safety

organisation we strongly feel that expressions or terms of art used must communicate clearly and simply.

19. **Further guidance has been provided on when a young person who has capacity might not be able to consent, but the term “overwhelmed” has been removed as it is thought to be confusing. Are the relevant sections clearer?**

**Response:**

AvMA does not feel that it has sufficient knowledge to respond to this question.

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

**Response:**

AvMA does not feel that it has sufficient knowledge to respond to this question.

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

**Response:**

AvMA does not feel that it has sufficient knowledge to respond to this question.

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

**Response:**

AvMA has limited experience with patients who have been subjected to restricted practices.

The background to the case of **KG**, was that he was an inpatient at a large teaching hospital, he had been admitted, treated and was in early post-operative recovery following an orthopaedic procedure. KG began to display symptoms of aggression and paranoia, the medical team’s response to this was to refer to the psychiatry department for advice and assistance with the management of KG.

KG was not seen by a psychiatrist but nonetheless they advised by phone that KG should be tranquilised with Haloperidol and Lorazepam, KG was to be reviewed by psychiatry as soon as possible. In response to questions asked by staff, KG’s mother gave a history of KG having smoked small amounts of cannabis in the past but there was no suggestion that KG had taken any illegal or recreational drugs as an inpatient.

In fact, KG’s symptoms were as a result of KG being in addisonian crisis. This example illustrates the need for:

- A full and thorough assessment of a patient’s alleged mental disorder
- A consultation and review by a consultant psychiatrist before prescribing medication

- Proper and full consideration of the patient's previous medical history
- Proper and full consideration of family/carers' views on the patient's presentation
- Staff to be open minded and not to form conclusions based on such limited history.
- Open to considering differential diagnoses which may be the cause of any behavioural disturbances
- Not to presume and make judgements about previous behaviour

Although paragraph 26.15 of the Code proposes that patients, their families and advocates should be involved in developing behaviour support plans, we would suggest that a similar emphasis is put upon the need to document relevant historical factors which are relayed by families/carers and any other factors which families/carers consider relevant or pertinent to the presentation.

It should also be documented that where restrictive interventions are used, particularly any form of drug which has a sedative effect, the patient needs to be seen by a treating consultant psychiatrist urgently as well as by his treating doctor (if relevant) and reviewed more regularly than might otherwise be expected. This should particularly be the case where restrictive interventions have been used on minors or where the patient has a learning disability making communication more difficult.

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

**Response:**

AvMA does not feel that it has sufficient knowledge to respond to this question.

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

**Response:**

AvMA does not feel that it has sufficient knowledge to respond to this question.

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

**Response:**

We fully support enhancing the role of family/carers in decisions about a patient's discharge and/or entitlement to Section 17 MHA leave. In our experience, the failure to involve families and to continue to keep them informed of any subsequent changes can have devastating effects. Our experience is that families are rarely consulted or properly consulted about leave.

In the case of **MH** (outline facts set out in response to question 5 above) who had been detained under MHA and whose parents advised that in their view MH was not compliant with medications despite being an inpatient. On the same day this advice was communicated, staff granted some 30 minutes of unaccompanied leave to MH on the understanding that MH wished to collect items from his flat. In fact MH had absconded. The family were unaware that permission had been granted to allow MH to leave the hospital grounds at all, let alone unaccompanied. On this occasion, MH was in fact found the following day and returned to the hospital. However, when MH's parents telephoned the treating psychiatrist it was apparent that the decision to allow MH out on unescorted leave and MH's subsequent absconding had not been communicated to the psychiatrist.

When MH was returned to the ward following the period of absconsion, the family were assured that MH would see the psychiatrist in two days' time, and he was to be denied any further leave until then. In fact MH was granted a further leave of absence the next day. Again, the family were not told of the S17 leave of absence.

During his leave, MH returned to his flat which his family had attempted to secure whilst MH was on detention only to find that MH was unable to gain access to his own home. The family were not given the opportunity to contact MH and provide him with a key to the new lock to his home, let alone communicate their concerns about MH having leave at that particular time. This led to a rift between MH and his parents. MH withdrew consent for his parents to be informed about his condition; the rift was not repaired prior to MH's death.

In the case of **CB** (also referred to at the response to question 5) the Trust openly recognised that allowing leave was a balance of risks, particularly after a period of absconsion. It was also acknowledged that making changes to leave arrangements was always a potential time of risk.

In the case of **CB** periods of escorted leave were allowed, however there was no procedure or facility to enable families to feedback their observations on **CB** when the escorted leave was concluded. In that case the family consistently stated that they communicated their observations and/or concerns to staff about **CB** following periods of escorted leave but it subsequently became apparent that this was not documented.

Later the psychiatrists in charge of **CB**'s care allowed a period of unescorted leave. This was granted without consultation or discussion with the family.

On another occasion **CB** was allowed 1 hour of unescorted leave which he took at 7pm in the evening but **CB** failed to return with the hour, as required. The ward did not tell the family that **CB** had absconded; they only discovered this fact when they telephoned the ward at 10.15pm that evening.

The Code would benefit from not only highlighting the importance of consulting and engaging families/carers when Section 17 leave was granted but it should also reinforce the importance of reporting suspected absconsions timeously to police and the patient's family/carers.

The other learning point in the case of CB was that the status of CB's Section 3 MHA detention became uncertain as a result of S17 leave being granted. The trust advised the family that Section 17 leave superseded a Section 3 status. If it is the Trust's intention that a Section 3 MHA be rescinded following S17 MHA leave being granted then there needs to be clear provision for notifying that fact and how that affects the patient's status and care.

In both the case of MH and CB lip service was paid to the importance of family/carer involvement in aiding a patient's recovery. The reality has been that there was a distinct lack of engagement and involvement with families/carers when important decisions regarding Section 17 leave were made. In our experience, there is a lack of engagement and involvement about reviewing and assessing entitlement to Section 17 leave following periods of absconsion and in involving families/carers in decisions to contact the police once absconsion had been established. These patients were not afforded the care and protection they needed when they were at their most vulnerable and as a result, lost their lives.

The cases we have been involved in have also seen lack of continuity of care and no clear pathway to establish ownership of who is responsible for the patient in periods where the usual or established consultant psychiatrist and/or other key professional workers were absent whether on holiday, maternity leave or sick leave.

In our experience, the way in which mental health cases are conducted leads us to suggest that the Code needs to be clear and concise about the obligation to identify alternative carers or medics involved in the patient's care when the original professional is absent. It is also critical that this information is communicated to the family and that proper handover is arranged.

In the case of **HR**, the family repeatedly reported their concerns about HR's presentation: psychotic episodes, being withdrawn and other relevant symptoms. When HR was given a period of Section 17 leave the family were advised that they needed to "back off". The family followed that advice against their better judgment and subsequently inevitably felt that complying with this advice was a major contributor to the subsequent death of HR.

The case of HR was yet another situation where confusion arose as to whether HR had in fact been discharged or was simply on Section 17 leave.

The Code needs to make it clear that staff need to clarify this situation and where discharge is considered appropriate, reinforce the obligation to ensure that proper planning meetings and care plans are put in place. Further, that proper handover between any hospital where detention has been effected and other third parties such as care co-ordinators, community care or day care are fully appraised of the situation around detention and discharge, the patient's original presenting history, subsequent improvement and symptoms resulting in the discharge and the value of the family/carer's input where appropriate.

- 26. Does the revised Chapter provide as much guidance, within the current legislative framework, to ensure CTO are used effectively and appropriately to support patients to maintain stable mental health outside hospital and to**

**promote recovery, in line with the principle of least restriction option and autonomy. If not, what further guidance do you suggest?**

**Response:**

CTO's are an important part of a patient's road to recovery. In our experience difficulties often arise in relation to identifying whether a patient is compliant with medication or not, particularly when they are in the community. It would be helpful for the Code to give some guidance on how care coordinators or other relevant responsible parties are expected to manage patients who are suspected of being non-compliant with medication. High functioning patients are often very adept at side stepping issues related to compliance. Care coordinators report difficulties with walking a line which enables them to maintain patient confidence and build up a relationship of trust whilst testing a patient in a meaningful way as to whether they have been compliant with medication.

It is recognised that this is a difficult line to tread, however it is important that the code of practice sets out guidelines to help care coordinators put in place strategies which are considered acceptable in challenging whether a patient has been compliant.

It is our experience that relatives/carers do often feedback to care coordinators expressing concern about a patient's presentation and symptoms which may be suggestive of non-compliance with medication. The code would be reinforced if there were clear pathways identified for recording that information and setting out what action was taken in response to it.

In the case of **MH**, letters were written, telephone calls were made and concerns were raised by the family that MH was not compliant with medication. In that case Crisis and later care coordinators argued that they had discharged their duty by asking MH about compliance, when MH stated that he was compliant, they were satisfied with that response.

There was also third party evidence of potential non-compliance by MH in that he had during that period attempted to alter GP prescriptions. This fact had not been properly documented or reported back to care coordinators by the GP so that parties only became aware of it following MH's death. This illustrates the need to emphasise the importance of communication between GP's, care coordinators and other relevant parties which cannot be underestimated. The code should emphasise the need for information sharing.

This point also highlights the need for proper documentation, an issue we have already commented on.

The chapter on CTO's would be reinforced if there was cross referencing to the relevant sections in the Code on the importance of involving parents/carers in information sharing.

In the case of **MMD** the psychiatrist had been told by the care coordinator team that MMD was compliant with medication. However when the psychiatrist actually saw MMD he confirmed he was not taking medication because he believed he could solve his own problems which he considered stemmed from his taking recreational

drugs and that medication could not assist with this. The psychiatrist in this case was unaware and unable to explain how the home treatment team had identified that MMD was compliant with medication. The psychiatrist was also unable to identify whether MMD's mother and carer had been told that he was no longer compliant but expressed the view that if she had not been told that this would have been due to issues of confidentiality.

A similar issue was raised in the case of MH who had been detained. MH had successfully appealed to the Tribunal against his detention following which an interim discharge summary was prepared. The discharge summary stated that MH should receive prescribed medication for 14 days after discharge, such medication to be supervised by the CRISIS team. In that case CRISIS was satisfied before the expiry of the 14 day period that MH was compliant with medication and no longer needed CRISIS to be involved in his care. He was discharged back to his care coordinator but was not seen by anyone after his discharge even though MH failed to attend the discharge meeting. His badly decomposed body was later discovered some 3 weeks after he had last been seen by anyone from services.

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

**Response:**

In our experience, the CPA would be improved if a proper outline of the patient's relevant history was included with particular emphasis on behaviours that were previously seen as indicators of deterioration.

Although paragraph 34.2 of the code makes it clear that CPA requires close engagement with service users and their carers the importance of having parent/carers input and opportunities for them to feed into the CPA needs greater emphasis.

In the case of MH where the medical notes emphasised the importance of parental input as part of the scaffolding for MH's recovery they nonetheless had no input into the CPA, they were not consulted and key information was omitted.

Care coordinators do not always appreciate the need for delivering a care plan as soon as possible. In one case a care coordinator of in excess of 10 years experience, gave evidence that it was envisaged that a care plan would evolve over months or years as opposed to an assessment which needed to incorporate all the elements of assessments and care package in a single integrated process following discharge from detention. It is our impression that there is confusion over who is responsible for compiling the CPA and taking ownership of it and the code could help to clarify this.

In paragraph 34.9 the Code identifies that the care plan should be prepared by a suitable care coordinator. The Code should be more specific about what qualities are expected for a care coordinator to be considered "suitable".

Although the Code states that the care plan should be regularly reviewed (34.14) this in practice does seem to be open to interpretation. It would be helpful if the Code could give an indication of what a minimal review period might be considered to be.

Care planning does appear to be strengthened by the existence of a Relapse Prevention Plan; this again requires consultation particularly with regard to symptoms indicative of the patient's changing presentation. This is a helpful tool particularly in the early days following discharge. Greater weight should be given to completing a relapse prevention plan.

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

**Response:**

AvMA does not feel that it has sufficient knowledge to respond to this question.

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

**Response:**

Given that the Code of Practice is meant for use by families/carers we would suggest that Chapter 37, in particular the definition of hospital managers should be cross referenced to Chapter 12 and information provided on the tribunal. Particularly as it is the hospital manager's responsibility and duty to ensure that patient's understand their rights to apply for a tribunal hearing.

The Code of Practice is a necessarily lengthy document but nonetheless, in order to make it as accessible as possible to families/carers, many of whom will have no previous experience of mental health related legislation or legal backgrounds it is important to ensure that the document is as user friendly as possible.

We have previously made a point under the heading of complaints that there should be clear direction given to people using the Code of Practice, particularly lay people of the existence of independent organisations who may be able to assist them with understanding the patient's rights. Although there is reference in the Code to IMHA, we believe that the public would find the Code of Practice more accessible if there was reference to independent groups such as MIND who might be able to provide impartial information.

We have already alluded to our experience in the case of CB who was transferred from one hospital trust to another, many miles away on the basis that the patient had requested the transfer. This was despite the fact that the patient had talked about moving to various other different areas throughout the country and that there was a clear indication from the treating Trust that it was important that CB continued to have the support and input from his family. Chapter 37 refers to the needs and interests of the patient being considered when in fact the patient's needs and interests ought to be paramount.

Chapter 37.19 refers to **“wherever practicable, patients should be involved in the process leading to any decision to transfer them to another hospital.”** We would urge that not only should patients be involved in the process but their family/carers, particularly where there has been a long standing input.

We also suggest that the patient’s capacity to make such significant decisions – particularly where those decisions take them a long way away from family, familiar surroundings and security that their capacity to make that particular decision should be carefully assessed. It is our experience that when patients are going through an acute phase of their condition they often display symptoms of paranoia, anger, mistrust, the consequence of this can often be to reject involvement from family/carers and to make decisions to transfer which are not in their best interests.

It is also our experience (as set out above) that hospital trusts are often keen to transfer because of the costs and obligations associated with people with an enduring mental illness. This is particularly the case where patients require frequent access to mental services either by way of Section 2 and/or Section 3 detentions under the Mental Health Act.

Paragraph 37.23 states that professionals involved in a patient’s care should be prepared to discuss the possibility of transfer. Again, we refer to our experience where often the care co-ordinator is the person who has built up the most significant rapport and relationship of trust with the patient but who was not consulted. We accept that the definition of the relevant professionals involved may vary from case but we believe that the Code would be reinforced if reference were made to the professionals likely to become involved and for whom particular consideration of their involvement should be given. One might expect the list to include the patient’s consultant psychiatrist, mental health nurse, care co-ordinator, members of the crisis team (if they were involved with the patient in the preceding, say 6 months). This is not intended to be an exhaustive list but to be used as a prompt and to enable hospital managers to consider the sort of people who are likely to be able to offer some reasoned and valued judgment on the decision to transfer.

Paragraph 37.24 refers to the fact that every effort should be made to meet the patient’s wishes. Again, we would suggest that this paragraph could be improved by reinforcing the fact that weight must be given to the patient’s wishes and consideration of whether those wishes are in the patient’s best interests. Again, this may envisage some form of consultation with healthcare professionals as well as families/carers involved with the patient. Although paragraph 37.25 touches upon this, it merely states that the patient’s nearest relative **“should normally”** be consulted. Again we allude to the case of CB set out above where the trust in that case considered that notification equated with consultation.

The Code would be reinforced if reference to consultation could be expanded to include at least a meaningful discussion prior to any decision being made and identifying that in most cases a meeting of families/carers be arranged prior to the final decision to transfer being made.

Paragraph 37.38 of the Act refers to the duty to refer cases to the tribunal and at 37.39 the emphasis is on hospitals being able to comply properly with the duty only

if they maintain full and accurate records about the detention and discharge of the patient and other related issues.

Paragraph 12.11 refers to responsible clinicians, social workers or other professionals being required to provide reports to the Tribunal promptly and within the statutory timescale. The Code does not state that the responsible clinicians, social workers and other relevant professionals should be people who have actually been involved with the patient.

In the case of **MH**, who successfully appealed against his own detention the treating consultant psychiatrist provided a report which did not support a successful appeal. The tribunal also heard evidence from a staff nurse and a specialist community mental health nurse, both of whom provided reports; neither of them had actually met or had previous knowledge of the patient. In one case one of the witnesses had not seen the notes of the home treatment team, neither had she spoken to the care co-ordinator or any other member of the home treatment team. The tribunal in that case did have some medical notes but not all of the previous medical notes which included observations in the crisis team, attempts at self-harm, comments on lack of engagement and problems of treating the patient in the community.

Whilst it is accepted that the case of MH is an individual case, it is an important case as it serves to illustrate the importance of emphasising the need for access to all relevant previous medical notes and the need for reports to be compiled by medical staff and personnel who have had direct contact with the patient and/or with other relevant third parties who had engaged with the patient.

The Code of Practice should highlight the importance of opinions being obtained from people, medics and personnel who have had actual involvement with the patient rather than people with no actual knowledge of the patient.

Chapter 38.10 deals with when to review a detention or a CTO and the need for hospital managers to ensure that the appropriate level of support is provided to help the patient understand their rights in relation to applications for tribunal hearings and/or discharge is useful. The code should set out that it is equally important to ensure that carers/parents are also empowered to understand the implications of these steps. We recommend that the Code of Practice refers to independent bodies such as MIND who may be able to help parents/carers understand the proceedings which are taking place.

Paragraph 38 deals with procedure for reviewing detention or a CTO. Paragraph 38.23 refers to the fact that the exercise of this power is subject to the general law and to public law duties which arise from it.

In practical terms this reference is likely to mean little or nothing to most parents/carers and we would strongly recommend that clear reference is made to judicial review proceedings and, the time within which an application for judicial review may be made. It would also be helpful to include the fact that legal aid funding may be available for judicial review and the need to seek independent legal advice. Again we would urge that this paragraph contains information which would lead families to seek independent advice from support agencies which may be able to provide help and **direct to** families who wish to consider judicial review.

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

**Response:**

AvMA does not feel that it has sufficient knowledge to respond to this question.

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

**Response:**

Please see comments already made in the responses to existing questions above.

**Capacity**

CB's family had supported him at home for many years. On transfer of CB's care to another trust they were faced with having to deal with CB refusing to share information with his parents. CB was detained at that time and even though this step was unprecedented staff concerned did not explore whether CB had the requisite capacity to give this direction. The trust relied on a presumption of capacity even though it was clear from the medical notes and evidence given at inquest that the CB's capacity had never been properly considered.

MH had withdrawn his consent for his family to be informed and or involved in his care. The care coordinator accepted this at face value. This was despite the fact that there was a clear indication in the medical notes that MH was significantly propped up by family involvement and without it he would deteriorate further.

**Managing breaches of confidence**

The paragraphs on confidentiality are helpful. However, the guidance ought to go further and set out steps to be taken in circumstances where a confidence given by a third party has been breached to the patient.

In the case of CB there were two breaches of confidence relating to information provided by the family.

The two breaches of confidence served to fracture a critically important relationship between the patient and the family. The situation was exacerbated by the fact that the second breach of confidence was not disclosed to the parents and this prevented them from trying to put in place strategies to help reinforce trust between themselves and CB.

In the case of CB relevant staff had the opportunity to tell the family about the breach of confidence but failed to do so. The breach was only discovered when subsequent to the patient's death the family read CB's medical notes. The family were able to observe that in the last days with CB, their impression was that CB did not trust them but equally CB did not want to leave the family unit.

The family in this case felt very strongly that if medical staff believed it was necessary to breach confidence about the source of information which they have provided in confidence to them, then as a minimum they should at least have been informed that this had occurred. The family feel that the failure to inform them of the breach failed to give them the opportunity to rebuild confidence with CB. This is a situation where the family had wished to continue to play a positive role in the patient's life.

The clear conclusions in this case were that in the event that medics felt the need to breach a confidence. The importance of revealing this breach to people providing the information (in this case the family) cannot be overstated. The failure to reveal the breach quite simply took away their opportunity to explore with the patient the issues arising around the breach of trust and prevented them from attempting to heal and rebuild a relationship which was clearly of significant importance in the patient's life.

### **Importance of documenting**

It is recognised that the failure to document is a persistent and perennial problem within all forms of healthcare. Given that the Code fully recognises the importance of families, carers/loved ones in supporting patients with mental health problems, the Code needs to be clear that there is an expectation that information and/or concerns and/or observations made by family members or carers must be documented.

Although there are professional duties which insist that this done, if the Code were to reinforce this it would help to drive home the importance of taking this step. The Code already recognises that information which can be provided by family members/carers etc. can be of critical importance in analysing a patient's presentation and how that presentation can be an indication of progress or deterioration or some other significant factor.

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

#### **Response:**

We have already set out where appropriate additional information which we believe the Code should include, please see comments already made above.

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

#### **Response:**

The index to the Code is helpful.

We have recommended that where appropriate families/carers are given advice and information on independent agencies that may be able to offer impartial advice and assistance on matters affecting relatives/carers/lay people. If this recommendation

is accepted then we would suggest that the information about relevant agencies is contained in its own chapter and the index clearly makes reference to it.

We would also suggest that the Code could be made more accessible by having a separate abbreviation and definitions chapter. Relatives/carers seeking to access the Code will no doubt already be under existing pressure due to their responsibilities and concerns about the patient. It is important that those individuals and any other lay people are not bogged down or put off from reading the Code because of the difficulties in accessing the language. It is accepted that the legislation around mental health is complex and detailed but a list of definitions could make this more accessible. For example a brief definition of who is likely to be the approved mental health professional (AMHP), who constitutes a “responsible clinician”, definition of “capacity”, “community trust orders”, “Section 2 Mental Health Act Detention”, “Section 3 Mental Health Act Detentions”, “hospital managers”.

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

**Response:**

Please comments above

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

**Response:**

No response

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

**Response:**

No response

**For further details or discussion about this response please contact:**

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