Essex Partnership University
NHS Foundation Trust

PROCEDURAL GUIDELINE FOR THE ADMINISTRATION OF THE MENTAL HEALTH ACT 1983

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PROCEDURE SUMMARY

The Essex Partnership University NHS Foundation Trust has (EPUT) has a statutory obligation to ensure that its service users, who become subject to the Mental Health Act 1983 (here after referred to in this document as the 'Act') are treated lawfully.
EPUT has produced this procedure to regulate the Administrative process its employees and any staff seconded to the Trust must observe when providing services and care for the service users subject to the Act.

The Trust monitors the implementation of and compliance with this procedure in the following ways:

The Trust will monitor the implementation of and compliance of this Policy & Procedure by MHA Audits, Scrutiny of Mental Health Act Documentation. The Policy will be reviewed on an annual basis; however any changes in Mental Health Law may necessitate changes/amendments to be made immediately.

Services	Applicable	Comments
Trustwide	✓	

The Director responsible for monitoring and reviewing this procedure is The Executive Nurse

ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST

PROCEDURAL GUIDELINE FOR THE ADMINISTRATION OF THE MENTAL HEALTH ACT 1983

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ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST

PROCEDURAL GUIDELINE FOR THE ADMINISTRATION OF THE MENTAL HEALTH ACT 1983

1.0 INTRODUCTION

1.1 This document will identify the individual Sections of the Act and the specific lawful documents that are required to be accurately and timely completed to ensure that an individual is not kept detained or treated unlawfully.

2.0 WARRANTS TO SEARCH FOR AND REMOVE A PERSON

2.1 Section 135(1)

An Approved Mental Health Professional (AMHP) can apply to a magistrate to forcibly enter a property to look for and remove a person to a place of safety – usually a hospital for assessment for a period of up to 24 hours, with a view to determining if detention under Section 2 or Section 3 is applicable, when all other attempts at contact have failed.

2.2 Section 135(2)

An authorised person (for example an officer on the staff of the NHS Trust) can make an application to the magistrate to forcibly enter a property to look for and remove a detained service user who has absconded from hospital. If the person allows entry to the property, there is no need to obtain at Section 135(2).

- It is the responsibility of the ward to obtain the warrant in relation to Community Treatment Order Recall;
- There will be a cost implication in relation to obtaining warrants from Magistrates' Court. Please contact the Mental Health Act Manager/Administrator at the Mental Health Act Office in relation to this process.

Please refer to MHA18 Section 135 - Warrant to search for and remove patients.

3.0 POLICE POWER TO DETAIN & CONVEY

3.1 Section 136

A Section 136 allows a police officer to take a person they have found in a public place who appears in need of care or control which may be linked to a symptom of mental disorder to a place of safety for a Mental Health Assessment. The power can only be exercised if the Constable considers that the person is suffering from mental disorder and is in immediate need of care or control. No medical evidence is needed – all that is required is that the Constable has a reasonable belief that the person is mentally disordered within the meaning of Section 1 of the Mental Health Act. Currently a person on a Section 136 can be held for up to 24 hours in order to arrange the assessment. Reference should be made to the joint Section 136 Policy with Essex Police which can be found on the Trust's Intranet site.

Please refer to MHA20 a joint policy in relation to Section 136.

4.0 HOLDING POWERS OF THE MENTAL HEALTH ACT

5. SECTION 5(4) – NURSE'S HOLDING POWER

5.1 Section 5(4) allows for an approved nurse to hold a patient who is already receiving care for a mental disorder and whose presentation or risk suggests that it is necessary to prevent them from leaving hospital.

5.2 Section 5(4) permits the patient to be held on the hospital premises for up to 6 hours to enable enough time for a doctor or approved clinician to attend, assess the patient and decide if further detention under the Act is necessary.

5.3 Section 5(4) is not a renewable Section, consequently if the 6 hour hold threshold is reached; the Section lapses and the individual would be free to leave the hospital.

5.4 However, it is not considered good practice to allow a Section 5(4) to run for a full 6 hours and lapse, as it is intended that a doctor should be sought to attend to the individual as soon as the Section 5(4) is implemented. As soon as the doctor is in attendance the Section 5(4) ends.

LAWFUL DOCUMENTATION REQUIRED

5.5 To ensure that an individual is lawfully held using a Section 5(4) Nurse's Holding power, the (pink) Section documents:-

- Form H2 (record for the purpose of holding an individual on a Section 5(4)) must be accurately completed, scanned and sent to the MHA Office email address and the originals forwarded to the Mental Health Act Manager/Administrator in the Mental Health Act Office.

5.6 There is no right of appeal for an individual held on Section 5(4) and discharge occurs as soon as the doctor is in attendance for the assessment or the Section 5(4) will end after 6 hours.

6. SECTION 5(2) – DOCTOR'S HOLDING POWER

6.1 Section 5(2) can be used to hold and prevent a patient from leaving the hospital when a doctor or approved clinician in charge of their treatment concludes than an application under the Act should be made.

6.2 It authorises the holding of the individual for up to 72 hours so that they can be assessed with a view to an application being made to detain them further under the Act. A Section 5(2) is not renewable, consequently if the 72 hour threshold is reached the Section lapses and the individual is free to leave the hospital.

6.3 However, it should be noted that allowing a Section 5(2) to lapse is not considered good practice as the assessment for Section 2 or Section 3 should take place within the 72 hour period and if the assessment has taken place and it is deemed that the individual isn't in need of further detention, the Section 5(2) should be ended with immediate effect.

LAWFUL DOCUMENTATION REQUIRED

6.4 To ensure that an individual is lawfully held using a Section 5(2) Doctor's Holding Power, the (pink) Section documents:-

- H1 (for the purpose of holding an individual on a 5(2)) must be completed accurately, scanned and sent by email to the MHA Team email address and the originals forwarded to the Mental Health Act Manager/Administrator in the Mental Health Act Office.

6.5 There is no right of appeal for an individual held on Section 5(2) and discharge will occur if it is decided that an assessment is not required. Discharge will occur if the assessment concludes that the individual doesn't need further detention. The Section ends after 72 hours.

7. SECTION 4 – EMERGENCY ADMISSION TO HOSPITAL FOR A MENTAL HEALTH ACT ASSESSMENT

7.1 In emergency situations Section 4 of the Act permits an application for detention for the purpose of admission to hospital for a full Mental Health Assessment of an individual. This application for admission by the AMHP can be made on the basis of a single medical recommendation.

7.2 Section 4 application should only be used where risk and the patient's need for urgent assessment outweighs the desirability of waiting for a second doctor's opinion.

7.3 A patient can be lawfully detained for up to 72 hours, however all efforts must be made to ensure there is no delay in seeking a second doctor who must be a Section 12 approved doctor attending the patient to assess the appropriateness of the admission and detaining the individual further under the Act.

7.4 Section 4 is not renewable; consequently if the 72 hour threshold is reached, without a second doctor's assessment and agreement to converting the Section 4 to a Section 2 of the Act, then the Section 4 lapses and the individual is free to leave the hospital. However, it is not considered good practice to allow the full 72 hours to run and the Section 4 to lapse as the assessment for Section 2 or Section 3 should take place within the 72 hours.

7.5 When converting to a Section 2 from a Section 4, the two medical recommendations when taken together must comply with the requirements of Section 2. That is at least one must be from a Section 12 approved doctor. The converted Section will run from the date the person is admitted to hospital. An AMHP or the nearest relative does not have to be involved in the conversion to a Section 2, but they should be informed that the Section has been converted.

7.6 If within the 72 hour period the Section 4 is converted to a Section 2, a second medical recommendation is required. However, if a Section 3 is put in place within the 72 hours it over-rides the Section 4 and it is important to recognise that the original medical recommendation used in the Section 4 application cannot be used as one of the medical recommendations for the Section 3.

LAWFUL DOCUMENTATION REQUIRED

7.7 To ensure that an individual is transferred lawfully to the hospital using a Section 4 Emergency Admission for Mental Health Assessment, the (pink) Section documents:-

- Form A9, (Application by the Nearest Relative)
- or Form A10 (Application by the AMHP),
- Form A11 (Application for Emergency Admission under Section 4) **and**
- Form H3 (Record of receipt of medical recommendation for admission to Hospital) must be completed accurately, scanned and forwarded to the MHA Office email address and the originals forwarded to the Mental Health Act Manager/Administrator in the Mental Health Act Office.

7.8 There is no right of appeal for an individual on a Section 4 and discharge will occur if the assessment concludes that further detention under Section 2 or Section 3 is not necessary. The Section will end after 72 hours.

8.0 DETAINING POWERS OF THE ACT FOR ASSESSMENT AND/OR TREATMENT

9.0 SECTION 2 – ASSESSMENT AND/OR TREATMENT

9.1 When it is unclear to the full extent of the nature and degree of a patient's mental disorder and they are refusing to accept assessment and treatment voluntarily, a Section 2 of the Act can be used to detain them for that purpose and to aid the formulation of a treatment care plan.

9.2 Section 2 is not renewable Section, consequently if the 28-day episode is reached without establishing their need to be treated for a mental disorder or a re-assessment resulting in a detention to a Section 3 being lawfully put in place, then the Section 2 ends and the individual is free to leave Hospital. However, it is not considered good practice to allow a Section 2 to lapse as any detention should end as soon as the legal criteria are no longer met.

LAWFUL DOCUMENTATION REQUIRED

9.3 To ensure that an individual is detained lawfully for the purpose of assessment and the formulation of a treatment plan using Section 2 of the Act the (pink) Section documents:-

- Form A1 (Application by the Nearest Relative
- Form A2 (Application by the Approved Mental Health Professional)
- Form A3 (Joint Medical Recommendation for Admission for Assessment) or
- Form A4 (Single Medical Recommendation for Admission for Assessment)
- Form H3 (Record or Receipt of Medical Recommendation for Admission to Hospital) must be accurately completed, scanned and sent to the MHA Office email address and the originals sent to the Mental Health Act Manager/Administrator in the Mental Health Act Office.

9.4 There must be no more than five clear days between each of the two medical recommendations taking place and they must be completed by two different doctors.

9.5 The AMHP must have seen the individual in the 14 days prior to making the application.

9.6 The individual must be admitted to hospital within 14 days from the date of the last medical examination for the Section.

9.7 There is a right of appeal to the Mental Health Tribunal within the first 14 days of the Section 2 commencing as well as the right of appeal to the Hospital Managers at any time. Discharge is permitted by the Responsible Clinician prior to the end of the 28 days as well as discharge by the Mental Health Tribunal and a hearing held by the Hospital Managers. Section 2 will end after 28 days and the nearest relative may make an application for discharge.

10.0 SECTION 3 - TREATMENT

10.1 An individual may become subject to a Section 3 of the Act when:-

- Currently detained on a Section 2 – re-assessed and it is deemed necessary to detain on a Section 3 to ensure continued treatment that otherwise would be refused by the individual;
- Patient with established diagnosis and chronic relapsing mental illness can be detained for treatment without using an assessment Section i.e. Section 2 of the Mental Health Act;
- The nature and degree of the individual's mental disorder is apparent and a treatment plan is in place but the individual refuses to engage and accept treatment.

10.2 Patients detained for treatment (rather than assessment) under part 2 of the Act and unrestricted part 3 of the Act patients may be detained initially for a maximum of 6 months. The authority for their detention can then be renewed for a further six months, and subsequently for a year at a time. Section 20 of the Act requires the patient's responsible clinician to examine the patient during the two months preceding the day on which the authority for detention is due to expire. The responsible clinician can only renew the Section if they believe the following legal criteria are met:-

- The patient is still suffering from mental disorder of a nature or degree which makes it appropriate for him to receive medical treatment in hospital **AND**
- It is necessary for the health and safety or the protection of other persons that he should receive such treatment **AND** that it cannot be provided unless he continues to be detained **AND**
- Appropriate medical treatment is available to him.

10.3 If however, the 6 month episode has lapsed prior to the application for renewal being made, the patient is no longer subject to the Act and is free to leave the hospital. Although it is not considered good practice to allow a Section 3 to lapse, any detention should end as soon as the legal criteria are no longer met.

LAWFUL DOCUMENTATION REQUIRED

10.4 To ensure that an individual is detained lawfully for the purpose of treatment using Section 3 the (pink) Section documents:-

- Form A5 (Application by the Nearest Relative)
- Form A6 (Application by Approved Mental Health Professional)
- Form A7 (Joint Medical Recommendation for admission for Treatment) OR
- Form A8 (Single Medical Recommendation for admission for Treatment)
- Form H3 (Record of receipt of Medical Recommendation for admission to Hospital) must be accurately completed, scanned to the Mental Health Act Office email address and the originals sent to the Mental Health Act Manager/Administrator in the Mental Health Act Office.

10.5 The must be no more than five clear days between the two medical examinations.

10.6 The AMHP must have seen the person in the 14 days prior to making the application.

10.7 The individual must be admitted to hospital within 14 days from the date of the last medical examination for the Section.

10.8 There is a right of appeal to the Mental Health Tribunal once within each period of detention and a right of appeal to the Hospital Managers at any time. Discharge is permitted by the Responsible Clinician prior to the end of the 6 months, as well as by the Mental Health Tribunal, Hospital Manager's or an application for discharge by the nearest relative.

11.0 SPECIAL RULES FOR THOSE UNDER 18 YEARS OF AGE

11.1 The Act contains a number of special rules for young people under the age of 18. Some of the rules apply whether or not the young person is detained.

11.2 A person aged 16-17 years who has capacity can consent to or refuse admission to hospital as an informal (voluntary) patient and their decision cannot be overridden by those with parental responsibility (usually parents).

11.3 Where a young person under the age of 18 years is admitted to hospital (informal or detained), the managers of that hospital must ensure that the environment in the hospital is suitable, having regard to their age, but subject to their needs, i.e.:-

- Appropriate physical facilities;
- Staff with the right training, skills and knowledge to understand and address their specific needs as children and young people;
- A hospital routine that will allow their personal, social and educational development to continue as normally as possible; **AND**
- Equal access to educational opportunities as their peers, in so far as that is consistent with their ability to make use of them, considering their mental state.

11.4 When young people under the age of 18 years are admitted to hospital (informal or detained), the managers must consult a person who appears to them to have knowledge or experience of cases involving those under 18 years. Typically, this

will mean that a Child or Adolescent Mental Health Service professional will need to be involved in decisions about the patient's accommodation, are and facilities for education in the hospital.

11.5 It is crucial to understand who holds parental responsibility when providing care or treatment to children. It will usually be the child's parent(s) but this is not necessarily the case. Where parental responsibility has been granted to a person through a Court Order, a copy of this should be taken and retained by the hospital. Care or treatment may be authorised by either parent where a child is not competent to consent to it themselves. However, where possible, both parents should be involved. In the event of a dispute between them, authority from the court may be sought.

11.6 Children looked after the by local authority (Section 22 of the Children Act 1989) – these are children who are looked after by Social Services, treatment decisions should be discussed with a parent or a person with parental responsibility.

11.7 Children voluntarily accommodated by the local authority – the rights of the person with parental responsibility remain the same as in other circumstances.

11.8 Children subject to a Care Order – In this situation, parental responsibility is shared between the parents and the local authority and consequently it is a matter to be agreed between the two parties. The local authority has powers under the Children Act to limit parental responsibility if needed.

11.9 In extraordinary circumstances if a child cannot be accommodated on a specialist CAMHs ward then admission to an adult ward with appropriate staffing may be a short term solution. This course of action will require care by child specialists and appropriate accommodation for young women.

11.10 The Care Quality Commission (CQC) must be notified without delay if an under 18 year old is placed on an adult psychiatric ward for longer than a continuous period of 48 hours. Section 140 of the Mental Health Act requires Clinical Commissioning Groups to notify local authorities in their area of the hospitals that are designed to be specifically suitable for patients under the age of 18.

11.11 In all cases where an under 18 year old is admitted to an adult ward, the reasons for the admission should be recorded, including an explanation as to why this is considered to be suitable having regard to their age and why other options were not available and/or suitable. Details of whether action will be necessary to rectify the situation, and what action taken by whom, and when, should also be recorded.

11.12 Chapter 19 of the Mental Health Act 1983 Code of Practice, paragraphs 19.90 to 19.104 provide further guidance in detail in regard to age appropriate services.

12. PART III OF THE MENTAL HEALTH ACT – CRIMINAL PROCEEDINGS

12.1 An individual who is subject to criminal proceedings has the same rights to a psychiatric assessment and treatment as anyone else. If such an individual is found to be suffering from mental disorder, it may be that they are diverted from prison by way of a Hospital Order.

12.2 The court making the order is responsible for providing transportation to the hospital. However, it then becomes the responsibility of the hospital to ensure that transport and appropriate supervision is provided for the individual returning to court for future hearings. Once the individual is at court they come under the supervision of the police or prison officers in attendance.

12.3 On these occasions, the courts will issue the appropriate documentation that provides the hospital with jurisdiction in accordance with that documentation. This will typically be in the form of a court order or warrant.

13. SECTION 35

13.1 Remand to hospital for **assessment** lasting up to 28 days, which can be extended by the court up to a maximum of 12 weeks. The hospital is required to provide the court with a report on the individual to the extent of any mental disorder.

There is no provision for Section 17 Leave to be granted. This Section is not covered by the treatment powers of the Act, so medication can only be given if the person consents.

The Mental Capacity Act 2005 could be used if the person lacks capacity to consent. If the person has capacity and refuses treatment they can be referred back to court with a recommendation for either a Section 36 (only the Crown Court can make this order) or a Section 37.

If the court cannot provide a hearing for this and treatment is assessed as being urgent, it is possible to complete a Section 2 or Section 3 whilst a person is also subject to a Section 35.

13.2 The court can extend the person's detention at the end of the criminal process by sentencing them to hospital under Section 37.

13.3 There is no right of appeal for an individual on a Section 35 and discharge of Section 35 can only be initiated by the court.

14. SECTION 36

14.1 Remand to hospital for **treatment** by the Crown Court lasting up to 28 days which can be extended by the court up to a maximum of 12 weeks. Admission to hospital must be within 7 days of the order being made by the Crown Court. The court can extend the person's detention at the end of the criminal process by sentencing them to hospital under Section 37.

14.2 There is no right of appeal for an individual on a Section 36 and discharge from Section 36 can only be initiated by the court.

15. SECTION 37

15.1 A court may order an individual to hospital for **treatment** for up to 6 months which can be extended by the responsible clinician for further periods of time.

15.2 The responsible clinician may as part of a care plan, grant Section 17 leave to an individual detained under Section 37.

15.3 There is a right to appeal to the Mental Health Tribunal, but only once in the **second** 6 months of detention and then once within each subsequent period of detentions. Further appeals are allowed to the Hospital Managers at any time as well as to the court to have the sentence quashed. Discharge from the Section is allowed by the responsible clinician, Mental Health Tribunal, Hospital Manager's and the court. Lapsing of the Section 37 after 6 months would not be considered as good practice as any detention should be ended as soon as the legal criteria are no longer met.

16. SECTION 38

16.1 Section 38 allows a hospital to detain a convicted offender initially for up to 12 weeks to **assess** whether a Section 37 is appropriate.

16.2 The Section 38 can be extended for up to a maximum of 1 year by the court. Extensions are made on the recommendation to the court by the Responsible Clinician. The individual must be represented if they choose not to attend court themselves. There is no provision during the period for Section 17 leave to be granted.

16.3 There is a right of appeal to the court to have the sentence quashed and discharge from Section 38 is by the court only.

17. SECTION 47

17.1 This Section allows the transfer of a sentenced prisoner to hospital for up to 6 months initially **for treatment** with or without their consent. Once the individual is detained in hospital, the Section 47 behaves the same as a Section 37. The Section can be renewed by the Responsible Clinician for a further 6 month period and yearly thereafter.

17.2 There is a right to appeal to the Mental Health Tribunal once in the first 6 months and then once in each subsequent period of detention as well as the right to appeal to the Hospital Managers at any time. Discharge from Section 47 is by the Responsible Clinician, Mental Health Tribunal and Hospital Manager's. Discharge to a Community Treatment Order is also allowed.

18. SECTION 48

18.1 Removal to hospital of an un-sentenced prisoner **for treatment** without their consent. The Responsible Clinician can allow Section 17 Leave to the individual and the Responsible Clinician has the right to discharge the individual from hospital.

18.2 The Section 48 is not a renewable Section but remains in place until the Court or Ministry of Justice directs its conclusion.

18.3 There is a right of appeal to the Mental Health Tribunal once in the first 6 months and then once in each of the subsequent period of detention as well as appealing to the Hospital Managers as any time. Discharge can be made by the Mental Health Tribunal and Hospital Managers. Discharge to a Community Treatment Order is also allowed.

19. PART III OF THE ACT – FORENSIC RESTRICTED SECTIONS

19.1 Restricted Sections are applied when it is considered that an individual requires additional supervision for the protection of the public at large. The restriction order is made either at the point of sentencing by a court or through the transfer of a prisoner to hospital.

19.2 A 'restriction' means that decisions concerning Section 17 Leave, transfer and discharge must be authorised by the Secretary of State.

20. SECTION 37/41

20.1 A Crown Court orders a convicted individual to hospital **for treatment** with or without their consent. The individual must be admitted to hospital within 28 days of the order being made. Section 37/41 does not require renewal to prevent it lapsing, but remains in force until it is discharged by the Responsible Clinician with the agreement of the Secretary of State or by the Mental Health Tribunal. The restriction prevents the Responsible Clinician from being able to grant Section 17 leave.

20.2 The Responsible Clinician is required to provide the Secretary of State with annual reports on the progress of the individual.

20.3 There is a right of appeal to the Mental Health Tribunal but only once in the second 6 months and then once every year thereafter. There is a right of appeal to the Hospital Managers at any time, however the Hospital Manager's **do not** have the authority to discharge but can recommend discharge to the Secretary of State. In addition to this there is a right of appeal to the court. Discharge from the Section can be made by the Mental Health Tribunal, the Secretary of State (usually on recommendation) and by the court.

21. SECTION 47/48

21.1 Transfer from prison to hospital for sentenced prisoner to receive treatment with or without their consent.

21.2 The individual must be admitted to hospital within 14 days of the order being made.

21.3 The restriction prevents the Responsible Clinician from being able to:-

- Renew (the Section cannot be extended as it runs for a set period of time, or indefinitely as set by the restriction);
- Permit Section 17 leave (the authority of leave rests with the Ministry of Justice).

21.4 There is a right of appeal to the Mental Health Tribunal once in the first 6 months, once in the second 6 months and thereafter yearly. In addition there is a right of appeal to the Hospital Managers at any time, however the Hospital Manager's **do not** have the authority to discharge but can recommend discharge to the Secretary of State. The Mental Health Tribunal can inform the Secretary of State that the individual no longer requires treatment – the person would then be returned to prison. The Responsible Clinician can inform the Secretary of State that the individual no longer requires treatment – the person would then be returned to prison.

22. SECTION 48/49

22.1 Removal to hospital of an un-sentenced prisoner f**or treatment** with or without their consent.

22.2 The Section can only be extended by the court imposing another Section at the end of the trial. This would typically be:-

- Section 37;
- Section 37/41

22.3 The authority of leave rests with the Ministry of Justice. Leave is not normally granted unless there are exceptional grounds for doing so.

22.4 There is a right of appeal to the Mental Health Tribunal once in the first 6 months, once in the second 6 months and thereafter yearly. In addition there is a right of appeal to the Hospital Managers at any time, however the Hospital Manager's **do not** have the authority to discharge but can recommend discharge to the Secretary of State. The Mental Health Tribunal can inform the Secretary of State that the individual no longer requires treatment – the person would then be returned to prison. The responsible clinician can inform the Secretary of State that the individual no longer requires treatment – the person would then be returned to prison.

23. ELECTRONIC MEDICAL SCRUTINY

23.1 Section papers are medically scrutinised electronically by scanning the Medical Recommendations to a nominated Consultant colleague with an attached medical scrutiny template for completed and sending by secure email using NHS.net. Once scrutinised the form is returned by the Consultant colleague to the Mental Health Act Team inbox using the same secure NHS.net. The completed scrutinised form is then scanned by a member of the Mental Health Act Team to Mobius or Paris (whichever the appropriate) to record that the detention papers have been subject to a robust scrutiny process and visible for staff to view, as well as any visiting CQC Inspectors. A list of Section 12 Approved Doctors is supplied on a regular basis to the Mental Health Act Office by the Deputy Medical Director and this list is used for allocating of papers to Consultant colleagues to carry out the scrutiny process. 15 Doctors on a monthly basis are used with the usual allocation of 10 scrutinies. Should all 15 Doctors be used before the end of a month, then the Mental Health Act Office would start again from the top of the list, allocating five further scrutinies to each Doctor until the end of that month.

24. MENTAL HEALTH ACT ELECTRONIC DOCUMENT PROCEDURE

24.1 The amendment to the 2008 regulations includes minor changes to the statutory forms. These comprise of an addition of a field in which the author's email address can be entered and, where relevant, an option to indicate that the form has been served electronically. Note that all electronic forms, apart from the discharge order form, should be considered 'served' once they have been successfully sent.

24.2 Where an AMHP submits an application for detention electronically and then delegates conveyance of the patient, for example to ambulance staff, a paper copy of the form is not needed to indicate that conveyance is lawful so long as the AMHP can provide evidence of a completed application supported by the necessary medical recommendations It is vital that these statutory documents are retained and sent to the receiving hospital as a package.

24.3 Staff should continue to communicate statutory forms and other notifications to patients in hard copy, they should actively offer the patient the option of also receiving the form electronically, if that is their preferred method of communication. This offer should be made to all patients giving assistance as required

24.4 Electronic forms should be considered equivalent in status to paper forms. Neither is more valid than the other. This means that, for example, where forms authorising an individual's detention are in an electronic format and they need to be transferred from one hospital to another, there should be no question over the validity of these forms by the receiving hospital simply because they’re electronic.

24.5 Where rectifications to forms are made, including those under Section 15 of the MHA, a transparent audit trail must be maintained that shows who edited the form, when they made the edit and what was added and/or omitted. All electronically completed forms should include the author's (secure) email address, alongside the postal address, in the relevant Section of the statutory form so that the author can be easily contacted in case rectifications are required.

24.6 Electronic signatures on electronically submitted statutory forms may be a typed name or initials, a scan or photo of a wet ink signature, or an electronically drawn signature.

24.7 **Note**, It is the Department of Health and Social Care's view that minor discrepancies between a form and the statutory templates should be accepted. However, it will be for recipients to decide on a case by case basis whether it is appropriate to accept such forms (and if the matter were ever litigated the court would determine the form's validity).

24.8 In the case of a discharge order form sent electronically by the nearest relative to hospital managers, the amendment to the 2008 regulations means that service is considered to have taken place at the beginning of the next business day after which it was sent (12.01)

24.9 A CTO 3 – can't be electronically delivered to the patient

24.10 The Trust has produced a Mental Health Act Electronic Document Procedure to support this process (MHAPG1B)

25. COMMUNITY TREATMENT ORDER

25.1 The purpose of a Community Treatment Order is to allow suitable patients who have been subject to the Act to be safely treated in the community rather than under detention in hospital. It is a way of providing help to rehabilitation, prevent relapse and harm to the patient or to others that this might cause. It is intended to help patients to maintain stable mental health outside the hospital and to promote their recovery within the community setting.

25.2 Community Treatment Orders provide a framework for the management of a patient's care in the community by joint agreement between the patient and the Responsible Clinician of a community treatment plan that they both sign up to. However if the patient refuses to accept the treatment once in the community and reneges on their agreed treatment care plan and in the interests of the individual or others, the Responsible Clinician does have the power to recall the patient to hospital for treatment.

25.3 Only those individuals who are detained on the following Sections are eligible for a Community Treatment Order:-

- Patients detained under Section 3
- Patients detained under Part 3 unrestricted Hospital Orders – Section 37
- Patients detained under Part 3 Hospital or Transfer Directions – Section 45a or Section 47 or Section 48 – without limitation or restriction directions.

25.4 Community Treatment Orders cannot be used for any patient detained under Section 2 or Section 4 or any restricted patients. Nor can it be retrospectively applied to any patient living in the community who were previously detained under a Section which has now ended.

LAWFUL DOCUMENTATION REQUIRED

25.5 To ensure that an individual is lawfully treated in the community on a Community Treatment Order, the Section Documents:-

- Form CTO1 (Community Treatment Order Section 17a)
- Form CTO11 (Community Treatment Order for Medication to Continue) must be accurately completed, scanned and emailed to the Mental Health Act Office and the originals sent to the Mental Health Act Manager/Administrator in the Mental Health Act Office.

25.6 There is a right of appeal to the Mental Health Tribunal as well as to the Hospital Managers at any time. Discharge is by the responsible clinician prior to the end of the 6 months. Discharge can also be made by the Mental Health Tribunal and the Hospital Manager's. The Community Treatment Order can be revoked by the Responsible Clinician and an application for discharge can be made by the nearest relative. Allowing the Section to lapse would not be considered as good practice as any detention should be ended as soon as the legal criteria are no longer met.

26. SECTION 7 – GUARDIANSHIP – A COMMUNITY BASED SECTION

26.1 A community based Section that the Local Authority is responsible for considering and accepting. This Section lasts for up to six months and may be extended (renewed) for further periods of time. A Section 7 can be used both as an alternative to admitting an individual to hospital and as a route to the discharge of an individual from hospital.

26.2 To be received into Guardianship – Section 7 requires the following:-

- The patient should have attained the age of 16 years;
- Be suffering from a mental disorder of a nature or degree which warrants his/her reception into guardianship under this Section **AND**
- It is necessary in the interests of the welfare of the patient or for the protection of others that the patient shall be so received.

26.3 A Guardianship Order can be made in civil cases under Section 7 and in criminal cases under Section 37. In both cases the effects of such an order are the same.

26.4 The powers of the Guardian are contained within Section 8 of the Act and can include the following:-

- The power to require the patient to reside at a place specified by the authority or person named as Guardian;
- The power to require the patient to attend at places and times so specified for the purposes of medical treatment, occupation, educations or training;
- The power to require access to the patient to be given at any place where the patient is residing to any Registered Medical Practitioner, AMHP or other specified person.

LAWFUL DOCUMENTATION REQUIRED

26.5 To ensure that the Section 7 is lawfully put in place, the (pink) Section documents:-

- Form G1 (Application by Nearest Relative)
- Form G2 (Application by Approved Mental Health Professional)
- Form G3 (Joint Medical Recommendation for admission for assessment) OR
- Form G4 (Single Medical Recommendation for admission for assessment)
- Form G5 (Record of acceptance of Guardianship application) must be accurately completed, scanned and forwarded to the Mental Health Act Office email address and the originals sent to the Local Authority.

26.6 There must be no more than five clear days between each of the two medical examinations taking place.

26.7 The AMHP must have seen the person in the 14 days prior to making the application.

26.8 The Guardianship Forms must be received by the Local Authority within 14 days of the second doctor's examination.

26.9 There is a right to appeal to the Mental Health Tribunal once during each period of detention. There is an additional right to appeal to the Local Authority. Discharge from the Section can be made by the responsible clinician for the Guardianship, the Local Authority, the Mental Health Tribunal and an application for discharge by the nearest relative.

26.10 Should the patient be detained under Section 3, the Guardianship Section will automatically end. However, where a person under Guardianship is in hospital voluntarily or under Section2, 4, 5(2), 5(4), the Guardianship Section does not end but its powers suspended until the person is discharged into the community or unless the Guardianship Section has expired in the meantime.

26.11 Transfer to hospital under Section 19 of the Act – the transfer requires two medical recommendations plus Local Authority Approval (Form G8) and acts in such a way that on admission the Guardianship Section is converted into a Section 3.

27. SECTION 15 - RECTIFICATION OF APPLICATIONS AND MEDICAL RECOMMENDATIONS

27.1 Introduction

Section 15 allows certain Section documentation to be amended.

The Mental Health Act Manual – Twenty Fourth Edition, Richard Jones states; ***'If within the period of 14 days beginning with the day on which a patient has been admitted to a hospital in pursuance of an application for admission for assessment or for treatment the application, or any medical recommendation given for the purposes of the application, is found to be in any respect incorrect or defective, the application or recommendation may, within that period and with the consent of the managers of the hospital, be amended by the person by whom it was signed; and upon such amendment being made***

the application or recommendation shall have effect and shall be deemed to have had effect as if it had been originally made as so amended'.

If a document which contains a minor error is not rectified within the 14 day period, this would not invalidate the application by virtue of the *de minimis* principle, i.e. the error is too trivial to be of any consequence

Section 15 does not apply to documents issued by a court nor in support of either a patient's transfer under Section 19, the renewal of the patient's detention under Section 20, Section 5 holding powers or to documents relating to Guardianship or Community Treatment Orders.

The Mental Health Act Manual's general note for Section 17A (CTO) states that although there is no provision in the Act for the documents relating to CTOs to be rectified, minor errors and or slips of the pen may be corrected and initialled without it affecting the validity of the CTO. This could also possibly be applied to the other documents that do not apply to Section 15.

A slip of the pen in recording the procedure is not a procedural failure.

27.2 Definition of incorrect and defective

In correct - in that, had the facts been correctly stated, the admission would have been justified, e.g. mis-stating dates, names or places.

Defective - means incomplete information has been provided, e.g. leaving a space blank, omitting to insert a date or failing to delete one or more alternatives in places where only one can be correct.

27.3 Errors which can't be rectified

a. The application is not accompanied by the correct number of medical recommendations
b. The application and the medical recommendations are for different Sections e.g. application for Section 3 medical recommendations for Section 2
c. If the application, medical recommendations are signed by someone who is not empowered under the Act to do so, or is not signed at all
d. No name of the hospital on the application or the wrong hospital named in the application
e. If the time limits of each Section are not complied with.
f. Form H5 or CTO7 not completed until after the Section 3/37/CTO has expired or completed more than 2 months before date of expiry.
g. Form H5 or CTO7 not completed either by the patient's RC or Acting Approved Clinician

If any of the above is applicable, there is no authority for a patient's detention and the Section is not valid. Authority for the patient's detention can be obtained only through a new application (or, in the interim, by the use of the holding powers under Section 5, if the patient has already been admitted to the hospital).

27.4 Errors which can be rectified

1. Mis-spelling or inconsistencies in the spelling of name/address of the patient.
2. Doctors or AMHP's don't give their full name or address.
3. Lack or incorrect information about the nearest relative.
4. No name or address for the patient. If it has not been possible to identify the name of the patient then the phrase 'the patient known by the name of John (or Mary) Smith' be entered in the patient name space on the application form. A note of the real name of the patient should be attached to the application as soon as it is discovered. A similar note should be made if it is discovered that the patient gave a false name at the time of admission. If the address of the patient is unknown, or if the patient is homeless, the current location of the patient should be entered in the address space on the application.
5. If neither doctor is Section 12 approved, only if the medical recommendation wasn't a joint recommendation then a fresh medical recommendation may be obtained by a doctor who is Section 12 approved within 14 days.
6. If neither doctor knew the patient nor the AMHP has not given reasons on the application why it was not possible to find a doctor who knew the patient.
7. If the doctor hasn't named or put the wrong name of hospital to which the patient is to be admitted on a Section 3 medical recommendation.

28. CONSENT TO TREATMENT

28.1 <u>First three months</u>

During the first three months of detention the Approved Clinician has the lawful authority to give medication for the treatment of mental disorder with or without the patients consent. This includes any time a patient is detained under Section 2 before that detention is changed – without a break to Section 3.

Although the Mental Health Act permits some medical treatment to be given without consent, the patient's consent should still be sought before treatment is given wherever practicable. The patient's consent or refusal should be recorded in their notes, as should the treating clinician's assessment of capacity to consent.

Note: Chapter 23.37 of the Code of Practice states: - ***Although the Mental Health Act permits some medical treatment for mental disorder to be given without consent, the patient's consent should still be sought before treatment is given wherever practicable. The patient's consent or refusal should be recorded in their notes, as should the treating clinician's assessment of the patient's capacity to consent'.***

The Care Quality Commission is actively looking to ensure that this is complied with.

If medication is likely to be continued beyond the 3 month period, the need for consent or a second opinion should be foreseen in good time. The RC should be satisfied at all times that consent remains valid.

28.2 At and after three months of detention

Section 58 applies to the administration of medication to detained patients for the treatment of mental disorder once three months have passed with the exception of medication administered as part of ECT which is covered in Section 58A.

Patients cannot be given medication to which Section 58 applies unless:-

- The Approved Clinician in charge of the treatment or a Second Opinion Appointed Doctor (SOAD) certifies that the patient has the capacity to consent and has done so by completing Form T2.
- A SOAD certifies that the treatment is appropriate and either that – the patient does not have the capacity to consent or the patient has the capacity to consent but has refused to do so by completing Form T3.

28.3 Form T2 and Consent

Where Approved Clinicians certify the treatment of a patient who consents, they should not rely on the certificate as the only record of their reasons for believing that the patient has consented to the treatment. A record of their discussion with the patient including any capacity assessment should be made in the patient's notes as normal. **COP 25.17.**

If the Approved Clinician – often the Responsible Clinician who signed the T2 for a patient changes, then a new T2 should be completed. Form T2 should be reviewed and a new form completed as appropriate following a change in treatment plan from that recorded, following re-establishment of consent, after this has been withdrawn and when detention is renewed or annually, whichever is earlier.

A copy of the Form T2 or T3 should be attached to the prescription card; treatment on a prescription card must agree with and follow what is authorised by the T2 or T3.

Instructions from the Care Quality Commission regarding developments within BNF and prescribing are such that there can be variable dose limits for the same drug when used to treat different mental health disorders. Drugs having different dose limits for one mental health indication than for another is a longstanding occurrence; it has never previously been viewed as necessary to specify the diagnosis for which a drug is used when it is prescribed within its product licence and within the terms described in the BNF; and it remains the position that it is not necessary to do so on statutory certificates.

In practice there can often be overlap between aspects of two conditions such that it may not be helpful to the patient or the Responsible Clinician to attempt to completely separate the two, for example schizophrenia, schizoaffective disorder and mood disorders. For these reasons it is not expected that practitioners will need to separate out on a T2 or T3, each condition for which a drug may be prescribed – it will be sufficient for practitioners to be clear that they are treating a mental disorder. It is therefore not necessary differentially to list dose limits for different diagnostic groups, but instead it will be sufficient to cite 'BNF advisory maximum dose limits', since the advice is detailed within each applicable portion of the BNF. The permitted maximum will be the maximum for any indication within that category.

28.4 Treatment for ECT

Section 58A applies to ECT and to medication administered as part of ECT to detained patients and to all patients aged under 18 years of age whether detained or not.

28.5 Important differences for Section 58A

- Patients who have the capacity to consent may not be given ECT unless they consent to it;
- No patient under 18 years of age can be given ECT unless a SOAD has certified the treatment as appropriate;
- A certificate is required for ECT at any time even in the first three months which should include medication administered as part of the ECT.

A patient who lacks capacity to consent may not be given ECT under Section 58a unless a SOAD certifies that the patient lacks capacity to consent and that:-

- The treatment is appropriate;
- No valid and applicable Advance Decision has been made by the patient under the Mental Capacity Act refusing treatment;
- No suitably authorised Attorney or Deputy objects to the treatment on the patient's behalf **AND**
- The treatment would not conflict with a decision of the Court of Protection which prevents the treatment being given.

If the SOAD decides to authorise treatment with ECT for an adult without capacity, they are required to complete a Form T6. If ECT is to be given to an adult with capacity, the approved clinician should complete a Form T4. In all cases the SOAD should indicate on the certificate the maximum number of administrations of ECT approved.

28.6 Section 62 Urgent Treatment

This is used in cases of urgency where Sections 57, 58 and 58a do not apply. Sections 57 and 58 do not apply if the treatment in question is:-

- Immediately necessary to save the patient's life;
- A treatment which is not irreversible, but which is immediately necessary to prevent a serious deterioration of the patient's condition;
- A treatment which is not irreversible or hazardous, but which is immediately necessary to alleviate serious suffering by the patient **OR**
- A treatment which is not irreversible or hazardous, but which is immediately necessary to prevent the patient from behaving violently or being a danger to himself or to others and represent the minimum interference necessary to do so.

28.7 When urgent treatment should be used

- Section 62 should be used when the initial three month period has been met and it has been identified that the patient either is objecting to the treatment or they lack the capacity to consent to the treatment and a SOAD has been requested by the RC but has not attended.

- Section 62A should be used when a CTO patient is recalled under Section 17 E or the patient is liable to be detained following the revocation of a CTO and the patient is objecting to the treatment or they lack the capacity to consent to the treatment and a SOAD has been requested but has not attended to complete a Form T3.
- Section 64G should be used when authorisation for treatment on the CTO is required (one month from the implementation of the CTO if they had previously met the three month rule) and the patient does not have the capacity to consent to the treatment and a SOAD has been requested.

28.8 Roles and Responsibilities

- As soon as the timescales are met in relation to Section 58/58A, the Responsible Clinician is required to assess the patient as to their capacity to consent to treatment and their agreement or not if appropriate to consent to that treatment.
- If the patient is capable and is consenting to the treatment, form T2/CTO12 together with the Trust's Capacity to Consent Form (CAC 1 Form) must be completed and the originals forwarded to the MHA Office with copies being filed in the patient's notes.
- If the patient is incapable or is refusing to consent to the treatment, a SOAD is required to authorise the treatment plan.
- The Responsible Clinician will need to complete the online SOAD request form via the CQC Website.
- If a SOAD hasn't attended to complete the T3/CTO11 by the date that the consent to treatment is due, the RC will need to complete either a Section 62/62A.64G to authorise any treatment until the SOAD attends.
- When the SOAD has attended and completed the T3, the RC is required to complete the Communication to SOAD's Decision by Responsible Clinician Form.

29. SECTION 132 – INFORMATION TO SERVICE USERS DETAILING THEIR RIGHTS WHILST DETAINED SUBJECT TO THE ACT

29.1 Section 132 places a duty on the Managers of a Hospital in which a patient is detained under the Act shall take such steps as are practicable to ensure that the patient understands:-

- The provision of the Act under which the patient is detained and the effect of that provision; and
- The patient's right of appealing against that provision to the First Tier Tribunal;
- This should be done as soon as practicable after the commencement of the patient's detention under the Act.

29.2 Effective communication is essential in ensuring appropriate care and respect for patient's rights. It is important that the language used is clear and unambiguous and that people giving information check that has been communicated has been understood.

29.3 Everything possible should be done to overcome barriers to effective communication, which may be caused by any of a number of reasons, e.g.

- If the patient's first language is not English;
- Patients may have difficulty in understanding technical terms and jargon or in maintaining attention for extended periods;
- They may have a hearing or visual impairment or have difficulty in reading or writing;
- A patient's cultural background may also be very different from that of the person speaking to them.

29.4 The Act requires that those patients subject to the Act receive certain pertinent information regarding their detention. This will include:-

- The reasons for their detention or CTO;
- The circumstances in which they can be treated without consent (if any);
- The maximum length of the current period of detention or CTO;
- That their detention or CTO may be ended at any time if it is no longer required or the criteria for it are no longer met;
- That they will not automatically be discharged when the current period of detention or CTO ends;
- That their detention or CTO will not automatically be renewed or extended when the current period of detention or CTO ends;
- Their rights whilst detained;
- Who they can appeal to and when, if this is appropriate to the Section they are detained under;
- The right to choose to inform their Nearest Relative;
- The rights (if any) of their Nearest Relative to discharge them (and what can happen if their Responsible Clinician does not agree with that decision).
- For CTO patients, of the effect of the Community Treatment Order, including the conditions which they are required to keep to and the circumstances in which their Responsible Clinician may recall them to hospital;
- Access to an IMHA (Independent Mental Health Advocate).
- Circumstances (if any) in which they can be treated without their consent and the circumstances in which they have the right to refuse treatment;
- The role of the Second Opinion Appointed Doctor (SOAD) and the circumstances in which they may be involved;
- Where relevant the rules on Electro-Convulsive Therapy (ECT).

29.5 The information must be given to the individual both verbally by staff on the ward and in writing by way of giving the patient a copy of the appropriate Department of Health Information Leaflet. The information provided should be unambiguous and it should be checked by the person conveying the information that it has been understood by the patient.

If it has been deemed that the patient has not understood the information, it must be clearly documented via the Trust's Rights Monitoring Form or in the case of the patient lacking capacity – a Multi-Disciplinary Team must agree the course of action and record accordingly. The information must be conveyed to the patient again when it is deemed appropriate. Where possible and appropriate relatives/carers should be given information.

29.6 It may prove necessary to find specialist expertise to support this process – for example:-

- An Interpreter;
- An IMHA;
- Someone who can use sign language

29.7 Patients should be informed:-

- Of the right of the Responsible Clinician and the Hospital Managers to discharge them (and for restricted patients, that this is subject to the agreement of the Secretary of State for Justice);
- Of their right to ask the Hospital Managers to discharge them;
- That the Hospital Managers must consider discharging them when their detention is renewed or the CTO is extended;
- Of their rights to apply to the Tribunal;
- Of the rights (if any) of their Nearest Relative to apply to the Tribunal on their behalf.

29.8 Patients should be offered assistance to request a Hospital Managers' Hearing or make an application to the Mental Health Tribunal. They should also be told:-

- How to contact a suitably qualified Legal Representative and should be given assistance to do so if required;
- That free legal aid may be available;
- How to contact any other organisation which may be able to help them make an application to the Tribunal.

29.9 CTO patients whose Community Treatment Orders are revoked, and conditionally discharged patients recalled to hospital, should be told that their cases will be referred automatically to the Mental Health Tribunal.

29.10 Patients must be informed about the role of the Care Quality Commission and of their right to meet visitors appointed by the Care Quality Commission in private. Patients should be told when the Care Quality Commission visit their hospital and be reminded of the role the Care Quality Commission undertake.

29.11 Patient may also make a complaint to the Care Quality Commission and they should be informed of the process for this. Support should be made available to patients to do this, if required. Patients should also be given information about the hospital's own complaints system and how to use it.

30. NEAREST RELATIVE OR THE NOMINATED PERSON

30.1 The Act also requires that the patient's Nearest Relative or nominated person should receive a written copy of the information given to the patient when they are detained – unless however, the patient requests otherwise.

30.2 When providing the patient with information, they should be told that the written information will be copied to their nearest relative or nominated person, thus giving the patient the opportunity to object.

30.3 Section 133 of the Act requires the Trust to inform the Nearest Relative or nominated person with the patient's permission to be informed that the individual is to be discharged from the Act. Wherever possible this should be done at least 7 days prior to discharge.

31. SECTION 17 LEAVE

31.1 Section 17 of the Mental Health Act 1983, as amended in 2007, makes provisions for patients who are liable to be detained under various Sections of the Act to be granted leave to be absent from hospital subject to such conditions that are considered necessary in the interests of the patient or for the protection of others

31.2 Section 17 applies to patients who are detained under Sections 2, 3, 37 and 47 of the Act. It also applies, with modifications, to those patients who are subject to a restriction order (Section 41 or Section 49), but leave cannot be granted to patients subject to Sections 35, 36 and 38

31.3 Only the Responsible Clinician (RC) can grant leave and cannot delegate the decision to grant leave to anyone else. In the absence of the RC (e.g. if they are on leave) permission can be granted only by the Approved Clinician who is for the time being acting as the patient's RC

31.4 Patients must only be granted leave in accordance with their clinical presentation. The granting of leave must be neither an alternative to discharge nor an adjunct to bed management, but must instead be part of a therapeutic process whereby the patient begins to re-engage with life in the community

31 .5 Leave should normally be for short durations of up to seven days. However, the Responsible Clinician may consider granting longer-term periods of leave provided that consideration has been given as to the patient's suitability/eligibility to be managed in the community under the conditions of a Community Treatment Order. Being eligible/suitable for CTO conditions should not restrict the Responsible Clinician to only using this option if longer term leave is considered to be more appropriate. Though the rationale for choosing either option must be discussed with the patient and clearly recorded in their notes.

31.6 Any proposal to grant leave for patients detained on a Section of the Mental health Act 1983 that is subject to a restriction order (Section 41 or 49), has to be approved by the Ministry of Justice. This process can take some time and the patient cannot have leave until written approval has been given. The Responsible Clinician must ensure they complete the Section for restricted patients in the Section 17 form and a copy of the letter of authorisation is kept in the patients notes together with the leave form.

31.7 Section 17 leave should be discussed at the multi-disciplinary team meeting (Ward Round) and form part of the patient's overall recovery process. The membership for this forum should include as a minimum the patient's Responsible Clinician (RC), the care coordinator and subject to feasibility and the patient's wishes, the patient's relatives/carers should be given an opportunity to contribute alongside with the in the decision making process.

31.8 The Responsible Clinician must record the dates and times, restrictions, terms and conditions of the leave on the patient's Section 17 leave form.

31.9 Copies of the Section 17 Leave form should be filed in the patients notes, a copy should be given to the patient and any relatives/carers (where appropriate).

31.10 In the event that the patient fails to return from leave, an up-to-date description of the patient should be available in their notes. A photograph of the patient should also be included in their notes, if necessary with the patient's consent (or if the patient lacks capacity to decide whether to consent, a photograph is taken in accordance with the Mental Capacity Act (MCA)) Mental Health Act 1983 Code of Practice (2015).

31.11 The outcome of leave whether or not it went well, particular problems encountered and concerns raised or benefits achieved should be recorded in the patients' note to inform future decision making.

31.12 The Responsible Clinician (or the Secretary of State in the case of a restricted patient) may revoke the patient's leave at any time if they consider it necessary to do so in the interests of their health or safety or for the protection of other persons. The Responsible Clinician must arrange for a notice in writing revoking the leave to be served on the patient or on the person who is for the time being in charge of the patients. The reasons for recall should be fully explained to the patient and a record of the explanation included in the patients notes.

32. ABSENCE WITHOUT LEAVE – SECTION 18 AWOL

32.1 Patients subject to the Act are considered AWOL (Absent without Leave) when:-

- They leave the hospital without Section 17 leave agreement with their Responsible Clinician;
- Fail to return from Section 17 leave at the agreed time;
- Absent without permission from a place where they are required to reside as a condition of Section 17 leave;
- Fail to return to hospital when their Section 17 leave has been revoked.

32.2 Responsibility for the safe return of an individual who is AWOL rests with the detaining hospital and ultimately the Trust. Every effort must be made to locate and return the individual to the hospital safely. However, it may occur that the individual is taken into custody and returned by an Approved Mental Health Professional, Police Officer or an Officer of the Staff of the Hospital.

32.3 If the patient fails to return from leave or absents him or herself during escorted leave the Trust's Missing Persons Procedure (CLPG34) should be followed.

33. SECTION 19 – TRANSFER OF A DETAINED PATIENT (FORM H4)

33.1 The Act makes provision for the transfer of detained patients between different hospitals, across borders within the UK and outside of the UK. The rules relating to transfers differ on the Section a person is detained under. If a person is transferred under the Act the power and responsibility to detain them is transferred to the new Hospital.

33.2 Who can be transferred?

- People on short-term Sections such as Section 4 and Section 5(2) **cannot be transferred;**
- People on Section 135(1) Section 136 can be transferred to other places of safety during the 24 hour assessment period;
- People on longer term Sections such as Section 2, Section 3 and Section 37 can be transferred by the hospital detaining them;
- People on Guardianship and Community Treatment Orders can be transferred to other areas. For Community Treatment Orders, the responsibility for the person can be transferred to another hospital (NHS Trust or other body) and for Guardianship a new Guardian can be appointed;
- People on Court Remand Orders such as Section 35, Section 36 and Section 38 would require permission from the Court that made the order prior to transfer;
- People on Forensic Restricted Sections such as Section 37/41, Section 47/49 and Section 48/49 require the consent of the Secretary of State in order to transfer them.

The Mental Health Act Office must be informed of any transfer of patients both internally and externally from the Trust. It is understood that transfers to other hospitals may have to take place urgently due to bed pressures and sometimes outside normal working hours, including weekends. Where at all possible the Mental Health Act Office should be advised of the transfer in advance so that copies of the paperwork can be sent to the receiving hospital. This process will aid the smooth transfer of the patent and address any potential discrepancies, which can be rectified prior to the transfer.

33.3 **Transfers between Places of Safety – Section 135(1) and Section 136**

During the 24 hour assessment period, a person can be transferred to one or more places of safety. This transfer can be carried out by either a police officer, Approved Mental Health Professional or anyone authorised by these two. The Code of Practice is quite specific in relation to transfers between places of safety:-

'*Unless it is an emergency, a person should not be transferred without the agreement of an AMHP, a doctor or another healthcare professional who is competent to assess whether the transfer would put the person's health or safety or that of other people at risk. Someone with the authority to affect a transfer should proceed by agreement wherever possible. It is for those professionals to decide whether they first need to see the person personally'. COP 16.57*

'A person should never be moved from one place of safety of another unless it has been confirmed that the new place of safety is willing and able to accept them'. COP 16.58

33.4 **Transfers within a NHS Trust**

The transfer of a patient between different hospitals of the same NHS Trust is not classed as a transfer under the Act; however the Trust requires staff to complete the 'in house' Section 19 Transfer Form. It should be noted that, Section 35, Section 36 and Section 38, Section 37/41, Section 47/49 and Section 48/49 moves should not be made without the prior permission of the Court or the Secretary of

State respectively. It is important to note that some restricted Sections are made out to a specific named ward or unit and any movement of that person, even to another ward within the same building would require the prior permission of the Secretary of State. If a restricted Section does not name a specific ward or unit and the person is going to be moved to another ward in the same building with a lower level of security, permission from the Secretary of State is required.

33.5 **Transfers within England & Wales**

Detained patients transferring to different NHS Trusts within England and Wales require Form H4 to be completed by the sending hospital together with the original Section papers. These papers should go with the transferring patient and upon arrival the receiving hospital should complete the final part of the form which authorises them to detain the patient.

33.6 **Transfers within UK Borders**

Transfers to Scotland, Northern Ireland, the Channel Islands or the Isle of Man require the additional intervention of either the Department of Health for Section 2, Section 3 and Section 37, or the Secretary of State for restricted Sections. If they agree to the transfer they can authorise the continuous detention of the person across the English or Welsh Border and allow for the conversion of the relevant Section to the equivalent legislation in the receiving country.

If a person is being transferred into England form another part of the UK, the same process would apply. For example, the Scottish Department of Health would issue the authority and on admission to Hospital in England the receiving Hospital would complete Form M1 or CTO10 for Community Treatment Orders.

33.7 **Transfers outside the UK**

The Act also provides the power to transfer a detained patient to countries outside the UK. This is used primarily to repatriate patients who do not have the right to live or remain in the UK. The power authorises the legal transfer of the patient – for example on an aeroplane, to the receiving country. Once in the receiving country, it becomes that country's responsibility to apply their own legislation.

All such transfers require the prior consent of the Mental Health Tribunal Hearing as well as authorisation by the Department of Health or the Ministry of Justice depending on the Section concerned.

34. INDEPENDENT MENTAL HEALTH ADVOCATE (IMHA)

34.1 The Independent Mental Health Advocate provides an additional safeguard to service users who are subject to the Act. They are specialist advocates who are trained specifically to work within the framework of the Act to meet the needs of individuals subject to the Act.

34.2 Patients eligible for IMHA Services are:-

- Those detained under the Act;
- Conditionally Discharged restricted individuals;
- Those subject to Guardianship;
- Those subject to Community Treatment Orders.

34.3 However it should be noted that those individuals subject to the following Sections of the Act are not eligible to access IMHA Services:-

- Section 5(4) Nurse's Holding Power;
- Section 5(2) Doctor's Holding Power;
- Section 4 Emergency Admission;
- Section 135 or Section 136 held in a Place of Safety.

35. REVIEW HEARINGS

35.1 The Associate Hospital Managers have a responsibility to hear and review cases of those individuals subject to the Act. Section 23 of the Act affords Hospital Managers the power to discharge most detained patients and all CTO service users provided that those individuals meet the criteria for discharge and it is appropriate to do so.

35.2 The Mental Health Tribunal is an independent body. Its main purpose is the review the case of detained, conditionally discharged and Community Treatment Order service users under the Act and to direct the discharge of any services users where it thinks it is appropriate to do so.

35.3 **Associate Hospital Managers Appeal Hearing**

An individual subject to particular Sections of the Act is entitled to apply via the Mental Health Act Manager/Administrator to the Hospital Managers to review their case. The Mental Health Act Manager/Administrator will contact the following individuals:-

- Responsible Clinician;
- Care Co-ordinator;
- Ward Manager;
- Patient;
- Named Nurse;
- Nearest Relative and/or Solicitor

35.4 They will advise that a Hospital Managers' Appeal is to be arranged and that professional reports must be submitted to the Associate Hospital Managers prior to the panel meeting. The Mental Health Act Manager/Administrator arranges a suitable time/date/venue for the hearing and informs all parties, including the nominated Associate Hospital Managers the arrangements.

35.5 **Renewal Hearing**

The Mental Health Act Manager/Administrator on receipt of the H5/CTO7 from the Responsible Clinician will initiate and co-ordinate the Renewal Hearing. The Mental Health Act Manager/Administrator will contact the following individuals:-

- Responsible Clinician;
- Care Co-ordinator;
- Ward Manager;
- Patient;
- Named Nurse;
- Nearest Relative and/ or Solicitor

35.6 They will advise that the Responsible Clinician intends to renew the individual's Section and that professional reports will be required for submission to the Associate Hospital Manager's Panel. The Mental Health Act Manager/Administrator arranges a suitable time/date/venue for the hearing and informs all parties, including the nominated Associate Hospital Managers of the arrangements.

35.7 On occasions 'Paper Reviews' will take place for Uncontested Renewal Hearings. The decision to complete a Paper Review will be predicated on whether:-

- The Mental Health Act Manager/Administrator has received the Contested/Uncontested form completed by the patient to indicate if they wish to contest the renewal
- If there is any doubt that the patient lacks the capacity to make this decision then a capacity statement from either the Responsible Clinician or the Care Co-ordinator that indicates that in their opinion the patient has the capacity to decide that they neither wish to contest or attend, nor avail themselves of legal support at their Renewal Hearing or not;
- Have a written request for a Paper Review from the patient's solicitor.
- If a patient has had two consecutive uncontested hearings and the patient requests a further uncontested hearing, this will be a full hearing with all professionals in attendance

35.8 The nearest relative can request the discharge of their nearest relative from detention this is called a Baring Hearing.

35.9 The nearest relative will need to put their request in writing to the Mental Health Act office, they are the only persons authorised by the Trust to receive such a requested.

35.10 If the RC bars the discharge a Managers Hearing will be held as per the above processes.

35.11 **Mental Health Tribunal**

An individual subject to some Sections of the Act can apply for a Mental Health Tribunal. The Tribunal will make all the arrangements for the Hearing to be heard. However, the Mental Health Act Manager/Administrator will liaise with:-

- Responsible Clinician;
- Care Co-ordinator;
- Ward Manager;
- Nearest Relative and/or solicitor.

35.12 The Mental Health Act Manager/Administrator will ensure that they submit professional reports and are made aware of the time/date/venue of the forthcoming Hearing.

35.13 **Automatic Referral to the Tribunal**

If an individual subject to those parts of the Act do not apply to the Tribunal within the detained period themselves, the Trust is obliged to refer them. These Sections would typically be:-

- Section 3;
- Section 37;
- Section 17 A – Community Treatment Order.

35.14 Referral to the Mental Health Tribunal by Hospital Managers after the first six months for service users on Section 3 who have not lodged an appeal to the Mental Health Tribunal during that period must take into account any time the individual spent detained on Section 2 within that episode and include that time in the calculation for automatic referral to the Tribunal.

35.15 Thereafter, an individual needs only to be re-referred to the Mental Health Tribunal once every 3 years if they do not apply themselves.

35.16 However if the individual is aged up to and including 17 years of age they must be re-referred on an annual basis.

35.17 **Solicitor's access to Health Care Records for the purpose of Review/Tribunal**

To assist and support a patient in the Review/Tribunal process, a provision has been made that if a solicitor with the written consent of the patient requests to see an individual's Health Records and providing the Responsible Clinician in charge of their care agrees, the solicitor can arrange with the Charge Nurse of the ward to view the Health Care Records on site.

36. SECTION 134 – WITHHOLDING POST SENT OR RECEIVED BY A DETAINED PATIENT

36.1 Hospital Managers are permitted to withhold post sent to or by a detained patient in certain circumstances. There are detailed procedures that apply and any decision to do so may be subject to review by the Care Quality Commission.

36.2 A detained patient's outgoing post may be withheld if:-

- It is addressed to a person who has stated they no longer wish to receive post from the service user;
- The service user is at a High Security Hospital and it is considered that the post is likely to cause distress to the addresses or to any other person – this does not apply to members of the Hospital staff;
- The service user is at a High Security Hospital and the post is likely to cause danger to any person.

37. NOTIFYING THE CARE QUALITY COMMISSION OF THE DEATH OF A DETAINED PATIENT

37.1 In order for the Care Quality Commission to fulfil its role and simplify matters following the death of a detained patient, Registered Providers are required to notify the CQC of death of detained patients under regulation 17 of the Care Quality Commission (Registration) Regulations 2009.

37.2 Notifications in these cases must be made by accessing the CQC Portal and reporting according, completing the patient details in the required fields.

37.3 Notify the Mental Health Act Manager/Administrator of the death of the detained patient and confirm that the death has been notified through the CQC Portal.

38. MENTAL HEALTH ACT TRAINING

Mental Health Act Training is mandatory across all qualified and un-qualified staff in the Trust. The Training is accessed via 'e learning and consists of two elearning packages, one for qualified staff and one for un-qualified staff. Completion of training is automatically tracked via the online management system as well as the Trust's Training Tracker.

Mental Health Act Training is delivered by the Mental Health Act Managers from Mental Health Act Team. Training needs are usually highlighted through results from ongoing Mental Health Act Audits, Mental Health Act Care Quality Commission visits and requests from Wards Managers to address team or individual needs. Since the onset of Covid-19, alternative ways are currently in use by providing Mental Health Act Training using Microsoft Teams, as well as providing on the spot telephone discussions with clinicians who require immediate support with their individual training needs.

39. MENTAL HEALTH ACT ACTIVITY REPORTING

Mental Health Act Activity (number of detentions) is monitored on a monthly basis in order to identify emerging trends and any anomalies and presented at the Mental Health Act Business Meeting and Mental Health Act & Safeguarding Sub-Committee. Any anomalies and emerging trends identified are further investigated 'drill down' to understand the context and circumstances; and remedial action taken as appropriate.

40. RESPONSIBLE CLINICIAN COVER DURING ANNUAL LEAVE PERIODS

All applications for annual leave by a Responsible Clinician are reviewed and authorised by the area Clinical Director who will make sure there is RC Cover for the period of leave. The approved application is sent to Trust's Medical Staffing Department. Medical Staffing will advise the Mental Health Act Administration Office of the arranged cover. The Trust is moving to an electronic platform for approving leave which will essentially follow the same pathway.

41. REFERENCES TO OTHER EXTERNAL DOCUMENTATION AND TRUST POLICIES & PROCEDURES

- Mental Health Act 1983
- The Mental Health Act Code of Practice
- Care Quality Commission Guidance Notes on the admission of Children & Adolescents to Adult Mental Health Wards and the duty to provide Age Appropriate Services. www.cqc.org.uk
- Gillick Competence – www.dh.gov.uk/en.index.htm (search under consent)
- Section 136 Policy – Joint Policy with Essex Policy – MHA20
- ECT Treatment Policy & Procedure – CLP26
- Community Treatment Order Procedural Guidelines – MHAPG30
- Missing Person Policy – CLP34
- Consent to Examination or Treatment Guidelines – CLP16
- Advance Directives Clinical Policy – CLP6
- Search Policy – CLP75
- Mental Capacity Act and Deprivation of Liberty Safeguards Policy – MCP2
- Care Programme Approach (CPA) and Non CPA Policy – CLP30
- Clinical Risk Management Policy – CLP28
- Engagement & Supportive Observation Policy – CLP8
- Policy on Joint Working between Mental Health & Learning Disability teams with Essex – CLP66
- Mental Health Act Operational Procedure
- Mental Health Act Electronic Procedure

END