East London NHS
NHS Foundation Trust

Mental health law
Supplementary policy

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Services	Applicable
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Mental Health and LD	
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Version Control Summary

Version	Date	Author	Status	Comment
1.0	20th January 2016	Guy Davis - Associate Director of Mental Health Law	Final	Sets out legal and MHA code of practice requirements not covered in other policies
1.1	17th October 2018 7th July 2019 11th September 2019	Guy Davis - Associate Director of Mental Health Law	Draft	Examples of when information might be given to patients added to Para 2.6. Examples of when information should be given to Nearest Relatives added to 2.7. Amended appendix 1 scrutiny checklist. Changed title from 'MHA Monitoring' Added paras on leave and discharge
1.2	3rd September 2020	Guy Davis - Associate Director of Mental Health Law	Final	Changed title from 'Mental Health Act' to 'Mental Health Law' Amended scheme of delegation and medical scrutiny procedure as ratified by MHL Monitoring Group 3rd August 2020

Executive Summary

- This document sets out the effect of and directs the practice of Trust staff in relation to various aspects of mental health law that are not covered in other Trust policies – Giving Information, Emergency Detention, Holding Powers, Receipt & Scrutiny of section papers, renewals of detention, extension of Community Treatment Orders, Welfare of Children in Hospital, Leave and Discharge, DoLS.

Contents

1.0 Introduction

1.1 This policy sets out some of the Trust's responsibilities in respect of the Mental Health Act, which are not already covered in other policies.

1.2 The policy should be read in accordance with the Mental Health Act 1983 ('the Act'), the Mental Health Act Code of Practice 2015 ('the Code'; notably its guiding principles which should always be considered when making any decision under the Act); associated legislation, case-law and relevant Trust policies and guidance.

2.0 Duty to give information to detained patients, community patients and Nearest Relatives (sections 132, 132A and 133, Code of Practice 4.1 - 4.48)

2.1 It is a legal requirement under section 132 (detained patients) and 132A (Community Treatment Order patients) that the Trust takes such steps as are practicable to ensure that patients understand which provision of the Act they are subject to, the effect of that provision, what rights of appeal are available and how to access an Independent Mental Health Advocate (IMHA).

2.2 The Trust's Mental Health Act Scheme of Delegation allows for Band 4 (or equivalent) and all Mental Health Law staff to undertake this duty.

2.3 As soon as practicable after commencement of detention or community treatment order, patients should be given a copy of the relevant information/rights leaflet which can be found on the intranet. At the same time, a verbal explanation should also be given, allowing the patient to ask questions and clarify anything that they do not understand. Assistive technologies, interpretive and advocacy services should be used where appropriate.

2.4 A record of the steps taken to enable the patient to understand their position should be made on the electronic patient record (i.e. in Rio there is a 'section 132 rights' form), indicating whether or not the patient fully understood the information given to them.

2.5 A record should also be made as to when the procedure will be repeated, and if the patient did not fully understand the information, what practicable steps will be taken to help the patient to understand it.

2.6 The Code at 4.29 states that a fresh explanation of the patient's rights should be considered in certain situations such as:

- the patient is considering applying to the Tribunal, or when the patient becomes eligible again to apply to the Tribunal;
- the patient requests the hospital managers to consider discharging them, or such a request is refused;
- the rules in the Act about their treatment change (e.g. because three months have passed since they were first given medication, or because they have regained capacity to consent to treatment);
- any significant change in treatment is being considered;
- there is to be a care programme approach review (or its equivalent);
- renewal of detention, or extension of CTO is being considered;
- a decision is taken to renew detention or to extend CTO;
- a decision is taken to recall a community patient or revoke a CTO; or

- a decision is taken to recall a conditionally discharged patient to hospital.

2.7 It is a legal requirement that unless the patient otherwise requests, the Nearest Relative must be given a copy of any written information that was given to the patient. The patient's views should be made known to the Mental Health Law office, so that unless the patient has requested otherwise, a letter will be sent from that office to the Nearest Relative.

2.8 Unless either the patient or Nearest Relative has requested otherwise, the Mental Health Law office must, where practicable, inform the Nearest Relative that the patient is to be discharged from detention or a Community Treatment Order. Where practicable, this should be done at least seven days prior to the date of discharge.

3.0 Emergency Admission (section 4, Code of Practice 15.11)

3.1 Section 4 allows for an application for detention to be made in cases of urgency, where the applicant can rely on just one medical recommendation rather than two which would be required for sections 2 or 3.

3.2 The Trust will monitor the use of section 4 as a means of potentially identifying increases in its usage and to address any factors that might be contributing to such increases.

4.0 Holding Powers (section 5(2) & (4), Code of Practice 18.39)

4.1 In situations where an informal in-patient is suffering from a mental disorder to such a degree that they need to be immediately restrained from leaving hospital, section 5(4) allows a Registered Mental Health or Learning Disability nurse to order the detention of a patient for up to 6 hours, until a doctor can attend to consider whether or not further detention under the Act is required. This should be recorded on statutory Form H2.

4.2 In situations where the doctor or Approved Clinician in charge, or their nominated deputy (see 'Responsible Clinician and Nominated Deputy' policy) is of the opinion that an application for detention under sections 2 or 3 ought to be made, and due to the circumstances at the time it is not practicable to assess for detention under sections 2 or 3 (i.e. the patient has been administered rapid tranquillisation), that practitioner may complete and furnish Form H1 which has the effect of giving the hospital the authority to detain the patient for up to 72 hours, for the purpose of enabling assessments for detention under sections 2 or 3 to take place.

4.3 Having taken into account the circumstances of the case, it should be clearly indicated on Form H1 as to why informal care and treatment is no longer appropriate i.e. refusal of necessary treatment, refusal of necessary stay in hospital, lack of capacity to consent to an informal stay in hospital (if that stay means the patient is deprived of their liberty). These indicators should be clearly explained.

4.4 Arrangements for assessments to consider an application under sections 2 or 3 should be put in place as soon as practicable after the H1 form is furnished. There must be no undue delay; i.e. waiting for the Consultant Psychiatrist to come on duty.

4.5 The authority to detain under section 5(2) will end if a decision is made to not make an application for the patient's detention, or the doctor or approved clinician in charge decides that no assessments need to be carried out. As

such it should rarely be the case, if at all, that the 72 hour period will be allowed to lapse. The date and time that authority to detain under section 5(2) came to an end should be recorded in the patient's progress notes.

4.6 Neither of the powers in section 5 can be applied to someone who is an in-patient on a Community Treatment Order; consideration will have to be given to recalling the patient under section 17E.

5.0 Scrutinising, receiving and rectifying applications for detention (sections 6 and 15, Code of Practice chapter 35)

5.1 The Trust's Scheme of Delegation (see appendix 2) sets out who is authorised to receive applications for detention on behalf of the Trust. Using the Scrutiny Checklist in appendix 1, those practitioners should check that the necessary procedures have been carried out by scrutinising the statutory documents that comprise the application for detention. Where practicable, this should be done in the presence of the Approved Mental Health Professional (AMHP) who should also provide the Trust with a copy of their outline report. Important as those checks are, the process should never prevent, delay or otherwise interfere with the admission or the care and treatment needs of the patient.

5.2 The statutory documents should be placed in the designated 'Mental Health Law' box on the ward for collection by, or delivered to the Mental Health Law office staff.

5.3 The Mental Health Law office will then carry out further scrutiny of the documents and arrange for any necessary rectifications to be made.

5.4 In examining the medical grounds for detention on the recommendations, consideration should be given as to whether or not there is sufficient reasoning regarding the statutory criteria, to support the conclusions stated on the form.

5.5 If the written reasons on one of the medical recommendations are considered to be insufficient, the Mental Health Law team shall take the necessary steps to rectify matters, which may include seeking to obtain a fresh medical recommendation. If both recommendations are considered to be insufficient, the detention may need to be discharged and steps taken to obtain a fresh application if necessary.

5.6 In all cases where there is doubt about the authority to detain, the Mental Health Law office should escalate the matter to their line manager who should in turn seek advice from the Associate Director of Mental Health Law or Lead Nurse in Mental Health Law, to enable a final decision to be made.

6.0 Renewal of authority to detain and extension of Community Treatment Orders (sections 20 and 20A, Code of Practice chapter 32)

6.1 Responsible Clinicians should ensure that the on-going need for compulsory powers (detention or Community Treatment Order) is routinely reviewed and documented, especially where the authority is about to expire, so that compulsory powers are not in place unnecessarily.

6.2 If compulsory powers are to continue beyond the expiry of the original authority, the Responsible Clinician should carry out an examination of the patient within the statutory two month period prior to expiry.

6.3 If the Responsible Clinician submits a report renewing detention or extending a Community Treatment Order, this will allow a review by the Hospital Managers to take place (see 'Hospital Managers Power of Discharge' policy and associated guidance).

6.4 Prior to potential renewal of detention, the Responsible Clinician must consult at least one person who has been professionally concerned with the patient's medical treatment (as defined in section 145), and a professional not from the same profession as the Responsible Clinician (could be registered nurse, occupational therapist, social worker, psychologist, doctor etc) concerned with the patient's medical treatment who must agree by indicating in Part 2 of Form H5, that the conditions for renewal as set out in section 20(4), are met.

6.5 Prior to potential extension of a Community Treatment Order, the Responsible Clinician must obtain the written agreement of an AMHP (by way of Part 2 of Form CTO7), that the conditions for extension as set out in section 20A(6), are met. The Responsible Clinician must also consult with at least one person who has been professionally concerned with the patient's medical treatment (should not be the AMHP described above and must not be someone from the same profession as the Responsible Clinician, but possibly a registered nurse, occupational therapist, social worker, psychologist, doctor etc - see 32.13 of Code of Practice).

7.0 Welfare of certain children in hospital (section 116, Code of Practice 37.12)

7.1 For any child admitted to a hospital (for any reason) in the Trust who:

- Is in the care of a Local Authority by virtue of a Care Order under the Children Act 1989; or
- Is subject to the Guardianship of a local social services authority under section 7 of the Mental Health Act; or
- Has a local social services authority acting as their Nearest Relative,

the clinician in overall charge of the patient's care shall take steps to alert the relevant authority described above, of the patient's admission to hospital, so that visits by that authority can be made to the patient. The steps taken should be recorded in the electronic patient record system.

8.0 Leave of absence (section 17)

8.1 Only the Responsible Clinician may authorise leave of absence under section 17 in situations where the patient is going to exit the grounds of the hospital where they are liable to be detained (some patients may have been ordered by the court or Ministry of Justice to be detained in a particular unit, in which case the RC must authorise under section 17 if the patient is to leave the immediate unit).

8.2 Section 17 allows for conditions to be attached to the authorisation such as the patient remaining in the custody of a member(s) of staff, leave for certain periods of time or for specific events.

8.3 If leave is going to be granted for a period of more than seven days, the RC is required to consider the need for the use of a Community Treatment Order.

8.4 All of the above should be recorded on the relevant Trust form.

8.5 If a patient who is on leave contacts the hospital to ask for permission to extend their leave or explain that they will be late in returning, the matter must immediately be referred to the RC (the covering or on-call consultant psychiatrist if the usual RC is not available – see Responsible Clinician and Nominated Deputy policy).

9.0 Discharge from detention or Community Treatment Order by Responsible Clinician (section 23)

9.1 If the Responsible Clinician decides that compulsory powers are no longer required, they should order discharge in writing (this is the point at which discharge takes effect) by completing the Trust's section 23 discharge form which must be sent to the Mental Health Law office, a copy having being given to the patient where practicable.

9.2 The Mental Health Law office must inform the nearest relative unless the patient has stated that they do not want that to happen.

10.0 Discharge from detention or Community Treatment Order by Nearest Relative (section 23)

10.1 A patient's nearest relative has the power to give notice of order to discharge whilst the patient is detained under sections 2, 3 or 4, or subject to a community treatment order under section 17A.

10.2 Section 25 sets out the restrictions of this power and the related requirements of it are as follows:

a) The nearest relative must give not less than 72 hours notice before the order takes effect and the notice must either be furnished to someone authorised to receive it, or sent through the post to be received by the hospital, at which point the 72 hour notice period begins.

b) During this time, the notice must be handed/sent to the Responsible Clinician immediately; it must not be put in the internal mail or simply left in the clinical area. The Responsible Clinician should then consider whether or not, if the patient were to be released from hospital, he/she would be likely to act in a manner dangerous to other people or himself/herself. This is the only time that the word 'danger' appears in the Act and implies that there is a much higher threshold for continuing detention or use of CTO than the criteria which is set out for commencing those powers in the first place.

c) If the Responsible Clinician is of the opinion that the 'dangerous' threshold is not met, the order for discharge can take effect once the 72 hour period is reached and the patient should be released if still in hospital.

d) If the Responsible Clinician is of the opinion that the 'dangerous' threshold is met, statutory form M2 must be completed by that clinician and furnished to a member of staff prior to the ending of the 72 hour period. The form should be forwarded immediately to the Mental Health Law office. The nearest relative cannot make any further order for discharge within 6 calendar months, irrespective of any breaks in compulsory powers or change of identity of nearest relative.

Appendix 1

Scrutiny Checklist

Patients Name:	
Section and Start Date:	
Ward:	
Patient objects to rights information being given to nearest relative	YES / NO

(Provide comments overleaf if necessary)

	Yes	No	N/A
If 'no' on any of these, the application should not be accepted			
All the correct forms have been used for the correct section.			
Application and both medical recommendations are signed.			
To the best of your knowledge (no further checks required), the forms are completed by someone qualified to do so.			
Patient was admitted to the hospital stated on the application.			
Patient was admitted to hospital within 14 days of the second medical examination (Re s.4 within 24 hrs of med exam).			
Both section 3 medical recommendations indicate admission to the same hospital that the application is made out to (If neither do, do not accept. If one does, accept and Mental Health Law will rectify).			
Medical recommendations were made out on or before the application date.			
Application was made within 14 days of the AMHP seeing the patient (24 hours re s.4).			
To the best of your knowledge (no further checks required), there is no conflict of interest between the assessors or between any of the assessors, the patient or their nearest relative.			
If 'no' on any of these, accept and they may be rectified			
The patients name and address is the same on all forms.			
The hospital name and address is generally correct.			
If the two medical examinations were conducted separately, there was no more than 5 clear days between them e.g. [date of 1st examination] [① ② ③ ④ ⑤ days] + [date of 2nd examination] = OK			
At least one of the doctors is section 12 approved (not required for s.4).			
If neither doctor had previous acquaintance with the patient, the AMHP has stated the reasons for this.			
The AMHP has indicated the outcome of their requirement to inform/consult with the Nearest Relative.			
There is a copy of the AMHP report with the section papers.			
If the patient was transferred in from an external provider, Part 1 of Form H4 states the correct receiving hospital and is signed.			

SIGNED……. NAME……..

JOB TITLE…….. DATE…….

Appendix 2

MENTAL HEALTH LAW SCHEME OF DELEGATION

	FUNCTION	PRIMARY/SECONDARY LEGISLATION REFERENCE (or other as indicated)	CODE OF PRACTICE REFERENCE (or other as indicated)	AUTHORISED PERSON(S)
1	Hospital Managers authority to detain and exercise compulsory powers in the community	MHA sections 6(2), 17A, 35, 36, 40, 45B, 135 and 136	Chapter 37	The Trust as exercised by its staff
2	Receipt and scrutiny of statutory documents	MHA sections 11 and 15 Regulations 3 and 4	Chapter 35	All Mental Health Law staff and any clinical staff at Band 4 or above (or equivalent) who have completed in-house 'Receipt & Scrutiny' training
3	Scrutiny of medical grounds for detention	MHA section 15(2)	Chapter 35	All Mental Health Law staff and s.12 approved doctors other than the patient's Responsible Clinician or the doctor who made the medical recommendation
4	Arrangements for rectification of applications and recommendations	MHA section 15	Chapter 35	Mental Health Law staff
5	Receipt of Nearest Relative orders for discharge under section 23	MHA section 25 Regulation 25	Chapter 32	All Mental Health Law staff and any clinical staff at Band 4 or above (or equivalent) who have completed 'Overview of MHA' training.
6	Restrictions on discharge by nearest relative	MHA section 25	Chapter 32	Responsible Clinician report to be furnished to Mental Health Law staff

7	Request for social circumstances report from social services following receipt of an application for detention made by the Nearest Relative.	MHA section 14	Chapter 37	Mental Health Law staff
8	Deciding if, when and where a Hospital Managers Review should take place	N/A	Chapter 38	Mental Health Law staff
9	Hospital Managers power to discharge from compulsory powers	MHA Section 23(2)(a)	Chapter 38	Non-executive directors and appointed Associate Hospital Managers
10	Duty of Hospital Managers to give information to patients subject to compulsory powers	MHA sections 20(3), 20A(5) and 132	Chapter 4	All Mental Health Law staff and any clinical staff at Band 4 or above (or equivalent) who have completed 'Overview of MHA' training.
11	Duty of Hospital Managers to give information to patient's nearest relative	MHA sections 25(2), 132(4) and133	Chapter 4	Mental Health Law staff
12	Medical practitioner/approved clinician 'nominated deputy' power under section 5(2)	MHA section 5(3)	Chapter 18	Duty doctor as per duty doctor rota or as otherwise set out in writing.
13	Return of patients who are absent without leave (AWOL)	MHA section 18	Chapter 28	Any member of staff of the Trust or any other person authorised in writing by the Hospital Managers[1]
14	Transfer of authority to detain/exercise compulsory powers in the community	MHA sections 19 and 19A Regulations 7, 8, 9 and 10	Chapter 37	Mental Health Law staff and staff at Band 6 or above (or equivalent) who have attended

[1] For written authorisation purposes, the Scheme of Delegation directs that this function can be exercised by a Service Director, the patient's Responsible Clinician or anyone delegated by a Service Director or the Responsible Clinician.

				the relevant Trust training
15	Conveyance to Hospital on recall, transfer or other reasons	MHA sections 17C or 19 Regulations 11 and 12	Chapter 17	Any member of staff of the Trust or any person authorised in writing by the Hospital Managers (see AWOL above)
16	Record of detained patients moving within United Kingdom to England and Wales	MHA Part VI Regulations 15 and 16	N/A	Mental Health Law staff
17	Record of Renewal of compulsory powers	MHA sections 20, 20A and 21B Regulation 13	N/A	Mental Health Law staff
18	Evidence of admission arrangements	MHA sections 35(4), 36(3), 37(4), 38(4), 44(2) and 45A(5)	N/A	Evidence from the assigned Approved Clinician or another person authorised by that Approved Clinician.
19	Duty to refer cases to First Tier Tribunal (Mental Health), or requesting references to be made by the Secretary of State	MHA sections 67, 68 and 71	Chapters 12 and 37	Mental Health Law staff
20	Sending reports to First Tier Tribunal (Mental Health)	Rule 32 of Tribunal Procedure (First-tier Tribunal) (Health, Education and Social Care Chamber) Rules 2008	Chapter 12	Mental Health Law staff
21	Completion of Statement of Information for First Tier Tribunal (Mental Health)	Rule 32 of Tribunal Procedure (First-tier Tribunal) (Health, Education and Social Care Chamber) Rules 2008. First Tier Tribunal (Mental Health) Practice Direction 2012	Chapter 12	Mental Health Law staff
22	Completion of Responsible Clinician Report for First Tier Tribunal (Mental Health)	Rule 32 of Tribunal Procedure (First-tier Tribunal) (Health,	Chapter 12	Responsible Clinician or other clinician delegated by the

		Education and Social Care Chamber) Rules 2008. First Tier Tribunal (Mental Health) Practice Direction 2012		Responsible Clinician
23	Completion of Social Circumstances Report for First Tier Tribunal (Mental Health)	Rule 32 of Tribunal Procedure (First-tier Tribunal) (Health, Education and Social Care Chamber) Rules 2008. First Tier Tribunal (Mental Health) Practice Direction 2012	Chapter 12	Care Co-ordinator, Social Worker or other practitioner delegated by the care co-ordinator or relevant Team Manager
24	Completion of Nursing Report for First Tier Tribunal (Mental Health)	Rule 32 of Tribunal Procedure (First-tier Tribunal) (Health, Education and Social Care Chamber) Rules 2008. First Tier Tribunal (Mental Health) Practice Direction 2012	Chapter 12	Registered Nurse (Mental Health or Learning Disability) as delegated by Team Manager
25	Withholding Correspondence of Patients	MHA Section 134	Chapters 4 and 37	Staff at Band 6 or above (or equivalent)
26	Hospital Managers duty to give information to victims regarding unrestricted Part III patients	Domestic Violence, Crime and Victims Act 2004	Chapter 37	Responsible Clinician
27	Hospital Managers duty to ensure that in-patients under the age of eighteen (detained and informal) are accommodated in a suitable environment.	MHA Section 131A	Chapter 19	Senior clinician with knowledge and experience of cases involving patients under the age of eighteen who suffer with mental disorders
28	Duty on the NHS body to instruct an independent mental capacity advocate if serious medical treatment is prescribed and P who lacks capacity has no other person to consult	MCA Section 37		Consultant in charge of relevant care or treatment

29	Duty on the NHS body to instruct an independent mental capacity advocate if it is proposed to move P to a hospital or care home for a period likely to exceed 28 days and P who lacks capacity has no other person to consult	MCA Section 38		Consultant in charge of relevant care or treatment
30	Duty on the managing authority to alert the supervisory body for the purposes of appointing an independent mental capacity advocate when P is subject to SchA1 safeguards and there is no person to consult regarding best interests	MCA Section 39A-D		Ward manager
31	Duty on the managing authority to request a standard authorisation to deprive P of his liberty if P meets qualifying requirements	MCA Schedule A1 para 24)		Clinician with knowledge and experience of deprivation of liberty safeguards
32	Duty on the managing authority to request a fresh standard authorisation if there is one in force but there has been a change of the place of detention or circumstances	MCA Schedule A1 paras 25-30		Clinician with knowledge and experience of deprivation of liberty safeguards
33	Duty on the managing authority to keep written records of requests for standard authorisation to the supervisory body	MCA Schedule A1 para 32		Lead Nurse in Mental Health Law
34	Duty on the managing authority to give P information about the effects of an authorisation	MCA Schedule A1 para 59		Registered Nurse (Mental Health or Learning Disability) as delegated by Team Manager
35	Duty on the managing authority to give itself an urgent authorisation in relevant cases and make a request for extension of duration	MCA Schedule A1 paras 76 & 84		Clinician with knowledge and experience of deprivation of liberty safeguards

36	Duty on the managing authority to keep written records of urgent authorisations and provide a copy to the supervisory body and P or any S39A IMCA	MCA Schedule A1 para 82		Lead Nurse in Mental Health Law
37	Duty on the managing authority to give RPRinformation about the effects of an authorisation	MCA Schedule A1 para 83		Registered Nurse (Mental Health or Learning Disability) as delegated by Team Manager
38	Duty on the managing authority to give notice to the supervisory body that they are satisfied that P has ceased to meet the eligibility requirement or one or more of the qualifying requirements for P's existing standard authorisation are reviewable	MCA Schedule A1 paras 91(3) & 103(2)		Clinician with knowledge and experience of deprivation of liberty safeguards
39	Ensuring that required mental health law policies and procedures are in place, reviewed and updated.			Associate Director of Mental Health Law