

## TRUST-WIDE CLINICAL POLICY DOCUMENT

# OVER-ARCHING POLICY AND PROCEDURE OF THE MENTAL HEALTH ACT 1983

Policy Number:	MH01
Scope of this Document:	All Staff
Recommending Committee:	Patient Safety Committee
Approved by:	Executive Medical Director
Date Ratified:	July 2020
Next Review Date (by):	February 2023
Version Number:	2020 – Version 5
Lead Executive Director:	Executive Medical Director
Lead Author(s):	Mental Health Legislation Lead

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2020 – Version 5

*Striving for perfect care  
and a just culture*

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# OVER-ARCHING POLICY AND PROCEDURE OF THE MENTAL HEALTH ACT 1983

### Further information about this document:

Document name	<b>Over-Arching Policy and Procedure of the Mental Health Act 1983 (MH01)</b>
Document summary	<p>The objectives of this policy are to describe the standards expected and the supporting processes for</p> <ol style="list-style-type: none"> <li>1 Clinical and administrative application of the Mental Health Act 1983 (MHA).</li> <li>2 Describing the interface processes that exist between the Mental Health Act 1983, the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards.</li> <li>3 Monitoring the clinical and administrative application of the MHA.</li> <li>4 Supporting those applying or monitoring the MHA through cross-referencing with the Act's Code of Practice and other relevant literature, documentation.</li> <li>5 Review and monitoring of the above process.</li> </ol>
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Published by Copies of this document are available from the Author(s) and via the trust's website	<p style="text-align: right;"><b>Mersey Care NHS Foundation Trust</b> V7 Building Kings Business Park Prescot Merseyside L34 1PJ Trust's Website <a href="http://www.merseycare.nhs.uk">www.merseycare.nhs.uk</a></p>
To be read in conjunction with	<p>Ref: MC01: Over-arching Policy and procedure of the Mental Capacity Act 2005 Ref MC04: Policy and Procedure for the DManagement of the Deprivation of Liberty Safeguards (DoLS) within the meaning of the Mental Capacity Act 2005 Ref MH16: Inter-agency policy and procedure for Section 136 Ref MH20: Mental Health Act Managers' Policy Ref SDG3: Section 117 – Aftercare under the Mental Health Act 1983 Ref SD50: Victim's Rights Ref: SD02: Policy and Procedure following the Death of a Service User</p>

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### Version Control:

		Version History:
Version 1	Circulated to clinical staff and administrative staff working within the framework of the Mental Health Act  Presented to the Executive Committee for Approval	December 2013
Version 2	Presented to the Executive Committee for Approval	November 2015
Version 3	Presented to the Executive Committee for Approval	May 2016
Version 4	Circulated to MHA/MCA leads for the Calderstones Site and Liverpool Community Health Trust  To be approved by the Executive Lead following minor amendments that do not alter the content or meaning of the policy.	March 2017
Version 5	Updated as per Policy Review due February 2020. Approved by the Executive Medical Director	July 2020

## SUPPORTING STATEMENTS

this document should be read in conjunction with the following statements:

### SAFEGUARDING IS EVERYBODY'S BUSINESS

All Mersey Care NHS Foundation Trust employees have a statutory duty to safeguard and promote the welfare of children and adults, including:

- being alert to the possibility of child / adult abuse and neglect through their observation of abuse, or by professional judgement made as a result of information gathered about the child / adult;
- knowing how to deal with a disclosure or allegation of child /adult abuse;
- undertaking training as appropriate for their role and keeping themselves updated;
- being aware of and following the local policies and procedures they need to follow if they have a child / adult concern;
- ensuring appropriate advice and support is accessed either from managers, *Safeguarding Ambassadors* or the trust's safeguarding team;
- participating in multi-agency working to safeguard the child or adult (if appropriate to your role);
- ensuring contemporaneous records are kept at all times and record keeping is in strict adherence to Mersey Care NHS Foundation Trust policy and procedures and professional guidelines. Roles, responsibilities and accountabilities, will differ depending on the post you hold within the organisation;
- ensuring that all staff and their managers discuss and record any safeguarding issues that arise at each supervision session

### EQUALITY AND HUMAN RIGHTS

Mersey Care NHS Foundation Trust recognises that some sections of society experience prejudice and discrimination. The Equality Act 2010 specifically recognises the *protected characteristics* of age, disability, sex, race, religion and belief (or lack thereof), sexual orientation, gender reassignment, pregnancy and maternity and marital and civil partnership status. The Equality Act also requires regard to socio-economic factors.

The trust is committed to promoting and advancing equality and removing and reducing discrimination and harassment and fostering good relations between people that hold a protected characteristic and those that do not both in the provision of services and in our role as a major employer. The trust believes that all people have the right to be treated with dignity and respect and is committed to the elimination of unfair and unlawful discriminatory practices.

Mersey Care NHS Foundation Trust also is aware of its legal duties under the Human Rights Act 1998. Section 6 of the Human Rights Act requires all public authorities to uphold and promote Human Rights in everything they do. It is unlawful for a public authority to perform any act which contravenes the Human Rights Act.

Mersey Care NHS Foundation Trust is committed to carrying out its functions and service delivery in line the with a Human Rights based approach and the FREDA principles of **F**airness, **R**espect, **E**quality **D**ignity, and **A**utonomy

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## **1. PURPOSE AND RATIONALE**

- 1.1 The rationale for developing this policy and procedure is, essentially, to assist in enabling Trust personnel to use and comply with the Mental Health Act 1983, its Code of Practice and to manage its interaction between associated legislation, particularly the Mental Capacity Act 2005.

## **2. OUTCOME FOCUSED AIMS AND OBJECTIVES**

- 2.1 The aims of this policy and procedure are to describe the standards expected and the supporting processes for:
- (a) the clinical and administrative application of the Mental Health Act 1983;
  - (b) describing the interface processes that exist between the Mental Health Act 1983, the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguard;
  - (c) the monitoring of the clinical and administrative application of the Mental Health Act 1983;
  - (d) supporting those applying or monitoring the Mental Health Act 1983
  - (e) review and monitoring of the above process.

## **3. SCOPE**

- 3.1 This corporate policy and procedure applies in part and/or whole to:
- (a) all patients who are detained in hospital under the Mental Health Act 1983;
  - (b) all patients who have given their informed consent to in-patient hospital admission for assessment, care and/or treatment of mental disorder;
  - (c) all patients who are in receipt of supervised community treatment within the meaning of the Mental Health Act 1983;
  - (d) all patients who are in receipt of section 117 Aftercare;
  - (e) the Nearest Relative (within the meaning of the Mental Health Act 1983) of any patient identified in section 3.1, a-d above;
  - (f) the Trust's Mental Health Act Managers (Hospital Managers);
  - (g) all staff working with the patient group identified in section 3.1, a-d above and their respective Nearest Relative;
  - (h) the Trust's Mental Health Law Administrators;
  - (i) the Trust's Legal Team.

## 4. DEFINITIONS

### 4.1 Key Words and Phrases

For a full list of definitions please refer to Glossary of Terms below:

Phrase or Term	Definition and Explanation
(the) Act	In this document, unless specifically stated this will always refer to the Mental Health Act 1983
Absent Without Leave (AWOL)	Sometimes referred to as <i>Absent Without Authority</i> . The term applies to:- <ol style="list-style-type: none"> <li>1. A detained patient who leaves hospital without getting permission</li> <li>2. A detained patient who fails to return from prescribed section 17 leave of absence</li> <li>3. A patient placed in receipt of Guardianship who leaves the accommodation where the Guardian has said they should live</li> <li>4. A patient in receipt of Supervised Community Treatment who fails to return to hospital when <b>Recalled</b> (or leaves hospital without permission during a period of <b>Recall</b>)</li> <li>5. A <b>Restricted</b> Patient who has been conditionally discharged but fails to return to hospital when <b>Recalled</b> (or leaves hospital without permission during a period of <b>Recall</b>).</li> </ol>
Advance Decision	A decision under the <b>Mental Capacity Act 2005</b> to refuse specified treatment made in advance by a person who has capacity to do so. This decision will apply at a point in the future should that person subsequently lack the capacity to refuse the specified treatment in question.
Advocacy	Independent help and support with understanding issues and assistance in putting forward one's views, feelings and ideas (See also <b>Independent Mental Capacity Advocate</b> and <b>Independent Mental Health Advocate</b> )
Aftercare	Community care services following discharge from hospital; especially the duty of health and social services to provide aftercare under section 117 of the Mental Health Act 1983 for those people discharged from a care and treatment detention order made under that Act. The section 117 duty applies to:- <ol style="list-style-type: none"> <li>1. Patients in receipt of <i>Supervised Community Treatment</i></li> <li>2. <i>Restricted Patients</i> who are in receipt of <i>Conditional Discharge</i></li> <li>3. Patients who have been given full discharge from hospital</li> </ol>
Application for detention	An application made by an <b>approved mental health professional</b> , or a <b>nearest relative</b> , under <b>Part 2 of the Act</b> for a <b>patient</b> to be detained in a hospital either for <b>assessment</b> or for <b>medical treatment</b> .  Applications may be made under section 2 (application for admission for assessment), section 3 (application for admission for medical treatment) or section 4 (emergency application for admission for assessment).
Appropriate medical treatment	<b>Medical treatment for mental disorder</b> which is appropriate taking into account the nature and degree of the person's <b>mental disorder</b> .
Appropriate medical treatment test	The requirement in some of the <b>criteria for detention</b> , and in the <b>criteria for SCT</b> , that <b>appropriate medical treatment</b> must be available for the <b>patient</b> .

Approved clinician	A mental health professional approved by the <b>Secretary of State</b> (or the <b>Welsh Ministers</b> ) to act as an approved clinician for the purposes of <b>the Act</b> . Some decisions under the Act can only be taken by people who are approved clinicians. All <b>responsible clinicians</b> must be approved clinicians.
Approved mental health professional (AMHP)	A social worker or other professional approved by a <b>local social services authority (LSSA)</b> to carry out a variety of functions under <b>the Act</b> .
Assessment	Examining a <b>patient</b> to establish whether the patient has a <b>mental disorder</b> and, if they do, what treatment and care they need. It is also used to mean examining or interviewing a patient to decide whether an <b>application for detention</b> or a <b>guardianship application</b> should be made.
Attorney	Someone appointed under the <b>Mental Capacity Act</b> who has the legal right to make decisions (eg decisions about treatment) within the scope of their authority on behalf of the person (the donor) who made the power of attorney. Also known as a “donee of lasting power of attorney”.
Capacity	The ability to take a decision about a particular matter at the time the decision needs to be made. Some people may lack capacity to take a particular decision (eg to <b>consent</b> to treatment) because they cannot understand, retain, use or weigh the information relevant to the decision. A legal definition of lack of capacity for people aged 16 or over is set out in section 2 of the <b>Mental Capacity Act 2005</b> .  See also <b>competence to consent</b> .
Care Programme Approach (CPA)	A system of care and support for individuals with complex needs which includes an assessment, a care plan and a care co-ordinator. It is used mainly for adults in England who receive specialist mental healthcare and in some CAMHS services. There are similar systems for supporting other groups of individuals, including children and young people (Children’s Assessment Framework), older adults (Single Assessment Process) and people with learning disabilities (Person Centred Planning).
Carer	Someone who provides voluntary care by looking after and assisting a family member, friend or neighbour who requires support because of their mental health needs.
Child (and children)	A person under the age of 16.
Child and adolescent mental health services (CAMHS)	Specialist mental health services for children and adolescents. CAMHS cover all types of provision and intervention – from mental health promotion and primary prevention and specialist community-based services through to very specialist care, as provided by in-patient units for children and young people with mental illness. They are mainly composed of a multi-disciplinary workforce with specialist training in child and adolescent mental health.
Commission (Care Quality Commission)	The independent body which is responsible for monitoring the operation of the Act.
Community treatment order (CTO)	Written authorisation on a statutory form for <b>the discharge</b> of a <b>patient</b> from <b>detention</b> in hospital onto <b>supervised community treatment</b> .
Competence to consent	Similar to <b>capacity to consent</b> , but specifically about children. As well as covering a child’s inability to make particular decisions because of their mental condition, it also covers children who do not have the maturity to take the particular decision in question.
Compulsory treatment	<b>Medical treatment for mental disorder</b> given under <b>the Act</b> against the wishes of the <b>patient</b> .
Conditional discharge	The <b>discharge</b> from hospital by the <b>Secretary of State for</b>



	<b>Justice</b> or the <b>Tribunal</b> of a <b>restricted patient</b> subject to conditions. The patient remains subject to <b>recall</b> to hospital by the Secretary of State.
Conditionally discharged restricted patient	A <b>restricted patient</b> who has been given a <b>conditional discharge</b> .
Consent	Agreeing to allow someone else to do something to or for you. Particularly consent to treatment. Valid consent requires that the person has the <b>capacity</b> to make the decision (or the <b>competence to consent</b> , if a child), and they are given the information they need to make the decision, and that they are not under any duress or inappropriate pressure.
Convey (and conveyance)	Transporting a patient under the Act to hospital (or anywhere else), compulsorily if necessary.
Court of Protection	The specialist court set up under the <b>Mental Capacity Act</b> to deal with all issues relating to people who lack <b>capacity</b> to take decisions for themselves.
Criteria for detention	A set of criteria that must be met before a person can be <b>detained</b> , or remain detained, under <b>the Act</b> . The criteria are different in different sections of the Act.
Criteria for SCT (also referred to as Community Treatment Order or CTO)	A set of criteria that must be met before a person can become an <b>SCT patient</b> or remain an SCT patient.
Deprivation of liberty	A term used in Article 5 of the <b>European Convention on Human Rights (ECHR)</b> to mean the circumstances in which a person's freedom is taken away. Its meaning in practice has been developed through case law.
Deprivation of liberty safeguards	The framework of safeguards under the <b>Mental Capacity Act</b> (as amended by the Mental Health Act 2007) for people who need to be deprived of their liberty in their best interests for care or treatment to which they lack the <b>capacity to consent</b> themselves.
Deputy (or Court-appointed deputy)	A person appointed by the <b>Court of Protection</b> under section 16 of the <b>Mental Capacity Act</b> to take specified decisions on behalf of someone who lacks <b>capacity</b> to take those decisions themselves.  This is not the same thing as the <b>nominated deputy</b> sometimes appointed by the <b>doctor</b> or <b>approved clinician</b> in charge of a patient's treatment.
Detained patient	Unless otherwise stated, a patient who is <b>detained</b> in hospital under the Act, or who is liable to be detained in hospital but who is (for any reason) currently out of hospital.
Detention (and detained)	Unless otherwise stated, being held compulsorily in hospital under <b>the Act</b> for a period of <b>assessment</b> or <b>medical treatment</b> .  Sometimes referred to colloquially as "sectioning".
Detention for assessment (and detained for assessment)	The <b>detention</b> of a person in order to carry out an <b>assessment</b> . Can normally only last for a maximum of 28 days. Also known as "section 2 detention".
Detention for medical treatment (and detained for medical treatment)	The <b>detention</b> of a person in order to give them the <b>medical treatment for mental disorder</b> they need. There are various types of detention for medical treatment in <b>the Act</b> . It most often means detention as a result of an <b>application for detention</b> under section 3 of the Act. But it also includes several types of detention under <b>Part 3</b> of the Act, including <b>hospital directions</b> , <b>hospital orders</b> and <b>interim hospital orders</b> .
Discharge	Unless otherwise stated, a decision that a <b>patient</b> should no longer be subject to <b>detention</b> , <b>supervised community treatment</b> , <b>guardianship</b> or <b>conditional discharge</b> .  Discharge from detention is not the same as being discharged

	from hospital. The patient might already have left hospital on <b>leave of absence</b> , or might agree to remain in hospital as an <b>informal patient</b> .
Displacement (of nearest relative)	The provision under section 29 of <b>the Act</b> , under which the county court can order that the functions of the <b>nearest relative</b> be carried out by another person or by a <b>local social services authority</b> .
Doctor	A registered medical practitioner.
Doctor approved under Section 12	A doctor who has been approved by the <b>Secretary of State</b> (or the <b>Welsh Ministers</b> ) under the Act as having special experience in the diagnosis or treatment of mental disorder. In practice, <b>strategic health authorities</b> take these decisions on behalf of the Secretary of State in England.  Some medical recommendations and medical evidence to courts under the Act can only be made by a doctor who is approved under section 12. (Doctors who are <b>approved clinicians</b> are automatically treated as though they have been approved under section 12.)
Electro-convulsive therapy (ECT)	A form of <b>medical treatment for mental disorder</b> in which seizures are induced by passing electricity through the brain of an anaesthetised <b>patient</b> ; generally used as treatment for severe depression.
Emergency application	An <b>application for detention for assessment</b> made only one supporting <b>medical recommendation</b> in cases of urgent necessity. The patient can only be detained for a maximum of 72 hours unless a second medical recommendation is received. Also known as a "section 4 application".
European Convention on Human Rights (ECHR)	The European Convention for the Protection of Human Rights and Fundamental Freedoms. The substantive rights it guarantees are largely incorporated into UK law by the <b>Human Rights Act 1998</b>
GP	A patient's general practitioner (or "family doctor").
Guardian	See <b>guardianship</b> .
Guardianship	The appointment of a <b>guardian</b> to help and supervise patients in the community for their own welfare or to protect other people. The guardian may be either a <b>local social services authority (LSSA)</b> or someone else approved by an LSSA (a <b>private guardian</b> ).
Guardianship application	An application to a <b>local social services authority</b> by an <b>approved mental health professional</b> or a <b>nearest relative</b> for a <b>patient</b> to become subject to <b>guardianship</b> .
Guiding principles	The principles set out in <b>chapter 1</b> that have to be considered when decisions are made under the Act.
Habilitation	Equipping someone with skills and abilities they have never had. As opposed to <b>rehabilitation</b> , which means helping them recover skills and abilities they have lost.
Holding powers	The powers in section 5 of <b>the Act</b> which allow hospital in-patients to be detained temporarily so that a decision can be made about whether an <b>application for detention</b> should be made.  There are two holding powers: under section 5(2), <b>doctors</b> and <b>approved clinicians</b> can detain patients for up to 72 hours; and under section 5(4), certain nurses can detain patients for up to 6 hours.
Hospital direction	An order by the court under <b>Part 3 of the Act</b> for the <b>detention for medical treatment</b> in hospital of a <b>mentally disordered offender</b> . It is given alongside a prison sentence. Hospital directions are given under section 45A of the Act.
Hospital managers	The organisation (or individual) responsible for the operation of

	<b>the Act</b> in a particular hospital (eg an <b>NHS trust</b> , an <b>NHS foundation trust</b> or the owners of an <b>independent hospital</b> ). Hospital managers have various functions under the Act, which include the power to <b>discharge</b> a patient. In practice, most of the hospital managers' decisions are taken on their behalf by individuals (or groups of individuals) authorised by the hospital managers to do so. This can include clinical staff. Hospital managers' decisions about discharge are normally delegated to a " <b>managers' panel</b> " of three or more people.
Human Rights Act 1998	A law largely incorporating into UK law the substantive rights set out in the <b>European Convention on Human Rights</b> .
Independent hospital	A hospital which is not managed by the NHS.
Independent Mental Capacity Advocate (IMCA)	An advocate available to offer help to patients under arrangements which are specifically required to be made under the <b>Mental Capacity Act 2005</b>
Independent Mental Health Advocate (IMHA)	An advocate available to offer help to patients under arrangements which are specifically required to be made under <b>the Act</b> .
Informal patient	Someone who is being treated for a <b>mental disorder</b> and who is not <b>detained</b> under <b>the Act</b> . Also sometimes known as a "voluntary patient".
Interim hospital order	An order by a court under <b>Part 3 of the Act</b> for the <b>detention for medical treatment</b> in hospital of a <b>mentally disordered offender</b> on an interim basis, to enable the court to decide whether to make a <b>hospital order</b> or deal with the offender's case in some other way. Interim hospital orders are made under section 38 of the Act.
Leave of absence	Permission for a <b>patient</b> who is <b>detained</b> in hospital to be absent from the hospital for short periods, eg to go to the shops or spend a weekend at home, or for much longer periods. Patients remain under the powers of <b>the Act</b> when they are on leave and can be <b>recalled</b> to hospital if necessary in the interest of the patient's health or safety or for the protection of other people
Local social services authority (LSSA)	The local authority (or council) responsible for social services in a particular area of the country
Managers	See <b>hospital managers</b> .
Managers' panel	A panel of three or more people appointed to take decisions on behalf of <b>hospital managers</b> about the <b>discharge</b> of patients from <b>detention</b> or <b>supervised community treatment</b>
Medical recommendation	Normally means a recommendation provided by a <b>doctor</b> in support of an <b>application for detention</b> or a <b>guardianship application</b> .
Medical treatment	In <b>the Act</b> , this covers a wide range of services. As well as the kind of care and treatment given by <b>doctors</b> , it also includes nursing, psychological therapies, and specialist mental health <b>habilitation, rehabilitation</b> and care.
Medical treatment for mental disorder	<b>Medical treatment</b> which is for the purpose of alleviating, or preventing a worsening of, the <b>mental disorder</b> , or one or more of its symptoms or manifestations.
Mental Capacity Act	The Mental Capacity Act 2005. An Act of Parliament that governs decision-making on behalf of people who lack <b>capacity</b> , both where they lose capacity at some point in their lives, eg as a result of dementia or brain injury, and where the incapacitating condition has been present since birth.
Mental disorder	Any disorder or disability of the mind. As well as mental illnesses, it includes conditions like personality disorders, autistic spectrum disorders and <b>learning disabilities</b>
Mentally disordered offender	A person who has a <b>mental disorder</b> and who has committed a

	criminal offence.
Nearest relative	A person defined by section 26 of <b>the Act</b> who has certain rights and powers under the Act in respect of a <b>patient</b> for whom they are the nearest relative.
Nominated deputy	A <b>doctor</b> or <b>approved clinician</b> who may make a report detaining a <b>patient</b> under the <b>holding powers</b> in section 5 in the absence of the <b>doctor</b> or approved clinician who is in charge of the patient's treatment.
Part 2	The part of <b>the Act</b> which deals with <b>detention, guardianship and supervised community treatment</b> for civil (ie non-offender) patients.  Some aspects of Part 2 also apply to some patients who have been detained or made subject to guardianship by the courts or who have been transferred from prison to detention in hospital by the <b>Secretary of State for Justice</b> under <b>Part 3 of the Act</b> .
Part 3	The part of <b>the Act</b> which deals with <b>mentally disordered offenders</b> and defendants in criminal proceedings. Among other things, it allows courts to <b>detain</b> people in hospital for treatment instead of punishing them, where particular criteria are met. It also allows the <b>Secretary of State for Justice</b> to transfer people from prison to detention in hospital for treatment.
Part 4	The part of <b>the Act</b> which deals mainly with the <b>medical treatment for mental disorder of detained patients</b> (including <b>SCT patients</b> who have been <b>recalled</b> to hospital). In particular, it sets out when they can and cannot be treated for their mental disorder without their <b>consent</b> .
Part 4A	The Part of the Act which deals with the <b>medical treatment for mental disorder of SCT patients</b> when they have not been <b>recalled</b> to hospital.
Part 4A certificate	A <b>SOAD certificate</b> approving particular forms of <b>medical treatment for mental disorder</b> for an <b>SCT patient</b> .
Place of Safety	A place in which people may be temporarily detained under <b>the Act</b> .  In particular, a place to which the police may remove a person for the purpose of assessment under section 135 or 136 of the Act. (A place of safety may be a hospital, a residential care home, a police station, or any other suitable place.)
Recall (and recalled)	A requirement that a <b>patient</b> who is subject to <b>the Act</b> return to hospital. It can apply to patients who are on <b>leave of absence</b> , who are on <b>supervised community treatment</b> , or who have been given a <b>conditional discharge</b> from hospital.
Rehabilitation	See <b>habilitation</b>
Remand to hospital (and remanded to hospital)	An order by a court under <b>Part 3 of the Act</b> for the <b>detention</b> in hospital of a defendant in criminal proceedings. Remand under section 35 is for a report on the person's mental condition.  Remand under section 36 is for <b>medical treatment for mental disorder</b> .
Responsible Clinician	The <b>approved clinician</b> with overall responsibility for a patient's case.  Certain decisions (such as renewing a patient's <b>detention</b> or placing a patient on <b>supervised community treatment</b> ) can only be taken by the responsible clinician.
Restricted patient	A <b>Part 3 patient</b> who, following criminal proceedings, is made subject to a restriction order under section 41 of <b>the Act</b> , to a limitation direction under section 45A or to a restriction direction

	under section 49. The order or direction will be imposed on an offender where it appears that it is necessary to protect the public from serious harm. One of the effects of the restrictions imposed by these sections is that restricted patients cannot be given <b>leave of absence</b> or be transferred to another hospital without the consent of the <b>Secretary of State for Justice</b> , and only the <b>Tribunal</b> can discharge them without the Secretary of State's agreement. See also <b>Unrestricted Part 3 patient</b>
Revocation (and revoke)	Term used in <b>the Act</b> to describe the rescinding of a <b>community treatment order (CTO)</b> when an <b>SCT patient</b> needs further treatment in hospital under the Act. If a patient's CTO is revoked, the patient is <b>detained</b> under the powers of the Act in the same way as before the CTO was made.
SCT patient	A patient who is on <b>supervised community treatment</b>
Second opinion appointed doctor (SOAD)	An independent <b>doctor</b> appointed by the <b>Commission</b> who gives a second opinion on whether certain types of <b>medical treatment for mental disorder</b> should be given without the patient's <b>consent</b> .
Secretary of State	Cabinet ministers in the Government. In the Act, either the Secretary of State for Health or the Secretary of State for Justice, depending on the context.
Secretary of State for Health	The <b>Secretary of State</b> who is responsible, among other things, for the NHS and social services for adults. The Secretary of State for Health is supported by the Department of Health.
Secretary of State for Justice	The <b>Secretary of State</b> who is responsible, among other things, for courts, prisons, probation, criminal law and sentencing. The Secretary of State for Justice is supported by the Ministry of Justice.
Supervised community treatment (SCT) (Also referred to as Community Treatment Order – CTO)	Arrangements under which patients can be discharged from detention in hospital under <b>the Act</b> , but remain subject to the Act in the community rather than in hospital. Patients on SCT are expected to comply with conditions set out in the <b>community treatment order</b> and can be <b>recalled</b> to hospital if treatment in hospital is necessary again.
Tribunal	A judicial body which has the power to discharge patients from <b>detention, supervised community treatment, guardianship and conditional discharge</b> . At the time of publication, this means the First Tier Tribunal (Mental Health) (FTT) which was established under the Tribunals, Courts and Enforcement Act 2007 and replaced the Mental Health Review Tribunal (MHRT).
Young person	A person aged 16 or 17

## 5. DUTIES

### 5.1 Trust Board

The Trust Board has a duty to ensure that the Trust has applied for and has been registered to accept and work with anyone who is managed under the authority of the Mental Health Act 1983.

### 5.2 The Hospital Managers and the Mental Health Act Managers (MHAM)

The Hospital Managers are defined as the Trust Board and are responsible for the Trust's implementation and management of the Mental Health Act, 1983. These functions are exercised by a sub-committee of the Board (The Mental Health Act Managers) as authorised under section 23(4) of the Act.

Many of these responsibilities are formally delegated to other Trust personnel through a Scheme of Delegation ratified, up-dated and held by the Trust Board (their ref. Table C of the Scheme of Reservation and Delegation – F03)

### 5.3 **Procedural Document Author**

The document author is responsible for ensuring that it is compliant with the relevant legislation, case-law and that it is consistent with the Trust's standards for procedural document format.

### 5.4 **Accountable Directors (Divisional Directors)**

Divisional Directors\* are responsible for ensuring there are robust governance systems in place implementation and management of the Mental Health Act 1983 in their area.

\*For High Secure Service this responsibility is held by the Executive Director of High Secure Services.

### 5.5 **The Legal Services Manager; Risk Management Department; Learning and Development Team; Clinical Audit Team; Research and Development Team; Knowledge Management Team**

- 5.5.1 Trust's Legal Team will be consulted for advice and guidance in relation to mental health law (and related topics) practice.
- 5.5.2 Risk Management Department will be consulted when appropriate in consideration of any risks arising from mental health law practice.
- 5.5.3 The Learning and Development Team must be consulted to enable the identification of potential implications for staff learning and development, in relation to mental health law practice. This will include a careful consideration of the provision and method of delivery for education and development.
- 5.5.4 The Clinical Audit, Research and Knowledge Management Teams will be consulted for general advice in relation to mental health law audits, research, reports etc).

### 5.6 **Managers**

- 5.6.1 Managers are responsible for ensuring:
  - (a) that the staff for which they are responsible are aware of their responsibilities for Mental Health Act practice commensurate with their role;
  - (b) that an infrastructure is in place to support the training of all staff required for mental health law practice;
  - (c) all staff in their area have are aware of their duty to pay due regard to the Code of Practice when working within the framework of mental health law.
- 5.6.1 All staff in their area have ready access to the Code of Practice and are aware of and understand their duty to apply the 5 Guiding (Key) Principles whenever they are working within the framework of the Act.

### 5.7 **Responsible Clinicians (RCs)**

All Responsible Clinicians employed within the Trust are responsible for ensuring that their registered Approved Clinician status (within the meaning of s.34 of the Act) is up-to-date. It is unlawful for a practitioner who does not have current s.34 Approved Clinician status to practice as a Responsible Clinician.

## 5.8 **Section 12 Approved Doctors**

All section 12 Approved Doctors employed within the Trust are responsible for ensuring that their registered Approved Clinician status (within the meaning of s.12 of the Act) is up-to-date. It is unlawful for a practitioner who does not have current s.12 Approved Clinician status to carry out s.12 duties.

## 5.9 **Approved Mental Health Professionals (AMHPs)**

All AMHPs working for or on behalf of the Trust must ensure that their registration with the relevant local social services authority is current at the time they conduct AMHP duties.

## 5.10 **All staff**

5.10.1 Staff are responsible for:

- (a) Ensuring that they pay due regard to the Code of Practice when working within the framework of the Mental Health Act.
- (b) Ensuring that they apply the Code's 5 Guiding (Key) Principles when working within the framework of the Mental Health Act.
- (c) Ensuring that they keep up-to-date with mental health law practice commensurate with their role.
- (d) Ensuring that patients/service users have information about rights and treatments in a format such as easy read or Braille or a language which they request.

## 6. **PROCESS**

### 6.1 **Mental Health Act Code of Practice and Supporting Procedures**

#### 6.1.1 **Introduction (MHA Code of Practice: Paragraphs i-xix)**

6.1.1.1 Purpose and legal status of the Code of Practice  
-MHA Code of Practice: Paragraphs. I - IX

6.1.1.2 *Additional Guidance*  
Mental Health Act 1983, sections 118(1)-118(5)

6.1.1.3 Scope of the Code  
MHA Code of Practice: Paragraphs X - XI

6.1.1.4 Presentation of (the Code of Practice)  
MHA Code of Practice: Paragraphs XII - XVI

6.1.1.5 Reference Guide to the Act:  
MHA Code of Practice: Paragraphs XVII - XIX

#### 6.1.2 **References to patients, children and young people and commissioners**

6.1.2.1 MHA Code of Practice: Paragraphs XX – XXII

- 6.1.2.2 The Care Quality Commission  
MHA Code of Practice: Paragraphs XXIV – XXVII
- 6.1.2.3 What to do if you think the Code is being inappropriately applied  
MHA Code of Practice: Paragraphs xxviii – XXX
- 6.1.2.4 Safeguarding  
MHA Code of Practice: Paragraphs XXXI – XXXIV
- 6.1.2.5 Whistleblowing  
MHA Code of Practice: Paragraphs XXXV - XXXVI
- 6.1.2.6 Mental Capacity Act 2005  
MHA Code of Practice: Paragraphs XXXVII – XL
- 6.1.2.7 Care Act 2014  
MHA Code of Practice: Paragraphs XLI - XLII

### 6.1.3 **Additional Guidance**

- 6.1.3.1 All services and units working within the framework of the Mental Health Act 1983 must be able to access at least one, up-to-date copy of the **Code of Practice Mental Health Act 1983** (2015 ed) in their area. Copies can be obtained from the Trust's Legal Team.
- 6.1.3.2 All staff working within the framework of the Mental Health Act 1983 must electronically download (or must be able to download as required) the **Code of Practice Mental Health Act 1983** (2015 ed).
- 6.1.3.3 The **Code of Practice Mental Health Act 1983** (2015 ed). can be electronically accessed in the following ways:-
  1. Google: Mental Health Act Code of Practice 2015 (dh)
  2. Click on the Embedded Code of Practice icon in Appendix 1 of this Policy and Procedure
- 6.1.3.4 All earlier versions of the Code of Practice (electronic or hard copied) **must** be disposed of

## 6.2 **Guiding Principles**

MHA Code of Practice Chapter 1, paragraphs 1.1- 1.24, p 22-25

- 6.2.1 Guiding Principle No. 1 - Least restrictive option and maximising independence  
MHA Code of Practice paragraph 1.2 – 1.6
- 6.2.2 Guiding Principle No.2 - Guiding Principle No. 1 - - Empowerment and Involvement  
MHA Code of Practice paragraph 1.7 – 1.12
- 6.2.3 Guiding Principle No. 3 - Respect and Dignity  
MHA Code of Practice paragraph 1.13 – 1.14
- 6.2.4 Guiding Principle No. 4 - Purpose and effectiveness  
MHA Code of Practice paragraph 1.15 – 1.17
- 6.2.5 Guiding Principle No. 5 - Efficiency and equity  
MHA Code of Practice paragraph 1.18 – 1.21



6.2.6 Using the principles  
MHA Code of Practice paragraph 1.22 – 1.24

6.2.7 *Additional Guidance*  
Mental Health Act 1983 Sections 118(2A)-118(2C)

### 6.3 **Information and rights for patients, nearest relatives and others**

MHA Code of Practice Chapter 4, paragraphs 4.1 - 4.68, pp.36 48

6.3.1 Communication with patients MHA Code of Practice: 4.3 – 4.8

6.3.2 Information for detained patients and patients on CTOs  
(MHA Code of Practice: Paragraphs 4.9 – 4.12)

6.3.3 Information about detention and CTOS  
MHA Code of Practice Chapter 4, paragraphs 4.13 – 4.17

6.3.4 Information about recall to hospital whilst on a CTO  
MHA Code of Practice Chapter 4, paragraphs 4.18 – 4.19

6.3.5 *Additional Guidance*  
Mental Health Act 1983 Sections 132 and 132A  
Reference Guide Chapters 12 (detention) and 15 (SCT)  
Rights Leaflets:- See 8.3.3 below

6.3.6 Information about consent to treatment  
(MHA Code of Practice: paragraph 4.20)

6.3.7 Information about seeking a review of detention or CTO  
(MHA Code of Practice: Paragraphs 4.21 – 4.24)

6.3.8 Information about the CQC  
(MHA Code of Practice: Paragraphs 4.25 – 4.26)

6.3.9 *Additional Guidance relating to the CQC*  
**NB: all references to ‘the Commission’ or the Mental Health Act Commission are to be taken as being synonymous with the Care Quality Commission (CQC)**

6.3.10 Information about withholding correspondence  
(MHA Code of Practice: Paragraph 4.27, p12)

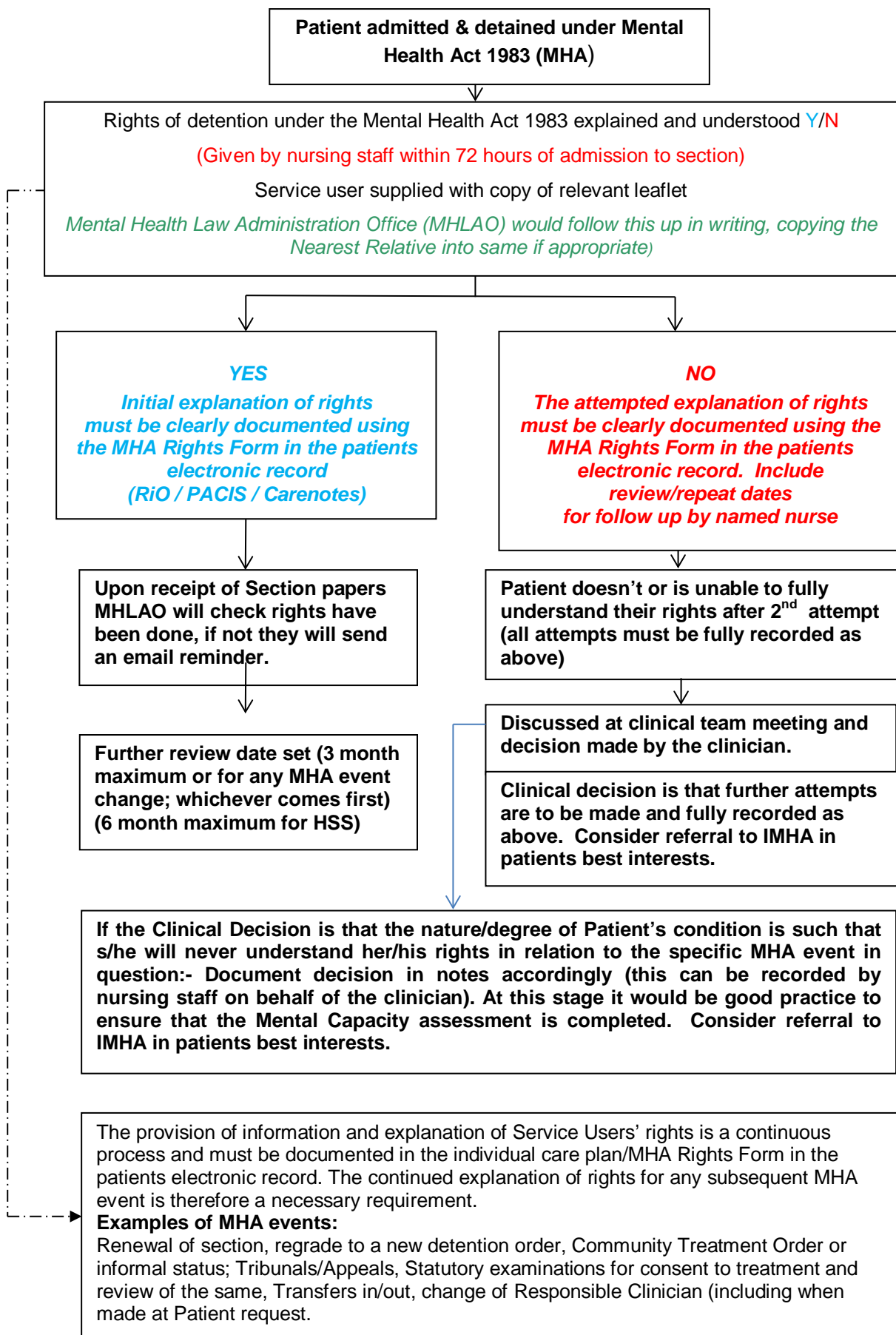
6.3.11 *Additional Guidance on withholding correspondence*  
Mental Health Act 1983: Sections 134 and 134A  
Safety & Security Directions 2011:  
Special rules apply to the Trust’s High Secure Services which are governed by statutory Safety and Security directions.

6.3.12 Keeping patients informed of their rights  
(MHA Code of Practice: Paragraphs 4.28 – 4.30, pp. 40-41)

*Additional Guidance on patient rights*  
Mental Health Act 1983: Sections 132, 132A ,133,134 and 134A

6.3.13 Mersey Care NHS Trust: Section 132 Flowchart:-

**INFORMATION TO DETAINED SERVICE USERS FLOWCHART (Section132)**



- 6.3.15 Right to Independent Mental Health Act Services  
(MHA Code of Practice: Chapter 6, paragraphs 6.1 – 6.38, pp. 54-60)
- 6.3.16 *Additional Guidance on Right to Independent Mental Health Act Services:-*
- (a) Mental Health Act 1983 Sections 130A – 130D (and Sections 130E – 130L for the provision of these services in Wales)
- (b) Mersey Care NHS Trust  
Access to Independent Mental Health Advocacy (IMHA) Services:-
- (c) High Secure Services
- POHWER Advocacy (Secure and SpLDD Division)  
Ashworth Hospital  
Parkbourn  
Liverpool L31 1HW  
Telephone: 0300 456 2363  
Email Address [pohwer@pohwer.net](mailto:pohwer@pohwer.net)  
Post PO Box 14042
- (d) All Other Services
- Advocacy Together (IMHA) Service  
Broad Oak Unit  
Broad Green Hospital Site  
Thomas Drive  
Liverpool L14 3LB  
Telephone: 0151 330 7273  
Email Address (1) [together.imha@merseycare.nhs.uk](mailto:together.imha@merseycare.nhs.uk)  
Email Address (2) [Shanna.wilksberg@merseycare.nhs.uk](mailto:Shanna.wilksberg@merseycare.nhs.uk)
- 6.3.17 Right to Independent Mental Capacity Advocacy Services  
(MHA Code of Practice: Introduction, para. XXXIX & Chapter 34, paragraph 34.12, p. 364)
- 6.3.18 *Additional Guidance on Right to Independent Mental Capacity Advocacy Services*  
Code of Practice, Chapter 10  
Mental Capacity Act Code of Practice (Chapter 10, pp.178 – 215)  
Deprivation of Liberty Safeguards Code of Practice (Chapter 7, Paragraphs 3.22-3.28; pp.36-38)
- 6.3.19 Where the person is the responsibility of either Liverpool or Sefton Clinical Commissioning Group (CCG), referrals to be sent to:-
- (a) Mersey Care NHS Trust  
Access to Independent Mental Capacity Advocacy (IMCA) Services  
(**nb.** For IMCA referrals the relevant address is the one where the person is to be assessed and therefore NOT automatically her/his home address):-
- Voiceability.org  
Toxteth Town Hall Community Resource Centre  
15 High Park Street  
Liverpool, L8 8DX
- Telephone: 0151 207 7557  
Email: [imca@voiceability.org](mailto:imca@voiceability.org)

Referrals: [liverpoolandseftonreferrals@voiceability.org](mailto:liverpoolandseftonreferrals@voiceability.org)

- (b) Where the person is the responsibility of St. Helens and Knowsley, Warrington or Halton Clinical Commissioning Group (CCG), referrals to be sent to:-

**Together**

Tel: **01744-451-531**

Email: [hkwsimca@together-uk.org](mailto:hkwsimca@together-uk.org)

Fax: **01704-759-937**

- (c) IMCA Lancashire  
Advocacy Focus  
54 Blackburn Road  
ACCRINGTON  
BB5 1LE  
T: 0300 323 0965  
Email: [admin@advocacyfocus.org.uk](mailto:admin@advocacyfocus.org.uk)  
Website: [www.advocacyfocus.org.uk](http://www.advocacyfocus.org.uk)  
Fax: 0300 323 0966
- (e) Rochdale and District Mind  
3-11 Drake Street  
ROCHDALE  
OL16 1RE  
T: 01706 752350  
Email: [imca@rochdalemind.org.uk](mailto:imca@rochdalemind.org.uk)  
Web: [www.rochdalemind.org.uk](http://www.rochdalemind.org.uk)  
Fax: 01706 353281

6.3.20 Patient Advice and Liaison Service (Mersey Care NHS Trust)  
Mental Health Act Code of Practice – No references

6.3.21 *Additional Guidance on Patient Advice and Liaison Service*  
NHS Choices

“The Patient Advice and Liaison Service (PALS) offers confidential advice, support and information on health-related matters. They provide a point of contact for patients, their families and their carers.

You can find officers from [PALS](#) in your local hospital” :-

- (a) Mersey Care NHS Trust  
Access to the Trust’s Patient and Liaison Service (PALS):-
- (b) How to contact PALS  
Telephone 0151-471-2377 or 0800 328 2941  
Email Address [PALS@merseycare.nhs.uk](mailto:PALS@merseycare.nhs.uk)
- (c) How to contact complaints  
Telephone 0151-472-4002  
Email Address [complaints@merseycare.nhs.uk](mailto:complaints@merseycare.nhs.uk)
- (d) Write to us  
PALS/Complaints Department

Mersey Care NHS Trust  
V7 Kings Business Park  
Prescot  
Liverpool L34 1PJ

- 6.3.22 Information for Nearest Relatives  
(MHA Code of Practice: Paragraphs 4.31 – 4.36, pp.41-42 See also Chapter 5, pp. 49-53) for information regarding identification of Nearest Relative, grounds for displacement and displacement process).

*Additional Guidance on Information for Nearest Relatives*  
Mental Health Act 1983 Sections 133, 134 and 134A

- 6.3.23 Involvement of Carers  
(MHA Code of Practice: Paragraphs 2.39-2.40, pp.16/17)

- 6.3.24 *Additional Guidance on Involvement for Carers*  
Mersey Care NHS Foundation Trust  
The Trust website offers a range of useful topics for carers, including:-

- (a) Are you a carer?
- (b) Become a member of Mersey Care NHS Trust
- (c) Young Carers
- (d) Confidentiality and information sharing
- (e) What is the Mental Health Act?
- (f) Finance
- (g) Diagnosis information
- (h) Tips for dealing with difficult behaviour
- (i) Popular treatments
- (j) Medication and side effects
- (k) Your own health and well being
- (l) Training and employment
- (m) Complaints, comments and suggestions
- (n) Contacts – 24 hours/day teams
- (o) Glossary of terms/who's who
- (p) Frequently asked questions

These can be accessed as follows:-

1. Go to the Trust website (eg Google Mersey Care NHS Trust)
2. From Home page click on <Information for carers>

- 6.3.25 Information for informal hospital in-patients  
(MHA Code of Practice: Paragraph 4.49 – 4.51, p.45)

- 6.3.26 *Additional Guidance on Information for Informal Hospital. In-patients managed within Mersey Care NHS Foundation Trust service:-*

- (a) All informal in-patients must be assessed for capacity to consent to hospital admission
- (b) All informal in-patients must be informed of their Mental Health Act Status (ie. Informal) at the point they become informal (this may be on admission or following regrade from detention to informal status)
- (c) An informal patient must be told that s/he has the right to leave BUT that should they wish to exercise this right staff have a duty of care to assess her/him at

that time to determine whether the grounds for detention under the Mental Health Act 1983 are satisfied.

- (d) By contrast staff are **not** authorised to tell informal patients that although they are informal if they try to leave they will be detained (this prediction of what will happen in advance of a person wanting to leave AND in the absence of any assessment being conducted at the time they wish to leave, amounts to de facto detention and is unlawful).
- (e) Informal patients need to be told that refusal of treatment is likely to amount to a refusal to consent to hospital admission and that, again such a decision may generate the need for a Mental Health Act assessment.
- (f) **NOTE** In-patients who are not detainable under the Mental Health Act 1983 but who lack the capacity to consent to informal admission are managed under the authority of the Mental Capacity Act 2005. Dependent upon the duration and intensity of restrictions placed upon this group, such patients may need to be assessed for detention under the Deprivation of Liberty Safeguards and/or Court of Protection powers. (See 8.55 below)

#### 6.3.27 Information for those placed in receipt of guardianship

(This responsibility lies with the local Social Services Authority:-See: MHA Code of Practice: Paragraph 4.52, p.45)

#### 6.3.28 Advance Decisions and Advance Statements

##### MHA Code of Practice

- (a) Chapter 9, paragraphs 9.1 – 9.23 pp.74-77

See also:-

- (b) Introduction, p-XXXIX
- (c) Paragraphs, 14.19, 14.21, 26.19, 24.19, 24.26 and 29.30

##### MCA Code of Practice

Chapter 9, pp. 158 – 177 (Advance Decisions Only)

#### 6.3.29 *Additional Guidance on Advance Decisions and Advance Statements*

- (a) Please read in conjunction with Trust Policy Reference No. SD19 Advance Statement/Advance Decision Policy
- (b) Advance Decisions are decisions made by a patient to refuse treatment.
- (c) They are binding in law except for treatments prescribed under Parts 4 and 4A of the Mental Health Act 1983.
- (d) Advance Statements are the views and wishes made by patients on all other decisions (ie. excluding decisions to refuse treatment).
- (e) Advance Statements are **not** binding in law but **must** be considered.
- (f) Any decision under the Mental Health Act 1983 which is not in accordance with an Advance Statement must be recorded, with reasons.

#### 6.3.30 The Statutory Rights of Victims Under the Mental Health Act

#### 6.3.31 MHA Code of Practice

Chapter 10 Paragraphs 10.9 – 10.21 p.80-82.

Chapter 37, paragraphs 37.34-37.36 p.380

#### 6.3.32 *Additional Guidance on Victim Rights*

The MHA Code of Practice is limited in its guidance. Additional guidance as follows:-

- (a) Rights are authorised under the Domestic Violence, Crime and Victims Act 2004 (DVCLA) and updated by the Mental Health Act 2007.
- (b) Further statutory rights have since been granted following a revision of the Mental Health Tribunal Rules in 2010
- (c) These rights apply to persons identified as victims by the Victim Liaison Officer who have asked that they be provided with the information they are entitled to in relation to...
- (d) Patients detained under sections 37, 37/41, 45A, 47, 47/49, 48, 48/49 and the Criminal Procedure (Insanity) Act 1964
- (e) Victims have a statutory right to:-
  - Submit representations to Mental Health Tribunal Hearings either directly or indirectly by a representative) [DVCLA]
  - Attend Mental Health Tribunal Hearings [Tribunal Rules]
  - Receive information about the outcome of such hearings
  - Be informed when a patient is to be discharged from hospital (but not where they are being discharged to) [DVCLA]
  - Be informed that section 17 leave of absence has been granted (but not any additional details regarding the leave) [DVCLA]
  - The patient's RC may also release additional information (for example, about leave of absence and discharge etc) if s/he thinks that to withhold such information would place person(s) at risk.

#### 6.4 **Definition of Mental Disorder: Cross-references**

##### 6.4.1 General

- (a) Mental Health Act  
Part 1, Section 1
- (b) MHA Code of Practice  
Chapter 2 Paragraphs 2.1 – 2.20, pp.-26-28

##### 6.4.2 Definition

- (a) Mental Health Act  
Part 1, Section 1(2)
- (b) MHA Code of Practice  
Paragraphs 2.4 – 3.7, pp. 26-27

##### 6.4.3 Exclusions & Exceptions to Exclusions (Alcohol & Drug Dependence)

- (a) Mental Health Act  
Part 1, Section 1(3)
- (b) MHA Code of Practice  
Paragraphs 2.9 – 2.13, p.27

##### 6.4.4 Learning Disability Qualification

- (a) Mental Health Act  
Part 1, Sections 1(2A), 1(2B) and 1(4)
- (b) MHA Code of Practice  
Paragraphs 2.14–2.18, p. 28 AND Chapter 20, paragraphs 20.1-20.49, pp.206-219

##### 6.4.5 Personality Disorders

- (a) Mental Health Act 1983 No specific reference
- (b) MHA Code of Practice  
Paragraphs 2.19 2.20 AND Chapter 21, paragraphs. 21.1-21.15, pp. 220-222

#### 6.5 **Hospital In-patient Admission: Alternatives to Compulsory Detention the Mental Health Act 1983**

- 6.5.1 Alternatives to Compulsory In-patient Detention
- (a) Mental Health Act 1983 Part X, section 131
  - (b) MHA Code of Practice Chapter 4, 14 paragraphs. 14.14 – 14.18 pp.115-116
- 6.5.2 Informal Admission
- (a) Mental Health Act 1983 Part X, section 131
  - (b) MHA Code of Practice Paragraphs 14.11 – 14.13, pp.115-116
- 6.5.3 Additional Guidance on Informal Admission (section 131 MHA)
- (a) A person who makes a mentally capable decision to consent to hospital in-patient admission for the purpose of assessment and/or treatment of mental disorder is admitted under section 131 of the Mental Health Act as an *Informal in-patient*
  - (b) The decision must be supported by a Mental Capacity Act compliant capacity assessment.
  - (c) There is no statutory documentation but it must be documented in the patient's electronic record that P has agreed to informal admission by completing the MCA Capacity Assessment Form in the relevant electronic record system. (RiO/PACIS/Carenotes)
  - (d) The patient must be informed of her/his rights on admission and must also be informed of any subsequent change to her/his Mental Health Act status.
- 6.5.4 Admission under sections 5 and 6 of the Mental Capacity Act 2005
- (a) MHA Code of Practice  
Paragraphs 14.19 – 14.25, 117-118 AND Chapter 19, pp. 168-205 (for persons under 18 years of age).
  - (b) MCA Code of Practice  
Chapters 3 – 10 and Chapter 12.
- 6.5.5 Additional Guidance for sections 5 and 6 of the Mental Capacity Act
- (a) Guidance provided within the MHA Code of Practice relating to mental capacity (and in particular, Chapters 13 & 14) take precedence over any conflicting guidance provided in both the MCA and the DoLS Codes of Practice (as it takes into account the more recent case-law).
  - (b) Where a person lacks capacity but does not object to in-patient admission, nor tries to leave once admitted, s/he may be admitted under the powers of the Mental Capacity Act 2005.
  - (c) All such patients should be assessed to ascertain whether or not the restrictions in place amount to a deprivation of liberty. (See 6.5.8 below)
  - (d) The decision must be supported by a Mental Capacity Act compliant capacity assessment.
  - (e) The patient must be informed of her/his rights on admission and must also be informed of any subsequent change to her/his Mental Health Act status.
- 6.5.6 Admission under the Deprivation of Liberty Safeguards (DoLS)
- NB: See 6.5.4 (b) above and all of 6.5.5 below**
- (a) MHA Code of Practice Paragraphs. 13.40-13.70 & 14.19-14.25)
  - (b) MCA Code of Practice Paragraphs 4.13 – 4.24, pp.28-31
  - (c) Deprivation of Liberty Safeguards Code of Practice (2008 ed)
  - (d) What are the deprivation of liberty safeguards...?  
Chapter 1, pp.9-15



- (e) What is deprivation of liberty?  
Chapter 2, pp.16-27
- (f) How and when can deprivation of liberty be applied...?  
Chapter 3, pp.28-38
- (g) What is the assessment process for a standard authorisation...?  
Chapter 4, pp.39-60
- (h) What should happen once the assessments are complete?  
Chapter 5, pp. 61-66
- (i) When can urgent authorisations of deprivation be given?  
Chapter 6, pp. 67-75
- (j) What is the role of the relevant person's representative?  
Chapter 7, pp.76-85
- (k) Review and ending of deprivation of liberty authorisations  
Chapter 8, pp.86-93
- (l) What happens if someone thinks a person is being deprived of their liberty without authorisation?  
Chapter 9, pp.94-97
- (m) What is the Court of Protection and when can people apply it?  
Chapter 10, pp.90-101
- (n) How will the safeguards be monitored?  
Chapter 11, pp.102-103
- (o) Checklists and Annexes: pp. 104-106 and 107-113 respectively
- (p) Key words and phrases used in this Code of Practice: pp.114-120

#### 6.5.6 *Additional Guidance on Admission under the Deprivation of Liberty Safeguards*

- (a) Where a person is being considered for in-patient admission under the Mental Capacity Act s/he must be assessed to determine if such in-patient admission amounts to a *restriction* or a *deprivation* of her/his liberty.
- (b) If the admission amounts to a *restriction* then the general powers of the Mental Capacity Act 2005 apply (sections 5 & 6).
- (c) BUT.. if the admission amounts to a *deprivation* then an application must be made for a Deprivation of Liberty Safeguards Order.
- (d) **NB: The criteria for establishing deprivation is driven by case law and is therefore subject to change. The Deprivation of Liberty Safeguards Code of Practice (2008ed) is therefore significantly out-dated and its guidance can no longer be relied upon. If practitioners consider that the criteria *may* apply (or are unsure if it does or not) they should contact the Trust's legal team for clarification before proceeding.**

#### 6.5.7 Mental Health Act 1983 or Mental Capacity Act 2005?

- (a) **NB: The criteria for determining which of the above Acts to use (and, in particular, where the Mental Capacity Act 2005 applies whether to use the general powers of the Deprivation of Liberty Safeguards) has changed significantly since a Supreme Court judgement has given on March 19<sup>th</sup> 2014.**
- (b) Guidance provided within the MHA Code of Practice relating to mental capacity (and in particular, Chapters 13 & 14) take precedence over any conflicting guidance provided in both the MCA and the DoLS Codes of Practice (as it takes into account the more recent case-law).

#### 6.5.8 *Guidance supporting the March 19<sup>th</sup> 2014 Supreme Court Judgement*

- (a) Any person who needs hospital in-patient admission for the purpose of assessment and/or treatment of mental disorder AND who either has capacity

- to consent to that admission but refuses OR lacks capacity to consent but objects, can **only** be admitted under the powers of the Mental Health Act 1983.
- (b) Any person who needs hospital in-patient assessment for the purpose of assessment and/or treatment of mental disorder AND lacks the capacity to consent to that admission BUT does NOT object should be admitted under the powers of the Mental Capacity Act 2005.
  - (c) If such admission amounts to a restriction of her/his liberty then the duration and intensity of that restriction will determine whether or not that person can be managed under the general powers of the Mental Capacity Act (sections 5 and 6) OR under the Deprivation of Liberty Safeguards and/or the Court of Protection.
  - (d) Where P is admitted to hospital for in-patient assessment, care and/or treatment under the Mental Capacity Act 2005, the admitting personnel must ask themselves: *if P were to leave and/or refuse treatment would s/he be prevented from leaving and/or have the treatment administered against her/his will?*
  - (e) If the answer is **YES** then P must be held under the Deprivation of Liberty Safeguards (refer to Trust Policy MC04)
  - (f) If the answer is **NO** (ie P would be allowed to leave and/or the treatment would be withheld) then P can be managed under sections 5 & 6 (general powers) of the Mental Capacity Act 2005 (refer to Trust Policy MC01)
  - (g) If, in accordance with the above, P has been placed under the Deprivation of Liberty Powers but then, subsequently, matter-of-fact does try to leave and/or refuse treatment, s/he must be assessed for detention under the Mental Health Act 1983 (and if subsequently detained under that Act, any pre-existing Deprivation of Liberty Safeguard order must either be formally suspended or terminated at that point).

#### 6.5.9 The Criminal Procedure (Insanity) Act 1964

- (a) Amended by both the Criminal Procedure (Unfitness to Plead) Act 1991 and the Domestic Violence, Crime and Victims Act 2004 this Act:- "... makes provision for persons who are found unfit to be tried, or not guilty by reason of insanity, in respect of criminal charges."
- (b) "Unfitness to plead to an indictment is not exclusively associated with mental disorder but almost invariably arises in that context. The issue only arises in Crown Court trial proceedings, though a magistrate's court has power under MHA 1983 s37(3) to make a hospital order without convicting the defendant.

##### "The Test of Unfitness

"The test to be applied is drawn from common law rather than statute, the leading case remaining R v Pritchard (1836) where the issue was posed thus;

'... whether he is of sufficient intellect to comprehend the course of proceedings on the trial, so as to make a proper defence.' (per Alderson B)

"Among relevant considerations, can the defendant understand and respond to the charge(s) and evidence against him or her, instruct his or her legal advisers and give evidence if s/he wishes?"

"A defendant may be unfit to plead even though neither 'insane' within the McNaughten rules nor suffering one of the four forms of mental disorder specified as a pre-requirement for the making of s s37 hospital order.

However, the mere fact that the defendant is incapable of acting in their best interests because of their mental condition is insufficient to justify a finding of unfitness. Thus in *R v Robertson* (1968) ... the defendant on a murder charge had suffered persecution mania and believed that members of the crew of the ship on which he served, including the deceased, were putting noxious chemicals on his clothes. He stabbed the victim in an ensuing fight and claimed self-defence. Though his delusions might interfere with his capacity to conduct his defence in his best interests, this did not amount to disability enough to deprive him of the right to be tried. Note that the issue of fitness concerns the offender's state of mind at the time of the trial, not at the time of the alleged offence."

(Stone, Nigel; *A Companion Guide to Mentally Disordered Offenders*; Owen Wells, 1995)

#### 6.5.10 Bail Conditions and mental health law

- (a) Sometimes a person is not detained under the Mental Health Act 1983 by the Courts but instead is directed to reside in hospital for a fixed period of time before returning to Court (usually under the charge of a Responsible Clinician).
- (b) Bail conditions may vary considerably. Unfortunately, it is not always the case that the Courts send a copy of the bail conditions to the Responsible Clinician or the Chief Executive of the hospital. This can cause problems, particularly if the detaining authority is unaware that these bail conditions even exist — never mind in what shape or form they are presented.
- (c) As a consequence, if a person has been admitted to hospital via the Courts AND there is no accompanying paperwork you should notify the local Mental Health Law Administration office (MHLAO) immediately (Obviously, if there is accompanying paperwork then a copy of this should be sent to the MHLAO office as well).
- (d) Bail Conditions are the responsibility of the person to whom they apply. However, it is imperative that the mental health care team are aware of these conditions so that they are in a position to remind the individual should s/he consider breaking them.
- (e) If a person is bailed to a hospital and instructed not to leave that site then, unless s/he is detainable under the Mental Health Act 1983, s/he cannot be prevented from leaving if s/he so insists.
- (f) However, where a risk of harm to the patient and or others (or risk to the patient's own health or safety) is identified, s/he may be prevented from leaving by applying section 5(4) and/or section 5(2) powers of the Mental Health Act 1983.
- (g) If a person does break such bail conditions it is the duty of the nurse in charge to notify the police. If and when the person is retaken s/he will *usually* be remanded in custody to be dealt with by the Courts.
- (h) The Consultant in charge of the patient's care may or may not have the power to grant leave of absence and/or discharge from hospital depending on whether the Bail Conditions authorise this or not.

## 6.6 The Minimum Criteria for Detention under the Mental Act 1983

### 6.6.1 Definition of Mental Disorder

- (a) Unlike previous versions of the Act, *mental disorder* is no longer defined through classification of mental illness, mental impairment, severe mental impairment and psychopathic disorder.

- (b) Instead it is simply defined as "... any disorder of the mind". [MHA 1983, Part 1, section 1(2)].
- (c) However, any person who has a learning disability will only be considered to meet the criteria of that definition (for the purposes of certain Sections (see Section 1(2B)) if, in addition, there is evidence of "...abnormally aggressive or seriously irresponsible conduct on his part". (MHA 1983, section 1(2A)). This additional requirement does not apply to Section 2 and the short-term powers of detention.
- (d) Note that *dependence* upon alcohol or drugs *alone* "... is not "... considered to be a disorder or disability of the mind" (MHA 1983, Part 1, section 3) but any adverse effects that alcohol or drugs may have upon the mind may meet the criteria and would require assessment under the Act in the usual way.

#### 6.6.2 Definition of Mental Disorder: Cross-references

- (a) General  
Mental Health Act: Part 1, Section 1  
MHA Code of Practice Chapter 2, Paragraphs 2.1-2.20, pp.26-28
- (b) Definition  
Mental Health Act: Part 1, Section 1(2)  
MHA Code of Practice Paragraphs 2.4-2.8, pp.26-27

#### 6.6.3 Exclusions & Exceptions to Exclusions (Alcohol & Drug Dependence)

- (a) Mental Health Act Part 1, Section 1(3)
- (b) MHA Code of Practice Paragraphs 2.9-2.20, p.27 AND Chapter 20, Paragraphs 20.1-20.30, pp206-11

#### 6.6.4 Learning Disability Qualification

- (a) Mental Health Act: Part 1, Sections 1(2A), 1(2B) and 1(4)
- (b) MHA Code of Practice: Paragraphs. 2.14-2.18, p.28 AND Chapter 34, paras. 34.1-34.27, pp.307-320

#### 6.6.5 Personality Disorders

- (a) Mental Health Act No specific reference
- (b) MHA Code of Practice Paragraphs 2.19-2.29, p.28 AND Chapter 21, Paragraphs 21.1-21.15, pp.220-223

#### 6.6.6 Mental Health Act Detention Criteria

- (a) MHA Code of Practice Chapter 14 paras 14.1 – 14.10, pp.113-115

#### 6.6.7 Additional Criteria on Mental Health Act Detention Criteria

- (a) A person requires hospital in-patient assessment and/or treatment, for at least a limited period, of mental disorder, AND..
- (b) That mental disorder is of a *nature* or *degree* which warrants such assessment and/or treatment, AND...
- (c) It is necessary for that person to be detained in hospital in the interests of his own health or safety, or for the purpose of protecting other(s), AND...
- (d) *Ordinarily*, but **not** absolutely, a person must be refusing or, if s/he lacks capacity, objecting to hospital in-patient admission\*, AND...

- (e) The decision to detain must be supported by a Mental Capacity Act compliant capacity assessment.
- (f) Where a person is admitted under a treatment order (eg. Section 3), s/he must be admitted to a named hospital where the *appropriate* treatment is matter-of-fact available.
- (g) \* ***Clinicians should consult the Trust's legal team before making a decision to detain a person who is consenting to admission.***

6.6.8 The Nature of Mental Disorder refers to:-

"...the particular mental disorder from which the patient suffers, its chronicity, its prognosis, and the patient's previous response to receiving treatment for the disorder" (Poplewell, J, R v Mental Health Review Tribunal... (1999) 47 BMLR, p.104)

6.6.9 The Degree of Mental Disorder refers to "... the current manifestation of the patient's disorder." (*ibid*)

6.6.10 Appropriate Treatment

To be appropriate, the treatment has to be available and must attempt to address aspects of the patient's mental disorder. (See MHA Code of Practice, paragraphs 23.11 – 23.21 pp.247-249)

6.6.11 The Threshold of the Deteriorating Patient

- (a) Historically, there has been a difference of opinion as to whether a person could be detained under the Mental Health Act in anticipation of a deterioration in her/his mental health.
- (b) Following case law ruling from various sources the general consensus of opinion is as follows:-
- (c) "There is probably no legal impediment to the readmission of a ['revolving door'] patient... at the point of loss of insight when he refuse[s] further medication". (Committee of Inquiry... , The Falling Shadow: One Patient's Mental Health Care 1978-1993, (1995), p. 160)
- (d) Such decisions cannot be taken lightly and simply refusing medication alone would be insufficient grounds to detain a person who is otherwise showing no symptomatic signs of relapse.
- (e) But... where a person is well-known to services AND refusal to take medication is a known indicator in respect of the *nature* of her/his mental disorder, there may be grounds for detention.
- (f) Richard Jones (Mental Health Act Manual, 22<sup>nd</sup> ed., paragraph 1-060, pp. 47-48) suggests that the following approach "... should be taken by those involved in the assessment of a 'revolving door' patient who has ceased to take medication for his mental disorder:
  - (i) a withdrawal from medication is a significant, but not determining factor in the assessment;
  - (ii) the role of the professionals involved in the assessment is to assess the patient's response to the withdrawal and to identify the reasons for the decision to cease taking medication;
  - (iii) the 'nature' test can be satisfied even though there is no evidence that the patient's mental health has begun to deteriorate.. :

- (iv) although it would not be possible to determine that the provisions of either ss.2(2)(a) or 3(2)(a) are satisfied solely on the ground that the patient has ceased to take medication, an evaluation of the patient's history and, in particular, of his reaction to withdrawal from medication in the past, could lead to a decision that the 'nature' of the mental disorder justifies an application being made".
- (g) The above is drawn from and supported by case law. For example:-
- (h) "There are, of course, mental illnesses which come and go, but where there is a chronic condition, where there is evidence that it will soon deteriorate if medication is not taken, I find it impossible to accept that that is not a mental illness of a nature or degree which makes it appropriate for the patient for the patient to be liable to be detained in hospital for medical treatment if the evidence is that, without being detained in hospital, the patient will not take that treatment". (Toulson, L.J, *R. (on the application of MM) v Home Secretary* [2007] EWCA Civ 687; [2007] MHLR paragraph 48, p.304
- (i) Clinicians should consult the Trust's legal team before making a decision to detain a person on the above grounds

**6.7 Section 2 or Section 3?**

6.7.1 MHA Code of Practice Paragraphs 14.26 – 14.29 pp.118-119

6.7.2 Additional Guidance

- (a) The Code of Practice states that section 2 may be used not only for patients unknown to the service but also for patients known to the service in circumstances where "... there is a need to carry out a new in-patient assessment in order to re-formulate a treatment plan...". (*MHA Code of Practice*, Paragraph 14.27, p.118).
- (b) It is a matter of fact that the need for re-detention of a patient known to services means that, for whatever reason, the treatment plan current at that time has been unable to prevent compulsory readmission [ie. "Something has happened in that patient's life to justify intervention under the Act and it is the factors that precipitated the detention and their impact upon the patient that need to be assessed." (Richard Jones, *Mental Health Act Manual*, 22<sup>nd</sup> ed., paragraph 1-043, p.34)]
- (c) Clinicians must therefore *always consider* if section 2 is appropriate before dismissing it and opting for section 3.
- (d) Although all the factors need to be accounted for, a key indicator would be 'Is there a need to consider a significant re-formulation of the treatment plan or am I satisfied that the current plan is broadly appropriate?' If the former the decision points towards section 2, if the latter, section 3.

**6.8 Mental Health Act Holding Powers and Detention Orders (Numerical Order)**

**6.8.1 Section 2 Admission for Assessment**

<b>CODE of PRACTICE</b>	Chapter 14, paras. 14.1 – 14.129, pp.113-135
<b>TITLE</b>	Admission for assessment
<b>PURPOSE</b>	Authority to detain and convey a patient from the community to hospital or to detain a patient who is already in hospital for the purpose of conducting a full mental health assessment or assessment followed by treatment.
<b>DURATION</b>	Up to a maximum of 28 Days
<b>EXPIRY</b>	No later than by midnight of the 28 <sup>th</sup> day.

<b>RENEWAL</b>	<p>No authority to renew but may be extended in two specific circumstances:-</p> <ol style="list-style-type: none"> <li>1. If the patient goes absent without leave and is returned with less than 7 days of the section remaining, the section 2 expiry date is deferred to no later than 7 days from the date of return.</li> <li>2. If a patient is to be detained under section 3 but the Nearest Relative objects AND... if an application for displacement of that Nearest Relative is submitted to the Courts, the status quo is maintained and the patient remains detained under the section 2 until the Court has reached a decision. A referral to the First Tier Tribunal should be made.</li> </ol>
<b>OUTCOMES</b>	<p>Either Discharge or Regrade to one of:- Mental Capacity Act, informal, or section 3 status within the 28 Day period (unless extended by the Courts) (See <i>Renewal points 1 &amp; 2</i> above)</p>
<b>ELIGIBILITY</b>	<p>Provided they meet the criteria for detention (see 6.6.2 to 6.6.4 above) any person can be detained under section 2 unless s/he is already currently detained under any one of sections 3, 37, 37/41, 38, 45A, 47, 47/49, 48 and 48/49..</p> <p>A person in receipt of section 7 Guardianship, or Supervised Community Treatment can be admitted under section 2 without either order being terminated.</p> <p>Persons in receipt of Part III Conditional Discharge arrangements can also be detained under section 2 (although the Secretary of State may subsequently issue a warrant for recall).</p>
<b>APPLICATION MADE BY:-</b>	<ol style="list-style-type: none"> <li>1. An AMHP makes the application (completes Form <b>A2</b>). Alternatively, the patient's Nearest Relative could make the application, completing Form <b>A1</b>.</li> <li>2. Two doctors, one section 12 approved and the other having a prior knowledge, make independent medical recommendations (either by each separately completing Form <b>A4</b>, or if they examine the patient together, by completing a Joint Form <b>A3</b>).</li> </ol> <p><b>NB:</b> <i>If section 2 has been converted from s.4 the existing s.4 papers remain valid and only need to be supported by the completion a second medical recommendation.</i></p> <ol style="list-style-type: none"> <li>3. On being admitted to hospital, and on receipt of the section papers, the admitting nurse completes Form <b>H3</b>.</li> </ol>
<b>PROCESS</b>	<p>On being alerted, the two medical practitioners and AMHP should arrange to see the patient (preferably together). In any event...</p> <ol style="list-style-type: none"> <li>1. The two examinations for the medical recommendations must be completed within 5 clear days of each other, and...</li> <li>2. The AMHP application must be completed within 14 days of having received both medical recommendations. BUT...</li> <li>3. Neither the 5 Day nor the 14 Day Rules above apply in circumstances where the patient is being detained under section 2 whilst subject to a holding power or emergency section for assessment (since these are limited to a maximum 72 hour duration).</li> </ol> <p>At this point the patient is <i>liable</i> to be detained and the AMHP can make arrangements to have her/him conveyed to the hospital identified.</p> <p>The admitting nurse on the ward receives the section papers (a process which must include a basic check to confirm they have been duly completed) and completes Form <b>H3</b>. The patient is now formally detained under section 2.</p> <p>As soon as is practicable after admission, a qualified nurse must ensure that the patient's rights are explained to her/him, both verbally and in writing and documented.</p>

	<p>The Nurse should determine if the patient understands her/his rights and a second verbal explanation of rights should be routinely given (and documented).</p> <p>If, after the second explanation of rights, the nurse either believes the patient has not understood her/his rights OR is not sure if the rights have been understood, further attempts must be made.</p>
	<p>Repetition of rights can stop once it is clear that the patient understands them or, conversely, once it is confirmed that s/he will never be able to understand them. Both these outcomes should be fully documented</p> <p>The section 2 ends once the patient is either discharged or regarded to one of:- The Mental Capacity Act, informal, or section 3 status within the 28 Day period (unless extended by the Courts (See <i>Renewal points 1 &amp; 2</i> above). Form <b>MCT H7</b> must be completed.</p> <p>If the section 2 runs its full 28 days then it automatically lapses and the completion of an Adverse Incident Form is required</p>
<b>NEAREST RELATIVE</b>	<p>The patient's Nearest Relative has no power to object to a section 2 being applied, but, should nonetheless be offered the opportunity to discuss the proposed detention.</p> <p>Once detained the Nearest Relative may exercise her/his section 23 powers of discharge from section by writing to the Hospital Managers notifying them of their intent.</p>
<b>TREATMENT</b>	Treatment under section 2 without consent is authorised under the Mental Health Act in accordance with Part IV powers
<b>LEAVE</b>	Section 17 leave of absence is authorised for section 2 patients.
<b>ABSENCE</b>	If the patient succeeds in leaving without authority, section 18 powers apply. Activate 'missing person's protocol' and the patient may be returned at any time within the 28 Day period (But see the note on <i>Extension</i> under <i>RENEWAL</i> above).
<b>TRANSFER</b>	Formal section 19 Transfer is authorised for s.2 patients.
<b>APPEALS</b>	<ol style="list-style-type: none"> <li>1. A patient may appeal to the Tribunal against her/his detention provided s/he notifies the Tribunal Office within the first 14 days of the section.</li> <li>2. An appeal against detention can be made to the Hospital Managers at any time during the 28 Day period.</li> </ol>
<b>IMHA</b>	The patient is entitled to access the <i>Independent Mental Health Advocacy (IMHA) service</i> for section 2 purposes and staff should assist her/him to do this if necessary.
<b>AFTERCARE</b>	Neither section 117 Aftercare, nor Supervised Community Treatment (Community Treatment Order, CTO) are authorised under this section (but there would be nothing to stop placing the patient in receipt of section 7 Guardianship if this was considered appropriate.
<b>DOCUMENTATION</b>	
<b>Form A1</b>	<p>Mental Health Act 1983 section 2 — application by nearest relative for admission for assessment</p> <p>Approved Mental Health Professional should offer support to nearest relative re. completion</p> <p>(NOT required if Form A2 is completed)</p>
<b>Form A2</b>	Mental Health Act 1983 section 2 — application by an approved mental health professional for admission for assessment NOT required if Form A1 has been completed.
<b>Form A3</b>	Mental Health Act 1983 section 2 — joint medical recommendation for admission for assessment



	NOT required if two separate Forms A4 have ben completed
<b>Form A4</b>	Mental Health Act 1983 section 2 — medical recommendation for admission for assessment. Two forms required by two separate doctors.  NOT required if Form A3 has been completed
<b>Form H3</b>	The admitting nurse on the ward receives the section papers (a process which must include a basic check to confirm they have been duly completed) and completes Form <b>H3</b> . The patient is now formally detained under section 2.
<b>Form MCT H7</b>	Mental Health Act 1983 section 23 — regrade to informal by responsible clinician
<b>Section 2 Rights</b>	Section 2 Rights Leaflet

### 6.8.3 Section 3

<b>CODE of PRACTICE</b>	Nothing to specific to s.3 alone. Linked to other aspects of the MHA such as treatment. Leave of absence etc.
<b>TITLE</b>	Admission for treatment
<b>PURPOSE</b>	Authority to detain and convey a patient from the community to hospital or to detain a patient who is already in hospital for the purpose of providing treatment
<b>DURATION</b>	6 months (May be discharged earlier)
<b>EXPIRY</b>	No later than by midnight of the last day of the relevant calendar month.
<b>RENEWAL</b>	Can be renewed (DURATION: 1 <sup>st</sup> renewal = 6 months, subsequent renewals = 12 months) May also be extended in two specific circumstances:- 3. If the patient goes absent without leave and is returned with less than 7 days of the section remaining, the section 3 expiry date is deferred to no later than 7 days from the date of return. 4. If a patient goes absent without leave s/he may be returned at any time within 6 months from the date of going absent OR when the section is due to expire (WHICHEVER OCCURS LATEST)
<b>OUTCOMES</b>	Either Discharge (either Absolutely or under section 17A, Supervised Community Treatment (CTO)) or Regrade to one of:- Mental Capacity Act or informal status within the 6 month period (section 3 and 1 <sup>st</sup> Renewal) or 12 month period (2 <sup>nd</sup> and subsequent renewals).
<b>ELIGIBILITY</b>	Provided they meet the criteria for detention (see 6.6.2 to 6.6.5 above) any person can be detained under section 3 Detention under section 3 has the effect of terminating any pre-existing section 7 Guardianship Order or Section 2.  A person in receipt of section 17A Supervised Community Treatment has her/his pre-existing section 3 (or section 37) held in suspension. It can only be activated through formal recall and revocation of the Supervised Community Treatment Order.  Persons in receipt of Part III Conditional Discharge arrangements can also be detained under section 3 (although the Secretary of State may subsequently issue a warrant for recall).
<b>APPLICATION MADE BY:-</b>	1. An AMHP makes the application (completes Form <b>A6</b> ). Alternatively, the patient's Nearest Relative could make the application, completing Form <b>A5</b> . 2. Two doctors, one section 12 approved and the other having a prior knowledge, make independent medical recommendations (either by each completing a separate Form <b>A8</b> , or if they examine the patient together, by completing a Joint Form <b>A7</b> ). 3. On being admitted to hospital, and on receipt of the section papers, the admitting nurse completes Form <b>H3</b> .
	On being alerted, the two medical practitioners and AMHP should arrange to see the patient (preferably together).In any event...

	<ol style="list-style-type: none"> <li>1. The two examinations for the medical recommendations must be completed within 5 clear days of each other, and...</li> <li>2. The AMHP application must be completed within 14 days of having received both medical recommendations. BUT...</li> <li>3. Neither the 5 Day nor the 14 Day Rules above apply in circumstances where the patient is being detained under section 3 from a holding power or emergency section for assessment (since these are limited to a maximum 72 hour duration).</li> </ol> <p>At this point the patient is <i>liable</i> to be detained and the AMHP can make arrangements to have her/him conveyed to the hospital identified by the doctor who made the first medical recommendation.</p> <p>The admitting nurse on the ward receives the section papers (a process which must include a basic check to confirm they have been duly completed) and completes Form <b>H3</b>. The patient is now formally detained under section 3.</p> <p>As soon as is practicable after admission, a qualified nurse must ensure that the patient's rights are explained to her/him, both verbally and in writing and documented.</p> <p>The Nurse should determine if the patient understands her/his rights and a second verbal explanation of rights should be routinely given (and documented).</p> <p>If, after the second explanation of rights, the nurse either believes the patient has not understood her/his rights OR is not sure if the rights have been understood, further attempts must be made.</p> <p>Repetition of rights can stop once it is clear that the patient understands them or, conversely, once it is confirmed that s/he will never be able to understand them. Both these outcomes should be fully documented.</p>
<b>DISCHARGE</b>	<p>The section 3 ends on the completion of Form <b>MCT H7</b>. The patient can be discharged by the RC, Nearest Relative or Hospital Managers.</p> <p>If the section 3 is allowed to lapse the completion of an Adverse Incident Form is required.</p>
<b>NEAREST RELATIVE</b>	<p>The patient's Nearest Relative has the power to object to a section 3 being applied and therefore has a statutory right to be consulted by the AMHP regarding the intention to detain. If the Nearest Relative objects the section 3 cannot proceed except on Court authority and only then following its formal displacement of the nearest relative.</p> <p>Once detained the Nearest Relative may exercise her/his section 23 powers of discharge from section by writing to the Hospital Managers notifying them of their intent.</p>
<b>TREATMENT</b>	<p>Treatment under section 3 without consent is authorised under the Mental Health Act in accordance with Part IV powers below).</p>
<b>LEAVE</b>	<p>Section 17 leave of absence is authorised for section 3 patients.</p> <p>If 7 or more consecutive days leave are granted then the Responsible Clinician must record the justification of this decision, explaining why the patient was not placed in receipt of section 17A Supervised Community Treatment.</p>
<b>ABSENCE</b>	<p>If the patient succeeds in leaving without authority, section 18 powers apply. Activate 'missing person's protocol' and the patient may be returned at any time within the limits outlined in RENEWAL, Points 1 &amp; 2 above).</p>
<b>TRANSFER</b>	<p>Formal section 19 Transfer is authorised for s.3. patients.</p>
<b>APPEALS</b>	<p>3. A patient may appeal once to the Tribunal against her/his</p>

	detention at any time during the first 6 month period and thereafter once during each period of section 3 renewal. 4. The same applies to appeals to Hospital Managers.
<b>IMHA</b>	The patient is entitled to access the <i>Independent Mental Health Advocacy (IMHA) service</i> for section 3 purposes and staff should assist her/him to do this if necessary.
<b>AFTERCARE</b>	On discharge from hospital a patient who has been detained under section 3 is entitled to section 117 Aftercare,  Patients may be placed in receipt of section 17A Community Treatment Orders. They may also be transferred into Guardianship (or a fresh application can be made).
<b>DOCUMENTATION</b>	
<b>Form A5</b>	Mental Health Act 1983 section 3 — application by nearest relative for admission for treatment Approved Mental Health Professional should offer support to nearest relative re. completion  (NOT required if Form A6 is completed)
<b>Form A6</b>	Mental Health Act 1983 section 3 — application by an approved mental health professional for admission for treatment.  NOT required if Form A5 has been completed.
<b>Form A7</b>	Mental Health Act 1983 section 3 — joint medical recommendation for admission for treatment  NOT required if two separate Forms A8 have been completed
<b>Form A8</b>	Mental Health Act 1983 section 3 — medical recommendation for admission for treatment. Two forms required by two separate doctors.  NOT required if Form A7 has been completed
<b>Form H3</b>	The admitting nurse on the ward receives the section papers (a process which must include a basic check to confirm they have been duly completed) and completes Form <b>H3</b> . The patient is now formally detained under section 3.
<b>Form MCT H7</b>	Mental Health Act 1983 section 23 — regrade to informal by responsible clinician
<b>Section 3 Rights</b>	Section 3 Rights Leaflet

### 6.8.3 Section 4 Admission for Assessment in case of Emergency

<b>CODE of PRACTICE</b>	Chapter 15, paras. 15.1 – 15.17 pp. 136-138
<b>TITLE</b>	Admission for assessment in case of emergency
<b>PURPOSE</b>	Authority to detain a patient from the community with one medical recommendation rather than two, solely on the grounds that it is too unsafe to wait for the second medical recommendation.
<b>DURATION</b>	Up to a maximum of 72 hours
<b>EXPIRY</b>	On completion of the Mental Health Act Assessment or after 72 hours, whichever occurs first
<b>RENEWAL</b>	No authority to renew or extend
<b>OUTCOMES</b>	Either Discharge or Regrade to one of:- Mental Capacity Act, informal, section 2 or section 3 status within the 72 hours
<b>ELIGIBILITY</b>	Only a person who, at the time, is still in the community and requires an emergency admission for the assessment of mental disorder is eligible. A person in receipt of section 7 Guardianship can be admitted under section 4 without the guardianship order being terminated. A person who has been held in a <i>general medical/surgical hospital</i> under section 5(2) can be detained under section 4 BUT otherwise hospital in-patients do not qualify.

	Persons in receipt of Supervised Community Treatment or Part III Conditional discharge arrangements cannot be detained under section 4.
<b>APPLICATION MADE BY:-</b>	A medical practitioner who has prior knowledge of the patient and an AMHP. There is no requirement for the doctor to be section 12 approved unless it has not been possible to get one who has prior knowledge of the patient.
<b>PROCESS</b>	On being alerted, the medical practitioner and AMHP should arrange to see the patient (preferably together but, in any event, within 24 hours of each other). Once satisfied that the criteria are met (including that it is necessary to admit the patient without having to wait for a second medical recommendation) Forms <b>A10</b> (AMHP Application) and <b>A11</b> (Medical Recommendation) must be completed. At this point the patient is <i>liable</i> to be detained and the AMHP can make arrangements to have her/him conveyed to the hospital identified by the doctor who made the first medical recommendation.
	The admitting nurse on the ward receives the section papers (a process which must include a basic check to confirm they have been duly completed) and completes Form <b>H3</b> . The patient is now formally detained under section 4. Once admitted under section 4, a qualified nurse must ensure that the patient's rights are explained to her/him, both verbally and in writing and documented. If detention beyond the 72 hours is required the patient may be detained under sections 2 or 3.
<b>PROCESS cont.</b>	Section 4 converts to section 2 if it is supported by a second medical recommendation that is completed within the 72 hour period. . Section 4 cannot convert to section 3 which would have to be completed in full as a fresh application. The AMHP <i>14 Day Application Rule</i> does not apply in these circumstances and the section 3 would need to be completed within the 72 hour period. The section 4 ends once the section 2 or 3 has been completed (or when one of the gatekeepers decides that further detention is not necessary). Form <b>MCT H7</b> must be completed.
<b>NEAREST RELATIVE</b>	The patient's Nearest Relative has no power to object to, or apply for, the discharge of a patient from this section.
<b>TREATMENT</b>	Treatment under s.4 without consent is not authorised under the Mental Health Act, but may be authorised under either the common law or the Mental Capacity Act (but only to prevent immediate risk of harm to self, other(s) and/or damage to the property of other(s)).
<b>LEAVE</b>	Section 17 leave of absence is authorised for section 4 patients but given the purpose of this section (emergency 72 hour admission for assessment) such instances are only likely to be exceptional, of short-duration and with escort support.
<b>ABSENCE</b>	If the patient succeeds in leaving without authority, section 18 powers apply. Activate 'missing person's protocol' and the patient may be returned at any time within the 72 hour period.
<b>TRANSFER</b>	Formal section 19 Transfer is authorised for s.4 patients.
<b>APPEALS</b>	The short duration of this section effectively prevents tribunal or hospital managers hearings being heard. However, a patient may make an application whilst detained under section 4 which can then be heard at a later date if it is converted to section 2 or replaced by section 3.
<b>IMHA</b>	The patient cannot access the <i>Independent Mental Health Advocacy (IMHA) service</i> for section 4 purposes [ <i>Mental Health Act, section 130C(2)</i> ]
<b>AFTERCARE</b>	Neither section 117 Aftercare, nor Supervised Community Treatment are authorised under this section (but there would be nothing to stop placing the patient in receipt of section 7 Guardianship if this was considered appropriate)

DOCUMENTATION	
<b>Form A9</b>	Mental Health Act 1983 section 4—emergency application by an nearest relative for admission for assessment. Approved Mental Health Professional should offer support to nearest relative re. completion  (NOT required if A10 is completed)
<b>Form A10</b>	Mental Health Act 1983 section 4—emergency application by an approved mental health professional for admission for assessment  (NOT required if A9 is completed)
<b>Form A11</b>	Mental Health Act 1983 section 4 — medical recommendation for emergency admission for assessment
<b>Form H3</b>	Mental Health Act 1983 sections 2, 3 and 4—record of detention in hospital (to be completed by the admitting nurse)
<b>Form MCT H7</b>	Mental Health Act 1983 section 23 — regrade to informal by responsible clinician
<b>Section 4 Rights</b>	Section4 Rights Leaflet

#### 6.8.4 Section 5(2) 72 Hour Doctor's Holding Power

<b>CODE of PRACTICE</b>	Chapter 18, paras. 18.1 – 18.21 & 18.37-18.45, pp.
<b>TITLE</b>	72 hour Holding power of doctors and approved clinicians under s.5(2)
<b>PURPOSE</b>	Authority to hold a hospital in-patient from leaving to make provision for a Mental Health Act assessment
<b>DURATION</b>	Up to a maximum of 72 hours. If the section 5(2) replaces a section 5(4), the 72 hours starts from the commencement time of the s.5(4)
<b>EXPIRY</b>	On completion of the Mental Health Act Assessment or after 72 hours, whichever occurs first
<b>RENEWAL</b>	No authority to renew or extend
<b>OUTCOMES</b>	Either Discharge or Regrade to one of:- Mental Capacity Act, informal, section 2 or section 3 status within the 72 hours
<b>ELIGIBILITY</b>	Must be an informal hospital in-patient, OR a person who is being held under section 5(4), OR who is being managed under the Mental Capacity Act.  Must be a patient who is refusing treatment and/or has a meaningful, persistent, unauthorised intent (evidenced by word or deed) to leave hospital
<b>APPLICATION MADE BY:-</b>	Patient's Responsible Clinician or her/his Nominated Deputy (s.5(2) clinician)
<b>PROCESS</b>	Ward staff notify the s.5(2) clinician who will examine the patient. If the patient is discharged or regraded to one of either The Mental Capacity Act or informal status, s/he is to be notified and an entry made in their notes without s.5(2) being activated. Otherwise, section 5(2) is applied Once section 5(2) has been applied, a qualified nurse must ensure that the patient's rights are explained to her/him, both verbally and in writing and documented. If sections 2 or 3 are to be applied, and if the examining clinician is section 12 approved, s/he will complete the relevant medical recommendation form. If not, a request for one must be made. The section 2 or 3 must be completed within the 72 hour period and the AMHP 14 day application rule for these sections does not apply. The section 5(2) ends once the section 2 or 3 has been completed (or when one of the gatekeepers decides that such detention is not necessary). Form <b>MCT H1A</b> must be completed.
<b>TREATMENT</b>	Treatment under s.5(2) without consent is not authorised under the Mental

	Health Act, but may be authorised under either the common law or the Mental Capacity Act (but only to prevent immediate risk of harm to self, other(s) and/or damage to the property of other(s)).
<b>LEAVE</b>	Section 17 leave of absence not authorised for section 5(4)
<b>ABSENCE</b>	If patient succeeds in leaving without authority, section 18 powers apply. Activate 'missing person's protocol' and the patient may be returned at any time within the 72 hour period.
<b>TRANSFER</b>	Formal section 19 Transfer not authorised for s.5(2)
<b>APPEALS</b>	No appeals for discharge to either the Mental Health Tribunal or the Hospital Managers are authorised under this section.
<b>IMHA</b>	The patient cannot access the <i>Independent Mental Health Advocacy (IMHA) service</i> for section 5(2) purposes [ <i>Mental Health Act, section 130C(2)</i> ]
<b>AFTERCARE</b>	Neither section 117 Aftercare, nor Supervised Community Treatment are authorised under this section (but there would be nothing to stop placing the patient in receipt of section 7 Guardianship if this was considered appropriate)
<b>DOCUMENTATION</b>	
<b>Form H1</b>	Mental Health Act 1983 section 5(2) — report on hospital in-patient
<b>MCT H1A</b>	Mental Health Act 1983 section 5(2) – Record of Disposal of section 5(2)
<b>Section 5(2) Rights</b>	Section 5(2)n Rights Leaflet

#### 6.8.5 **Section 5(4) 6 Hour Nurse's Holding Power**

<b>CODE of PRACTICE</b>	Chapter 18, paras 18.1, 18.2 & 18.22 – 18.45, pp. 162-165
<b>TITLE</b>	Nurse's 6 hour Holding power
<b>PURPOSE</b>	Authority for a qualified nurse to hold a hospital in-patient from leaving to make provision for a Mental Health Act assessment
<b>DURATION</b>	Up to a maximum of 6 hours.
<b>EXPIRY</b>	On the attendance of a doctor or approved clinician OR after the 6 hours has lapsed, whichever occurs first.
<b>RENEWAL</b>	No authority to renew or extend
<b>OUTCOMES</b>	Either Discharge or Regrade to one of:- Mental Capacity Act, informal, section 2 or section 3 status within the 6 hours
<b>ELIGIBILITY</b>	Must be an informal hospital in-patient, OR a person who is being managed in hospital under the Mental Capacity Act. Must be a patient who is refusing treatment and/or making meaningful, persistent, unauthorised attempts to leave hospital
<b>APPLICATION MADE BY:-</b>	A 1 <sup>st</sup> or 2 <sup>nd</sup> level qualified nurse (s.5(4) Nurse) with the appropriate mental health training (completes Form <b>H2</b> .)
<b>PROCESS</b>	Once the patient has been prevented from leaving the s.5(4) nurse will complete Form <b>H2</b> and inform the patient of her/his rights both verbally and in writing. Ward staff to notify the s.5(2) clinician (patient's Responsible Clinician or her/his Nominated Deputy) who will examine the patient. On the attendance of the s.5(2) clinician (or once the 6 hours has lapsed if no clinician attends) a qualified ward-based nurse ends the s.5(4) by completing Form <b>MCT H2A</b> . An incident form must be completed if the s5(4) lapses without the patient being seen by the s5(2) clinician.
<b>TREATMENT</b>	Treatment under s.5(4) without consent is not authorised under the Mental Health Act, but may be authorised under either the common law or the Mental Capacity Act [but only to prevent immediate risk of harm to self, other(s) and/or damage to the property of other(s)].
<b>LEAVE</b>	Section 17 leave of absence not authorised for section 5(4)
<b>ABSENCE</b>	If patient succeeds in leaving without authority, section 18 powers apply. Activate 'missing person's protocol' and the patient may be returned at

	any time within the 72 hour period.
<b>TRANSFER</b>	section 19 Transfer not authorised for s.5(4)
<b>APPEALS</b>	No appeals for discharge to either the Mental Health Tribunal or the Hospital Managers are authorised under this section.
<b>IMHA SERVICES</b>	Patients cannot access the <i>Independent Mental Health Advocacy (IMHA) service</i> for section 5(4) purposes [Mental Health Act, section 130C(2)].
<b>AFTERCARE</b>	Neither section 117 Aftercare, nor Supervised Community Treatment are authorised under this section (but there would be nothing to stop placing the patient in receipt of section 7 Guardianship if this was considered appropriate)
<b>DOCUMENTATION</b>	
<b>Form H2</b>	Mental Health Act 1983 section 5(4) — record of hospital in-patient
<b>MCT H2A</b>	Record of Disposal of section 5(4)
<b>Section 5(4) Rights</b>	Section 5(4) Rights Leaflet

#### 6.8.6 **Section 35 Remand to hospital for report on accused's mental condition**

<b>CODE of PRACTICE</b>	Chapter 22, paras. 22.1 – 22.14 & 22.16 – 22.17, pp. 224-227 (See also: Reference Guide: Chapter 14, paras. 14.1-14.7, pp.152/54 & 14.14-14.27, pp.156-58)
<b>TITLE</b>	Remand to hospital for report on accused's mental condition
<b>PURPOSE</b>	Magistrate & Crown Court Authority to detain and convey a patient from the Court to hospital for the purpose of conducting a full mental health assessment.
<b>DURATION</b>	Period fixed by the Courts up to a maximum of 28 Days
<b>EXPIRY</b>	Fixed date of return to Court but may be terminated by the Courts at any time prior to this.
<b>RENEWAL</b>	Renewable by the Courts for fixed periods not exceeding 28 days at a time. Total period of section 35 and renewals not to exceed 12 weeks in total.
<b>OUTCOMES</b>	All decisions made by the Court. May discharge from section and be dealt with by the Courts OR may be regarded to sections 38, 37, 37/41 or 45A.
<b>ELIGIBILITY</b>	<p><u>Magistrates' Court</u> Where the accused is convicted of an offence punishable on summary conviction OR Is charged with (but not convicted of such an offence if the Court is satisfied that the defendant did the act or omission charged) OR If the defendant consents to the section 35</p> <p><u>Crown Court</u> Where the accused is awaiting trial for an offence punishable with imprisonment OR Has been found guilty but has yet to be sentenced/dealt with for the offence (other than an offence of murder)</p>
<b>APPLICATION MADE BY:-</b>	Application and section 35 order made by the Court
<b>PROCESS</b>	<p>The Court makes the order if supported by an oral or written report submitted an Approved Clinician (or some other person representing the Hospital Managers of the admitting hospital) confirming that arrangements have been made for hospital admission.</p> <p>The admitting nurse on the ward receives the section papers (a process which must include a basic check to confirm they have been duly completed) The patient is now formally detained under section 35.</p>

	<p>As soon as is practicable after admission, a qualified nurse must ensure that the patient's rights are explained to her/him, both verbally and in writing and documented.</p> <p>The Nurse should determine if the patient understands her his rights and a second verbal explanation of rights should be routinely given (and documented).</p> <p>If, after the second explanation of rights, the nurse either believes the patient has not understood her/his rights OR is not sure if the rights have been understood, further attempts must be made.</p>
<b>NEAREST RELATIVE</b>	Patients detained under section 35 have no Nearest Relative within the meaning of the Act.
<b>TREATMENT</b>	Treatment under section 35 without consent is not authorised under the Mental Health Act in accordance with Part IV powers below). However, provided the detention criteria are met it is possible to apply section 2 or 3 to run alongside the section 35 in order that treatment may be administered.
<b>LEAVE</b>	The Responsible Clinician has no power to authorise section 17 leave under this section. The Courts <i>may</i> grant leave on request from the relevant Approved Clinician, although the legal power for this is not clear.
<b>ABSENCE</b>	If the patient succeeds in leaving without authority, section 18 powers do <b>not</b> apply. Activate 'missing person's protocol' If apprehended the patient is returned to the custody of the Courts
<b>TRANSFER</b>	Formal section transfer to another hospital is not applicable. If transfer is required the Court can remand to another hospital.
<b>APPEALS</b>	The patient has no rights of appeal either to the Mental Health Tribunal or the Hospital Managers.
<b>IMHA</b>	The patient is entitled to access the <i>Independent Mental Health Advocacy (IMHA) service</i> for section 35 purposes and staff should assist her/him to do this if necessary.
<b>AFTERCARE</b>	Neither section 117 Aftercare, nor Supervised Community Treatment are applicable under this section
<b>DOCUMENTATION</b>	
<b>s.35 Order</b>	Completed by the Courts. No other statutory detention forms for completion.
<b>Section 35 Rights</b>	Section 135 Leaflet

### 6.8.7 Remand of accused person to hospital for treatment

<b>CODE of PRACTICE</b>	Chapter 22, paras. 22.1 – 22.14 & 22.16 – 22.17, pp. 224-227 (See also: Reference Guide: Chapter.14. paras 14.8-14.13, pp.155-56 & 14.14-14.27, pp.156-58))
<b>TITLE</b>	Remand of accused person to hospital for treatment.
<b>PURPOSE</b>	Crown Court authority to detain and convey a patient from the Court to hospital for the purpose treatment
<b>DURATION</b>	Period fixed by the Courts up to a maximum of 28 Days
<b>EXPIRY</b>	Fixed date of return to Court but may be terminated by the Courts at any time prior to this.
<b>RENEWAL</b>	Renewable by the Courts for fixed periods not exceeding 28 days at a time. Total period of section 36 and renewals not to exceed 12 weeks.
<b>OUTCOMES</b>	All decisions made by the Court. May discharge from section and be dealt with by the Courts OR may be made subject to sections 38, 37, 37/41 or 45A.
<b>ELIGIBILITY</b>	<u>Crown Court</u> Where the person is in custody awaiting trial for an offence punishable with imprisonment (other than murder) OR



	In custody at any stage of such a trial prior to sentence
<b>APPLICATION MADE BY:-</b>	Application and section 36 order made by the Court
<b>PROCESS</b>	<p>The Court makes the order if supported on the oral or written evidence of two doctors (at least one must be section 12 Approved) who agree that the defendant has a mental disorder of a nature or degree which makes it appropriate for her/him to be detained in hospital for medical treatment , AND... That such treatment is available.</p> <p>The Court is satisfied, on the oral or written evidence of the Approved Clinician who would become the patient's Responsible Clinician (or of some other person representing the admitting hospital's Hospital Managers) that arrangements have been made to admit that person within 7 days, starting with the date of remand.</p> <p>The section 36 begins on the Court's completion of the s.36 Form. The admitting nurse on the ward receives the section 36 Court Order (a process which must include a basic check to confirm they have been duly completed).</p> <p>As soon as is practicable after admission, a qualified nurse must ensure that the patient's rights are explained to her/him, both verbally and in writing and documented.</p> <p>The Nurse should determine if the patient understands her/his rights and a second verbal explanation of rights should be routinely given (and documented).</p> <p>If, after the second explanation of rights, the nurse either believes the patient has not understood her/his rights OR.is not sure if the rights have been understood, further attempts must be made.</p>
<b>NEAREST RELATIVE</b>	Patients detained under section 36 have no Nearest Relative within the meaning of the Act.
<b>TREATMENT</b>	Treatment under section 36 without consent is authorised under the Mental Health Act in accordance with Part IV powers (See 8.XXXX below).
<b>LEAVE</b>	The Responsible Clinician has no power to authorise section 17 leave under this section. The Courts <i>may</i> grant leave on request from the relevant Approved Clinician.
<b>ABSENCE</b>	If the patient succeeds in leaving without authority, section 18 powers do <b>not</b> apply. Activate 'missing person's protocol' If apprehended the patient is returned to the custody of the Courts
<b>TRANSFER</b>	Formal section transfer to another hospital is not possible. The Court can remand the patient to another hospital.
<b>APPEALS</b>	The patient has no rights of appeal either to the Mental Health Tribunal or the Hospital Managers.
<b>IMHA</b>	The patient is entitled to access the <i>Independent Mental Health Advocacy (IMHA) service</i> for section 36 purposes and staff should assist her/him to do this if necessary.
<b>AFTERCARE</b>	Neither section 117 Aftercare, nor Supervised Community Treatment are applicable under this section
<b>DOCUMENTATION</b>	
<b>s.36 Order</b>	Completed by the Courts. No other statutory detention forms for completion.
<b>Section 36 Rights</b>	Section 36 Rights Leaflet

#### 6.8.8 Section 37 (and Section 37/41) Power of Courts to order hospital admission or guardianship (with or without additional section.41 restrictions)

<b>CODE of PRACTICE</b>	Chapter 22, paras. 22.1-22.63, pp.224-236 & 22.75-22.92, pp.236-242) (See also Reference Guide:- Chapter 15, Paras 15.1-15.41, pp.159-165)
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<b>TITLE</b>	<i>Section 37:</i> Powers of courts to make hospital orders or guardianship <i>Section 41</i> <i>(Additional Ministry of Justice) Restrictions</i>
<b>PURPOSE</b>	<i>Section 37:-</i> Court hospital order authorising detention in hospital of a patient convicted of an offence punishable with a prison sentence (other than murder). <i>Section 41:-</i> Additional Ministry of Justice restrictions attached to the section 37 limiting powers and rights of leave, transfer and discharge from hospital.
<b>DURATION</b>	<i>Section 37</i> 6 months, 1 <sup>st</sup> renewal = 6 months, Subsequent renewals = 12 months. <i>Section 37/41</i> Without time limit
<b>OUTCOMES</b>	<u>Without section 41 attached:</u> The Responsible Clinician may regrade to informal or Mental Capacity Act Status OR may discharge the patient from hospital <u>With section 41 attached</u> Any change in the patient's Mental Health Act status requires Minister of Justice approval (who may authorise either absolute or conditional discharge from hospital).
<b>ELIGIBILITY</b>	<u><i>Section 37</i></u> People remanded in custody by Magistrate's Court; OR Civil Prisoners: ie committed by a Court to prison for a limited term but are not sentenced prisoners; OR People detained under the Immigration Act 1971 or under s.62 of the Nationality, Immigration and Asylum Act 2002 <u><i>Section 41</i></u> On the authority of the Courts, a Ministry of Justice restriction which may be additionally applied to patient's detained under sections 45A, 47 or 48.
<b>APPLICATION MADE BY:-</b>	Court makes the order on the support of the written or oral evidence of two doctors (at least one must be section 12 Approved)  The evidence must confirm that both doctors agree that the offender has a mental disorder AND The person has a mental disorder of a nature or degree making it appropriate for her/him to be detained in hospital for medical treatment, AND... The person is in urgent need of such treatment, AND... Appropriate medical treatment is available
<b>PROCESS</b>	Having made the section 37 (with or without the section 41 attachment) the Court arranges for the defendant to be conveyed to the hospital. The patient must be admitted within 28 days else the order lapses. The admitting nurse on the ward receives the section 37 or section 37/41 papers (a process which must include a basic check to confirm they have been duly completed). As soon as is practicable after admission, a qualified nurse must ensure that the patient's rights are explained to her/him, both verbally and in writing and documented.  The Nurse should determine if the patient understands her his rights and a second verbal explanation of rights should be routinely given (and documented).  If, after the second explanation of rights, the nurse either believes the patient has not understood her/his rights OR is not sure if the rights have been understood, further attempts must be made.
<b>NEAREST</b>	Patients detained under section 37/41 have no Nearest Relative within the

<b>RELATIVE</b>	meaning of the Act but do under s.37 (and can apply to a Tribunal after 6 months).
<b>TREATMENT</b>	Treatment under sections 37 and 37/41 without consent is authorised under the Mental Health Act in accordance with Part IV powers
<b>LEAVE</b>	<i>Section 37</i> Section 17 Leave can be granted by the Responsible Clinician (RC) BUT... <i>Section 37 with section 41 attached</i> The RC must get the leave approved by the Ministry of Justice.
<b>ABSENCE</b>	<i>Sections 37 and 41</i> If the patient succeeds in leaving without authority, sections 18 (abscond whilst on leave) or 138 (abscond from hospital) powers apply as appropriate. Activate 'missing person's protocol' An patient who absconds whilst subject to sections 37 or 37/41 may be returned to the hospital at any time.
<b>TRANSFER</b>	<i>Sections 37</i> Formal section transfer to another hospital can be authorised by the RC <i>Section 41</i> Formal section transfer to another hospital can only be authorised by the Ministry of Justice
<b>APPEALS</b>	<i>Section 37 and 37/41</i> The patient has the right to appeal to the Mental Health Tribunal after 6 months starting with the day the Hospital Order was made.
<b>IMHA</b>	The patient is entitled to access the <i>Independent Mental Health Advocacy (IMHA) service</i> for sections 37 and 37/41 purposes and staff should assist her/him to do this if necessary.
<b>AFTERCARE</b>	Section 117 Aftercare and Supervised Community Treatment are applicable to this section
<b>DOCUMENTATION</b>	
<b>Sections 37 &amp; 37/41</b>	<i>Section 37</i> Order made by the Court <i>Section 41</i> Order made by the Court
<b>Sections 37 &amp; 37/41 Rights</b>	Section 37/41 Rights Leaflet

### 6.8.9 **Section 38 Interim Hospital Order**

<b>CODE of PRACTICE</b>	Ch. 22, para. 22.15, p. 227
<b>TITLE</b>	Interim Hospital Order.
<b>PURPOSE</b>	Magistrate or Crown Court authority to detain a person before deciding whether to give an offender a hospital order, hospital and limitation directions, a prison sentence, or some other criminal disposal. In effect it provides a buffer between the cessation of remand orders and subsequent disposal of the defendant by the Courts.
<b>DURATION</b>	Period fixed by the Courts for up to 12 weeks.
<b>EXPIRY</b>	Fixed date of return to Court but will be terminated by the Courts at any time prior to this where subsequent disposal of the defendant has been determined.
<b>RENEWAL</b>	Renewable by the Courts for fixed periods not exceeding 28 days at a time. Total period of section 38 and renewals not to exceed 12 months.
<b>OUTCOMES</b>	All decisions made by the Court. May discharge from section and be dealt with by the Courts OR may be regraded to sections 37, 37/41 or 45A.
<b>ELIGIBILITY</b>	<u>Magistrates' Court</u> Where the defendant has been convicted by the Court of an offence punishable with imprisonment <u>Crown Court</u> Where the defendant has been convicted for an offence punishable with

	imprisonment (other than murder)
<b>APPLICATION MADE BY:-</b>	<p>Court makes the section 38 order on the support of the written or oral evidence of two doctors (at least one must be section 12 Approved and at least one must be employed by the admitting hospital). The evidence must confirm that both doctors agree that the offender has a mental disorder AND There is reason to suppose that the mental disorder is such that it may be appropriate for the section 38 to be made. AND The Court is in receipt of oral or written evidence from the Approved Clinician who will become the defendant's Responsible Clinician that arrangements have been made for hospital admission to occur within 28 days of the section 38 having been applied.</p>
<b>PROCESS</b>	<p>Having made the section 38 Order the Court arranges for the defendant to be conveyed to the hospital. If there are barriers to admission the Courts can arrange for the defendant to be detained at a Place of Safety.</p> <p>The admitting nurse on the ward receives the section 38 Court Order (a process which must include a basic check to confirm they have been duly completed).</p> <p>As soon as is practicable after admission, a qualified nurse must ensure that the patient's rights are explained to her/him, both verbally and in writing and documented.</p> <p>The Nurse should determine if the patient understands her/his rights and a second verbal explanation of rights should be routinely given (and documented).</p> <p>If, after the second explanation of rights, the nurse either believes the patient has not understood her/his rights OR is not sure if the rights have been understood, further attempts must be made.</p>
<b>NEAREST RELATIVE</b>	Patients detained under section 38 have no Nearest Relative within the meaning of the Act.
<b>TREATMENT</b>	Treatment under section 38 without consent is authorised under the Mental Health Act in accordance with Part IV powers below).
<b>LEAVE</b>	The Responsible Clinician has no power to authorise section 17 leave under this section.
<b>ABSENCE</b>	If the patient succeeds in leaving without authority, section 18 powers do <b>not</b> apply. Activate 'missing person's protocol' An offender who absconds whilst subject to section 38 may be arrested without warrant by any constable and returned to the Court that made the order.
<b>TRANSFER</b>	Formal section transfer to another hospital is not possible. It is possible that the Court could direct admission to another hospital.
<b>APPEALS</b>	The patient has no rights of appeal either to the Mental Health Tribunal or the Hospital Managers. However, they can appeal against their conviction or sentence through the criminal courts. BUT... this does not prevent the Court from making and executing a disposal decision in advance of any impending appeal hearing.
<b>IMHA</b>	The patient is entitled to access the <i>Independent Mental Health Advocacy (IMHA) service</i> for section 38 purposes and staff should assist her/him to do this if necessary.
<b>AFTERCARE</b>	Neither section 117 Aftercare, nor Supervised Community Treatment are authorised under this section
<b>DOCUMENTATION</b>	
<b>s.38 Order</b>	Completed by the Courts. No other statutory detention forms for completion.
<b>Section 38 Rights</b>	Section 38 Rights Leaflet

6.8.10 **Section 45A Power of higher courts to direct hospital admission with additional Ministry of Justice restrictions attached**

<b>CODE of PRACTICE</b>	Chapter. 22. 22.70 – 22.74, pp.237-238
<b>TITLE</b>	<i>Section 45A:</i> Powers of higher courts to direct hospital admission with additional (section 41) Ministry of Justice Restrictions <i>Section 41</i> <i>(Additional Ministry of Justice) Restrictions</i> (but referred to here as a <i>Limitation Order</i> )
<b>Sections 45A Rights</b>	Section 45A Rights Leaflet

6.8.11 **Section 47 and Section 47/49 Removal to hospital of persons serving sentences of imprisonment with or without section 49 additional transfer direction restrictions**

<b>CODE of PRACTICE</b>	Chapter 22, paras. 22.25 – 22.69, pp.229-269 (See also Reference Guide:-Chapter 19, paras. 19.1-19.27, pp.177-182)
<b>TITLE</b>	<i>Section 47:</i> Hospital Transfer (from Prison) Order <i>Section 49</i> <i>(Additional Ministry of Justice) Restrictions</i>
<b>PURPOSE</b>	<i>Section 47:-</i> Ministry of Justice order authorising transfer to detention in hospital of a sentenced prisoner. <i>Section 49:-</i> Additional Ministry of Justice restrictions attached to the section 47 limiting powers and rights of leave, transfer and discharge from hospital.
<b>DURATION</b>	<i>Section 47</i> 6 months, 1 <sup>st</sup> renewal = 6 months, Subsequent renewals = 12 months (acts like a section 37 except that tribunals can be heard during the first 6 months). <i>Section 49</i> Without time limit
<b>OUTCOMES</b>	<u>Without section 49 attached:</u> The Responsible Clinician may regrade to informal or Mental Capacity Act Status OR may be discharge the patient from hospital <u>With section 49 attached</u> Any change in the patient's Mental Health Act status requires Minister of Justice approval (who may authorise either absolute or conditional discharge from hospital).
<b>ELIGIBILITY &amp; APPLICATION</b>	<i>Section 47</i> Two medical reports (one by section 12 approved doctor) confirming that the person has a mental disorder the nature or degree of which warrants treatment in hospital <i>Section 49</i> Ministry of Justice restriction which may be additionally applied to patient's detained under sections 47 or 48.
<b>PROCESS</b>	Having received the section 47 order (with or without the section 49 attachment) the Prison arranges for the defendant to be conveyed to the hospital. The patient must be admitted within 14 days else the order lapses (although a fresh one could be issued). The admitting nurse on the ward receives the section 47 or section 47/49 papers (a process which must include a basic check to confirm they have been duly completed).

	<p>As soon as is practicable after admission, a qualified nurse must ensure that the patient's rights are explained to her/him, both verbally and in writing and documented.</p> <p>The Nurse should determine if the patient understands her his rights and a second verbal explanation of rights should be routinely given (and documented).</p> <p>If, after the second explanation of rights, the nurse either believes the patient has not understood her/his rights OR.is not sure if the rights have been understood, further attempts must be made.</p>
<b>NEAREST RELATIVE</b>	Patients detained under 47/49 have no Nearest Relative within the meaning of the Act (they do, however, under a straight s.47)
<b>TREATMENT</b>	Treatment under sections 47 and 47/49 without consent is authorised under the Mental Health Act in accordance with Part IV powers
<b>LEAVE</b>	<p><i>Section 47</i> Section 17 Leave can be granted by the Responsible Clinician (RC) BUT... <i>Section 47 with section 49 attached</i> The RC must get the leave approved by the Ministry of Justice.</p>
<b>ABSENCE</b>	<p><i>Sections 47 and 49</i> If the patient succeeds in leaving without authority, sections 18 (abscond whilst on leave) or 138 (abscond from hospital) powers apply as appropriate. Activate 'missing person's protocol' An offender who absconds whilst subject to sections 47/49 may be returned to the hospital at any time. Otherwise the patient must be returned within 6 months of going AWOL or on expiry of the section 47 (whichever comes LAST).</p>
<b>TRANSFER</b>	<p><i>Sections 47</i> Formal section transfer to another hospital can be authorised by the RC <i>Section 49</i> Formal section transfer to another hospital can only be authorised by the Ministry of Justice</p>
<b>APPEALS</b>	<p><i>Section 47 and 47/49</i> The patient has the right to appeal to the Mental Health Tribunal within 6 months starting with the day of the transfer direction</p>
<b>IMHA</b>	The patient is entitled to access the <i>Independent Mental Health Advocacy (IMHA) service</i> for sections 47 and 47/49 purposes and staff should assist her/him to do this if necessary.
<b>AFTERCARE</b>	Section 117 Aftercare and Supervised Community Treatment are applicable under this section
<b>DOCUMENTATION</b>	
<b>Sections 47 &amp; 47/49</b>	<p><i>Section 47</i> Completed by the Ministry of Justice <i>Section 49</i> Authorised by the Ministry of Justice..</p>
<b>Sections 47 &amp; 47/49 Rights</b>	Section 47 Rights Leaflet AND Section 47/49 Rights Leaflet

#### 6.8.12 Section 48 and Section 48/49 Removal to hospital of unsentenced mentally disordered prisoners

<b>CODE of PRACTICE</b>	Chapter 22, paras 22, paras. 22.42 – 22.43, 22.53 – 22.56 & 22.64 – 22.69, pp. 232-237 (See also: Reference Guide, Chapter 20, paras. 20.1–20.31.31, pp177).
<b>TITLE</b>	<p><i>Section 48:</i> Removal to hospital of other (un-sentenced) prisoners <i>Section 49:</i> (Ministry of Justice) Restriction on discharge of prisoners removed to hospital</p>

<b>PURPOSE</b>	<p><i>Section 48:-</i> Secretary of State warrant authorising the transfer of an un-sentenced prisoner from prison to hospital for treatment where that treatment is urgently needed.</p> <p><i>Section 49:-</i> Additional Ministry of Justice restrictions attached to the section 49 limiting powers and rights of leave, transfer and discharge from hospital.</p>
<b>DURATION</b>	Duration of the patient's period of remand fixed by the Courts
<b>EXPIRY</b>	Date of termination of remand unless, in the meantime, the patient is dealt with by the Courts in some other way
<b>OUTCOMES</b>	As determined by the Courts. May discharge from section and be dealt with by the Courts. Alternatively, may be further remanded OR may be made subject to sections 37, 37/41 or 45A.
<b>ELIGIBILITY</b>	<p><i>Section 48</i> People remanded in custody by Magistrate's Court; OR Civil Prisoners: ie committed by a Court to prison for a limited term but are not sentenced prisoners; OR People detained under the Immigration Act 1971 or under s.62 of the Nationality, Immigration and Asylum Act 2002</p> <p><i>Section 49</i> On the authority of the Courts, a Ministry of Justice restriction which may be additionally applied to patient's detained under sections 45A, 47 or 48.</p>
<b>APPLICATION MADE BY:-</b>	<p>Court makes the order on the support of the written or oral evidence of two doctors (at least one must be section 12 Approved)</p> <p>The evidence must confirm that both doctors agree that the offender has a mental disorder AND The person has a mental disorder of a nature or degree making it appropriate for her/him to be detained in hospital for medical treatment, AND... The person is in urgent need of such treatment, AND... Appropriate medical treatment is available</p>
<b>PROCESS</b>	<p>Having made the section 48 (with or without the section 49 attachment) the Secretary of State who decides to transfer the defendant to be conveyed to the hospital. The patient must be admitted within 14 days else the order lapses.</p> <p>The admitting nurse on the ward receives the section 48 or section 48/49 papers (a process which must include a basic check to confirm they have been duly completed).</p> <p>As soon as is practicable after admission, a qualified nurse must ensure that the patient's rights are explained to her/him, both verbally and in writing and documented.</p> <p>The Nurse should determine if the patient understands her his rights and a second verbal explanation of rights should be routinely given (and documented).</p> <p>If, after the second explanation of rights, the nurse either believes the patient has not understood her/his rights OR is not sure if the rights have been understood, further attempts must be made.</p>
<b>NEAREST RELATIVE</b>	Patients detained under section 48/49 have no Nearest Relative within the meaning of the Act.
	Treatment under sections 48 and 48/49 without consent is authorised under the Mental Health Act in accordance with Part IV powers
<b>LEAVE</b>	<p><i>Section 48</i> Section 17 Leave can be granted by the Responsible Clinician (RC) BUT... <i>Section 49</i></p>

	If section 49 restrictions are attached the RC must get the leave approved by the Ministry of Justice.
<b>ABSENCE</b>	<i>Sections 48 and 49</i> If the patient succeeds in leaving without authority, section 18 powers apply. Activate 'missing person's protocol' An offender who absconds whilst subject to sections 48 or 48/49 may be returned to the hospital at anytime up to the end date of the section 48.
<b>TRANSFER</b>	<i>Sections 48</i> Where no section 49 is attached, section 19 criteria applies. <i>Section 49</i> Formal section transfer to another hospital, even under same managers, can only be authorised by the Ministry of Justice
<b>APPEALS</b>	<i>Section 48 and 48/49</i> The patient has the right to appeal to the Mental Health Tribunal within the 6 months starting with the day the Transfer Direction was made.
<b>IMHA</b>	The patient is entitled to access the <i>Independent Mental Health Advocacy (IMHA) service</i> for sections 48 and 48/49 purposes and staff should assist her/him to do this if necessary.
<b>AFTERCARE</b>	Section 117 Aftercare applies but Supervised Community Treatment is not authorised under this section
<b>DOCUMENTATION</b>	
<b>Sections 48 &amp; 48/49</b>	<i>Section 48</i> Completed by the Secretary of State <i>Section 49</i> Authorised by the Ministry of Justice.
<b>Sections 48 &amp; 48/49 Rights</b>	Section 48 Rights Leaflet No specific Rights Leaflet for section 48/49

### 6.8.13 Section 135 Protocol Remand of accused person to hospital for treatment Remand of accused person to hospital for treatment

<b>PROTOCOL STATEMENT</b>	This Mersey Care NHS Trust protocol has been written in consultation with the joint section 135 policy (between health, local authority and police services).
<b>TITLE</b>	SECTION 135: Warrant to search for and remove patients (from private property)
<b>GUIDANCE</b>	
<b>MHA Code of Practice</b>	Chapter 16, paras. 161.1-16.16, pp. 139-141 & 16.44-16.76 pp.147-132
<b>MHA Reference Guide</b>	Chapter 30, paras.30.6-30.15, pp.248-249
<b>Police and Crime Act 2017</b>  <b>Key changes to Sections 135 and 136 of MHA 1983</b>	The Police and Crime Act 2017 came into force on 11 <sup>th</sup> December 2017 and makes key changes to sections 135 and 136 of MHA 1983. The changes relate to: <ul style="list-style-type: none"> <li>• <b>Powers under s.136</b> – can now be exercised anywhere other than in a private property</li> <li>• <b>Places of safety</b> – A person subject to s.135 or 136 can be kept at, as well as removed to, a place of safety. Therefore, where a s.135 warrant has been executed, a person may be kept at their home (if it is a place of safety) for the purposes of an assessment rather than being removed to another place of safety It is unlawful to use a police station as a place of safety for anyone under the age of 18, in any circumstances. A police station can now only be used as a place of safety for adults in specific circumstances, which are set out in the regulations</li> <li>• <b>Time limits</b> – The previous maximum detention period of up to 72 hours has been reduced to 24 hours (unless a doctor certifies that</li> </ul>



	<p>an extension of up to 12 hours is necessary)</p> <ul style="list-style-type: none"> <li>• <b>Protective searches</b> – A new search power allows police officers to search persons subject to s.135 or 136 for protective purposes.</li> <li>• <b>The duty to consult</b> – before exercising a s.136 power, police officers must, where practicable, consult with one of the health professionals listed in s.136(1C) or in regulations made under that provision.</li> <li>• <b>Decreased detention times</b> – see above.</li> </ul>
<b>Section 136 Policy</b>	This protocol should be read in conjunction with the Joint section 136 Policy
<b>PURPOSE</b>	<ol style="list-style-type: none"> <li>1. Application by an Approved Mental Health Professional (AMHP) to a Magistrates Court for the purpose of obtaining a warrant enabling any police officer to enter, by force if necessary, to remove a person to a place of safety (within the meaning of s.135(6) of the MHA 1983) with a view to making an application for detention under Part II of the Mental Health Act 1983 (ie. either section 2 or 3) – See MHA 1983, section 135(1).</li> <li>2. Application by a police officer or authorised person, usually a qualified mental health nurse, to a Magistrates Court for the purpose of obtaining a warrant enabling any police officer to enter, by force if necessary, to retake and return (either into custody or to the hospital from which s/he has absconded from) a person who is currently detained under the Mental Health Act 1983 – See MHA 1983, section 135(2).</li> </ol>
<b>CRITERIA</b>	<ol style="list-style-type: none"> <li>1. The application to the Magistrate's Court must be made under oath.</li> <li>2. There must EITHER be 'reasonable cause' to believe that the person has a mental disorder and that s/he is ill-treated or neglected or is living alone and is unable to care for her/himself [s.135(1)] OR that s/he is liable to be detained under the MHA 1983 [s.135(2)].</li> <li>3. There must also be 'reasonable cause' to believe that the person will be found on the premises AND that admission to those premises has been refused (or that 'such a refusal of admission is apprehended' [MHA 1983, s.135(2)])</li> </ol>
<b>DURATION</b>	<p>Where the person is taken into custody or a place of safety the section 135 warrant lasts for up to a maximum of 24 hours (starting from the time the person arrives at the place of safety/ custody suite). [MHA 1983, s.135(3).</p> <p>Under sections 135(3A) and (3B) the person may be transferred between different places of safety within the 24 hour period provided that it is considered both necessary and in that person's best interests.</p>
<b>EXPIRY</b>	EITHER on completion of the Mental Health Act Assessment or after 24 hours, whichever occurs first OR (where the person was already detained and had absconded) once s/he has been returned to the ward of the hospital s/he had absconded from.
<b>RENEWAL</b>	Can be extended by up to a further 12 hours in exceptional circumstances only.
<b>OUTCOMES</b>	<ol style="list-style-type: none"> <li>1. Whilst the warrant authorises the entry to premises it does not place an automatic duty upon a police officer to do so (ie where appropriate the person should be offered the opportunity to grant access without the need to use the warrant).</li> <li>2. Following a Mental Health Act assessment the person may be admitted informally, under the Mental Capacity Act, detained under the Mental Health Act or discharged home (with or without support as necessary)</li> <li>3. A patient to which s.135(2) applies remains liable to be detained under the MHA and the s.135 ends on her/his return to the ward.</li> </ol>

**SECTION 135 PROTOCOL**

**This protocol has been developed to provide guidance for mental health professionals and police officers making decisions about the scope of police involvement in Mental Health Act assessments. The protocol also recognises the need for professionals to fully consider the Mental Health Act Code of Practice and apply professional judgment when making any decisions in relation to the Act.**

1. Section 135(1) allows an AMHP (and only an AMHP) to make an application to the Magistrates for a Warrant. The Warrant allows an Approved Mental Health Professional (AMHP), a Doctor and Police Officers to enter the premises (using force if necessary) where a person who is believed to be mentally disordered is staying (See *MHA1983 Code of Practice, paras. 16.3 and 16.4*)
2. Section 135(2) allows any person authorised under section 18 of the MHA1983 to retake EITHER:-
  - (a) a detained hospital in-patient who is absent without leave, OR...
  - (b) a Supervised Community Treatment patient who has breached her/his conditions of discharge ...... to make an application for the issue of a warrant by a magistrate authorising entry by the police to remove a patient who is liable to be taken or returned to hospital or any other place or into custody under the Act. (See *MHA1983 Code of Practice, paras. 16.4-16.16*)
3. Mersey Care NHS Trust acknowledge that, ordinarily, responsibility for making a s.135(2) application lies with either a qualified Community Psychiatric Nurse or a Hospital Ward-based Nurse but that, in exceptional circumstances AND by mutual agreement between the relevant parties this application could also be made by either an AMHP or police constable.
4. Possession of a s.135(1) or s.135(2) warrant does not mean it must be used. Where practicable P should be given the opportunity to grant free access in which case there would be no need to execute the s.135 warrant. However, if at any subsequent point P withdrew such consent then the police office attending mental health officers would either have to leave or execute the warrant.
5. Where P lacks capacity, informed consent cannot be given and the use of the s.135 warrant is required. The use of the Mental Capacity Act does not authorise the conveyance of P to a place of safety for the purpose of a Mental Health Act assessment [(*R(on the application of Sessay) v South London & Maudsley Foundation Trust, 2011*)]
6. If there is a need to conduct an emergency Mental Health Act assessment on private premises, the police should be requested to consider using their power of entry under Section 17(1)(e) of Police and Criminal Evidence Act 1984 (PACE). It is important to note that this power can only be used in extreme circumstances where there is an immediate need to protect "Life or Limb". It cannot be used where there are concerns about "welfare" (*Syed v DPP 2010*).
7. The Warrant allows the police to use force in the execution of the

	<p>Warrant if required. Case law would indicate that this use of force can include restricting the movement of persons within premises (<i>DPP v Meaden 2003</i>).</p> <ol style="list-style-type: none"> <li>8. When planning an assessment under the MHA, assessors must give consideration to the least restrictive alternative. The MHA Code of Practice 16.11 states that Magistrates must attempt to ascertain whether reasonable efforts have been made to gain access without the use of a Warrant. The Code states that AMHP's should provide documented reasons for applying for a Warrant if they have not already tried to gain access. Such reasons include an assessed likelihood of the person (or others at the address) exhibiting violence or aggression during the assessment.</li> <li>9. It may also be necessary to make an application for a warrant where the person is known to be objecting to an assessment occurring on the premises where they are. This will normally be ascertained by mental health professionals making efforts to assess the patient without a Warrant. Due to the need to safeguard a person's right to Private and Family Life under Article 8 of the human Rights Act 1998, the assessors should have a low threshold to what amounts to an "objection". The Mental Health Act Code of Practice 14.20 offers guidance to what may be considered as an "objection" in the context of admission to hospital.</li> <li>10. If there is likely to be a need for police assistance to undertake a Mental Health Act assessment in the community, the AMHP should initially contact the Police Operational Communications Branch (OCB). They should request that the local neighbourhood police team contacts them to discuss the request. There is only a statutory requirement for the police to attend an assessment where there is a S135 Warrant, although all requests for police assistance will be considered. This consultation should occur before an application is made to the Court for a Section 135 Warrant. This process will also allow the police to share information they hold on the person regarding the risks.</li> <li>11. When discussing the request for police assistance, AMHP's should be prepared to share details of their risk assessment relating to violence and aggression with the police officers to allow a decision about the level of police resources to be allocated.</li> <li>12. The Warrant only grants statutory authority to a (one) Doctor, AMHP and Police Officers to enter the premises to assess whether it is necessary for the removal of the person to the Place of Safety. It does not give authority to conduct an assessment on the premises if the person is objecting. However, the Code of Practice 16.8 indicates that it may be possible to conduct a full MHA assessment on the premises if the person is agreeable.</li> <li>13. Where the person is objecting to an assessment taking place at the premises, they must be removed to a Place of Safety where they can be detained for up to 24 hours. It is important when contacting the</li> </ol>
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	<p>police that the AMHP clearly communicates that the request is to convey the person to a place of safety under Section 135 MHA.</p> <p>14. Where an assessment has been completed at the premises and an application for detention is completed under Section 2 or 3 MHA,</p> <p><b>15. MAKING THE APPLICATION FOR A s.135(1) WARRANT</b> The responsibility for processing this lies with the relevant Local Social Services</p> <p><b>16. MAKING THE APPLICATION FOR A s.135(2) WARRANT</b></p> <p>Identify the mental health professional who will make the application (Community Psychiatric Nurse or Ward-based Nurse unless prior mutual agreement reached as per point 3 above).</p> <p>Identified Mental Health Professional to complete the relevant Forms and submit them to the Magistrates Court</p> <p>Mental Health Professional to attend the Court as requested and to provide evidence under oath.</p> <p>Once satisfied the Court will issue the s.135 Warrant.</p> <p>Current practice is for the Court to charge the relevant organisation (Local Social Services or Health Authority) for issuing the Warrant.</p> <p><b>17. EXECUTING THE WARRANT [s.135(1) or s.135(2)]</b> The warrant is time-limited to a maximum of 3 months from the date of issue [PACE, s.16(3)] and may only be executed once unless otherwise stated [PACE, s.16(7) and s.5A].</p> <p>If entry is granted without the need to execute the warrant then it remains valid until it is either executed or the expiry date is reached (whichever occurs first)</p> <p>The police officer executing the warrant should be accompanied by a doctor (preferably section 12 approved), an AMHP and /or a nurse.</p> <p>If P requires assessment under the Mental Health Act 1983 then, unless s.17 of PACE permits, P must be conveyed to a place of safety for that purpose.</p>
<p><b>MERSEYSIDE POLICE GUIDANCE</b></p>	<p><b><u>Mental Health Crisis in Private Premises &amp; Warrants Under S 135 Mental Health Act 1983</u></b></p> <p>Police involvement with incidents involving mental illness on private premises is normally required where someone's mental health has deteriorated to the extent that they are in crisis and are a risk to themselves or others. Incidents of this nature can also involve the police due to the need to gain entry using a warrant.</p> <p>These incidents fall into 3 categories:</p> <ol style="list-style-type: none"> <li>1. Pre-Planned – where an Approved Mental Health Professional (AMHP) contacts the police in advance requesting help for a mental health assessment they are planning with regards to a person e.g. at home, (with or without S135 (1) MHA 83 warrant).</li> </ol>

2. Pre-Planned – where a patient detained under MHA 83 is absent without leave and entry is required to a premises under S 135 (2) MHA 83.
3. Spontaneous incidents notified to the police by the individual themselves, a member of the public, a mental health professional or where police officers are in attendance at a person's address for another reason when it becomes apparent that the person is having a mental health crisis.

Health and social care professionals regularly attend home addresses to conduct assessments under the MHA 83. If the individual meets the criteria for detention under the MHA 83 (sectioned), the person is detained using section 2 or 3 MHA 83 and conveyed to hospital. This often takes place without police involvement.

### **Entering Private Premises**

When it is necessary to enter premises where there is a concern for an individual's mental wellbeing, police officers can enter only

- If consent to enter a premises has been given by the individual who there are concerns about or a co-occupier. Consent can be withdrawn at any time, in which case the AMHP and any others should leave. If, however, prescribed MHA 83 forms for compulsory detention have already been completed, the process can be continued.
- If the officer has reasonable grounds to suspect that the person on the premises is about to commit serious harm to themselves, entry can be gained, using the power under S 17 PACE in order to save life and limb.
- A warrant under s. 135(1) of the MHA 83 can be granted. This authorises a police officer to enter premises, by force if necessary, and if thought fit, remove the individual to a place of safety for a period not exceeding 24 hours. This is to enable an application under the MHA 83 to be made in order to detain the individual under Section 2 or 3 the MHA 83.
- A warrant under 135 (2) of the MHA 83 can be granted. This authorises a police officer to enter premises, by force if necessary, in order to search for and retake an individual who is liable to be detained under the MHA 83 and who is Absent Without Leave.

### **Legislation - Power to Enter and Search Premises and Remove Persons under MHA 83**

**Section 135 (1) MHA 83** – If it appears to a justice of the peace, on information on oath laid by an approved mental health professional, that there is reasonable cause to suspect, that a person believed to be suffering from mental disorder –

- a) has been, or is being, ill-treated, neglected or kept otherwise than under proper control
- or
- b) is living alone and unable to care for themselves

the justice of the peace may issue a warrant, authorising a police officer to enter, by force if necessary, any premises specified in the warrant, in

	<p>which that person is believed to be, and</p> <p>if thought fit, to remove them to a <u>place of safety</u>, with a view to making an application under part 2 of the Act (compulsory admission to hospital or guardianship in sections 2 to 34), or other arrangements for their treatment or care.</p> <p><b>Section 135 (2) MHA 83</b> – If it appears to a justice of the peace, on information on oath laid by any constable or other person who is authorised by or under this Act that**;</p> <p>a) there is reasonable cause to believe that a patient is to be found on premises within the jurisdiction of the justice, and</p> <p>b) admission to the premises has been, or is likely to be, refused,</p> <p>The justice of the peace may issue a warrant authorising an officer to enter, by force if necessary, the premises specified in the warrant, and remove the patient.</p> <p><b>Section 135 (3) MHA 83</b> – A patient that is removed to a place of safety in the execution of a warrant issued under this section may be detained there for a period not exceeding 24 hrs.</p> <p><b>Section 135 (4) MHA 83</b> - In the execution of a warrant issued under S 135 (1) MHA 83 above, a police officer <b>shall</b> be accompanied by an approved mental health professional and by a registered medical practitioner. In the execution of a warrant issued under S 135 (2) MHA 83 above, a police officer <b>may</b> be accompanied by a registered medical practitioner or by any person authorised by or under this Act**.</p> <p>** Person Authorised – This means persons authorised to retake patients under S18 MHA 83, they are, in addition to a police officer, any officer of the staff of the hospital, any AMHP or any person authorised by the hospital managers. In the case of a patient subject to Guardianship under MHA 83, any officer on the staff of a local social services authority.</p> <p><b><u>1. Dealing with Pre-Planned Mental Health Act Assessments on Private Premises</u></b></p> <p>Pre-planned assessments provide time to arrange staff availability, apply for a warrant if necessary and plan tactically what will take place.</p> <p>All requests for police assistance at pre-planned Mental Health Act assessments on private premises will be made via the Force Contact Centre. The AMHP should contact the police during the initial stages of the planning process, even if a definitive assessment time is unknown. This will allow all the relevant information to be recorded on the Storm log and consideration can be given to what police resources will be required.</p> <p>The AMHP should provide all relevant information, this will include;</p> <ul style="list-style-type: none"> <li>• Name and date of birth of the person to be assessed</li> <li>• Address of the proposed assessment</li> <li>• Time if known (if not known log can be created and delayed pending further call)</li> <li>• If a S 135 MHA Warrant exists</li> <li>• The reasons for the request for police involvement</li> <li>• The name and telephone number of the AMHP who will be</li> </ul>
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	<p>responsible for the assessment (including the time they are available until)</p> <ul style="list-style-type: none"> <li>• If there is a possibility the AMHP could go off duty prior to the commencement of the assessment, other colleague details and a contingency plan should be provided</li> <li>• Details of other persons likely or known to be on the premises</li> <li>• Details of any history of violence or absconding.</li> <li>• If the individual has any particular thoughts related to their condition about the police e.g. paranoia / conspiracy</li> <li>• Any other known or potential risk factors (children, dogs etc)</li> </ul> <p>The AMHP should also provide clear reasoning as to why the police are required;</p> <p>e.g. The individual has a history of violence  To execute a 135 MHA warrant and gain entry  There is likely to be a breach of the peace  The individual is likely to resist being taken to hospital  The individual is likely to leave the premises before the assessment is completed  Dangerous dog on the premises</p> <p>On receipt of this information, the FCC will create a Storm log. Mental Health Act assessments are difficult to coordinate as it requires professionals from different agencies to mutually agree a time within their working day to attend the premises. If it is apparent to FCC staff that it is unlikely that patrols will be available at the time suggested or there is a conflict with current operational commitments, a discussion should take place with the AMHP in relation to rearranging the time. If this is not possible, consideration should be given to the implications (including risks posed) if the assessment cannot go ahead due to the lack of available police resources.</p> <p><b>Force systems will be interrogated for any information that will inform the attending officers of any likely risks.</b></p> <p>The MHA 83 Codes of Practice emphasises that the AMHP has overall responsibility for co-ordinating the process of assessment and, where he or she decides to make an application for compulsory admission to hospital, for implementing that decision. The AMHP should always contact NWS to arrange for an ambulance to convey the individual to hospital. This should also be done at the planning stage, so that the individual and other agencies do not have to wait at the premises any longer than is necessary. The AMHP should provide the NWS log number to the Force Contact Centre.</p> <p>Where the police are involved in an assessment, it is essential that there is clarity between all agencies involved, that the police will control the operation for the purposes of entry into the premises and preventing a breach of the peace.</p> <p>At the very minimum this joint planning process should involve talking through issues over the telephone. The following points should be considered:</p> <ul style="list-style-type: none"> <li>• Whether entry is to be by means of a warrant or by consent.</li> <li>• If entry is by warrant, the method by which the police will gain entry and secure the premises.</li> <li>• If forced entry is anticipated, what provisions has the AMHP</li> </ul>
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arranged to secure the premises. \*\*

- If entry is without a warrant police will only enter and remain on the premises if they are satisfied that they are doing so with consent, until the AMHP has completed the admission papers and the person is deemed to be in legal custody.
- How and who should deal with passive resistance e.g. The person is not displaying or threatening violence but simply declines to go to hospital.
- Acceptance by the AMHP that they will brief all non-police personnel to ensure that each participant is fully aware of the plan for carrying out the assessment, including dealing with contingencies, and the role to be played by each agency.
- Contingencies, e.g. that the person leaves the premises before the completion of the assessment, or consent is refused or withdrawn at any stage.

#### **\*\* Securing Premises**

The securing of the property following removal of a person is the responsibility of the Social Services Authority under Section 48 of the National Assistance Act 1948. Any expenditure incurred should be passed to the Local Authority. It is therefore the AMHP's responsibility to ensure that the premises are re-secured at the end of the assessment.

#### **S 135(1) MHA 83 Warrant**

Where refused entry is anticipated, a S 135 (1) MHA 83 warrant can be obtained, granting a police officer access and allowing a Mental Health Act assessment by health and social care professionals.

It should be noted that, whilst the warrant is addressed to a constable, it can only be applied for by an AMHP. When there has been a request for the police to assist in relation to section 135(1), Section 135(4) MHA 83, it requires that the police constable must be accompanied by an Approved Mental Health Professional and by a registered medical practitioner.

#### **DISPOSAL and STORAGE of S 135(1) and S 135(2) MHA 83**

The warrant provides the police (accompanied by the AMHP and a registered medical practitioner) with the power to enter the premises. Two options are then available:

1. The person can, where it is considered proportionate and necessary, be removed under the authority of the warrant to a 'place of safety' (for a period not exceeding 24 hours) where an AMHP and two registered medical practitioners can carry out an assessment.
2. Being legally on the premises under the authority of the warrant, the AMHP and the registered medical practitioner(s) **may** be able to carry out the assessment on the premises. \*\*

\*\*The purpose of the warrant is to enable lawful access and to remove the individual to a place of safety. The purpose of the warrant is not to enable an assessment to take place on the premises. However, once entry has been gained, assessments frequently do take place on the premises. There is no power to remain on the premises to conduct an assessment. Therefore an assessment may continue up until the point that the person being assessed refuses to cooperate. At this point the warrant allows for the individual to be removed to a place of safety so that the assessment



can continue there.

If the assessment is conducted on the premises and the determination of that assessment is that the person should be admitted compulsorily to hospital under Sections 2 or 3 MHA 83 (and the formal paperwork has been completed), the removal to the named hospital will be under that section and not under the Section 135(1) warrant.

The warrant will authorise an entry on one occasion only (unless specified otherwise).

The position, following *Ward v Commissioner of Police for the Metropolis* [2005] UKHL 32, is that the relevant sections of the Police and Criminal Evidence Act 1984 ("PACE") also apply to warrants issued under s.135 MHA. Section 16 PACE therefore applies and requires the police to return a warrant, which has been executed (and endorsed) or has expired, to either:

1. (if the warrant was issued by a justice of the peace), the designated officer for the local justice area justice in which the justice was acting when he issued the warrant;
2. (if the warrant was issued by a judge), the appropriate officer of the court from which he issued it.

A copy of the endorsed warrant (or unexecuted warrant) must therefore be supplied to the appropriate contact at the Court, although it seems clear that responsibility for this falls to the police rather than the Trust. The Court will retain a copy for a period of 12 months.

Disposal and storage of the section 135 warrant (and copies of the same) should therefore be as follows:-

1. The officer should endorse the warrant stating whether the person sought was found.
2. A copy of the warrant should be left with the occupier or at the premises.(Any search that takes place will only be to the extent required for the purpose of the warrant).
3. If the patient is admitted to hospital a copy of the s.135 warrant should be left with the Mental Health Act Law (Administrators) Office
4. A copy will be retained by the police for their records
5. A copy of the endorsed warrant (or unexecuted warrant) must therefore be supplied to the appropriate contact at the Court

#### **Need a S 135(1) MHA 83 warrant be executed?**

Even where the constable is in possession of a warrant, it may be deemed that the most appropriate course of action is to request consent to enter the premises.

e.g. because of the adverse impact the formal serving of a warrant would have on the person.

There is no legal requirement to execute the warrant at this stage. Where entry is obtained with consent, and such consent is withdrawn before an assessment is completed, the warrant can then be executed.

#### **Hostels and Hotel rooms**

The requirement for a warrant to enter rooms within hostels or hotels to carry out an assessment can generate considerable debate between

police and mental health professionals.

Where an individual exclusively occupies a part of the premises, consent to enter that person's particular area is not always clear. The case *R v Rosso (Rosario)* [2003] EWCA Crim 3242; [2003] MHLR 404 provides guidance when deciding on the requirement to obtain a warrant in these kinds of situations.

The test applied by the court (at paragraph 19) as to whether a warrant would be required included the following considerations:

- Does the occupant have a right to exclusive occupation of the room?
- Does the occupant have a right to exclude others from the room?
- Does the occupant have the right to deny access?

It could be argued that where a hostel or hotel room is occupied exclusively by the occupant, that person does have the right to exclude others from the room; and in the absence of clear legal advice, where the occupant refuses or refusal is anticipated, a warrant would be required for a mental health team and accompanying police officers to enter without consent.

Where doubt exists, a warrant should be sought and the application for the warrant should clearly set out the access and consent issues in relation to the premises, leaving the court to decide.

#### **Passive Resistance and Patients Who Refuse to go to Hospital Once Detention is Authorised**

If, once the individual is detained, they refuse to leave the premises or go to the ambulance, there should not be an automatic assumption that it is the police officer who should handle the individual.

If the individual is not displaying or threatening violence but simply declines to go, the AMHP should take the time to understand and resolve the concerns raised by the detained person, this may lead the person to co-operate without the physical intervention.

The MHA 83 Code of Practice, paragraph 17.13 states *"If the patient is likely to be unwilling to be moved, the applicant should provide the people who are to transport the patient (including any staff or police officers involved ) with authority to transport the patient"*

The AMHP themselves and/or any police officer or member of health and social care staff so authorised by them may physically move the person using force if necessary.

Whilst the AMHP can authorise removal by a police officer they cannot direct. The decision whether or not to use the delegated power rests with the police officer. Police have a duty and a power to prevent a breach of the peace and the MHA code expects police to be involved where the threat of violence exists.

#### **Conveying a Patient Subject of a Section 2, 3 or 4 MHA 83 Detention to Hospital**

S. 6 MHA 83 provides a power for the applicant for that detention (usually an AMHP) to take and convey the patient to hospital.

S. 6 MHA 83 also allows the AMHP to authorise any person to take and convey the patient to hospital (any person authorised by the AMHP would usually be ambulance personnel and/ or the police).

S 137 MHA 83 reinforces that such a person will be in legal custody during that period of taking and conveying.

## **2. S 135 (2) MHA83 - Patients (Absent Without Leave) Refusing Entry**

When making enquiries to locate an individual who is liable to be detained under MHA 83 and they are suspected to be at premises and are refusing access. A warrant under S135 (2) MHA 83 should be considered.

A Magistrate may issue a warrant authorising a Constable to enter the premises, if need be by force, and retake the patient to the designated place of treatment/assessment i.e. the hospital or unit from which they are missing.

An application for a warrant under S 135(2) MHA 83 can be made to a Magistrate by any constable or person authorised including and AMHP.

In Merseyside the forms to make the application are held by the Local Authority, therefore discussion should take place with the patient's care team and a request should be made to the Local Authority to complete the application to a Magistrate.

The Justice of Peace needs to be satisfied on information laid on oath by any constable or other authorised person that:

- i) That there is reasonable cause to believe that the patient is to be found on premises within the jurisdiction of the justice; and
- ii) That admission to the premises has been refused or that a refusal is anticipated.

The warrant will authorise an entry on one occasion only.

When executing a warrant under S 135 (2), it is good practice for the police officer to be accompanied by a person from the individual's care team. If this is not achievable due to health resources, this should be documented on the relevant Storm log. It is likely that the individual concerned is also reported as a missing person, the CIM should then consider if it is appropriate to execute the warrant.

A copy of the warrant should be left with the occupier or at the premises.

Any search that takes place will only be to the extent required for the purpose of the warrant.

The officer should endorse the warrant stating whether the person sought was found.

## **3. Dealing with Spontaneous Mental Health Incidents on Private Premises**

There are incidents to which the police are called, that involve a person on private premises who appears to have a mental health condition and who is in crisis to the extent that action or assistance is required.

E.g.

- An individual in mental health crisis contacts the police for assistance
- Whilst on premises dealing with another issue, it becomes apparent that a person is has a mental health condition and is in crisis
- A Mental Health Practitioner visiting an individual in the community contacts the police as the person has become

violent.

Since such incidents are not pre-planned, a warrant will not exist, and due to the lack of powers available in this situation, these can potentially be extremely difficult situations to deal with.

It is not appropriate in such circumstances to persuade the individual to leave the premises, in order to detain them under S 136 MHA 83. S 136 MHA 83 dictates that you 'find' them in a place to where the public has access. In such circumstances it is likely it would be deemed the officer found them in private premises.

Any risk posed by the individual to themselves or others should form part of the decision making. The following options should also be considered;

- Ascertain if the individual is under the care of mental health or social care services.
- Contact any professionals involved asking for their advice and to attend if possible.
- Contact the local mental health crisis team to ascertain if the individual is known to them and for their advice.
- If the individual is known to mental health services, contact a manager within that service.
- If there is no risk posed and the individual has friends or family present or who they can go to.
- If not known to mental health services, make contact with their GP.
- Consider their capacity and powers under the Mental Capacity Act 2005. (see MCA 2005, Chapters 5 and 6, Mental Capacity Act 2005 Code of Practice, 2008 ed., Chapter 6, pp. 92-113)
- If the individual is prepared to go to AED, an ambulance should be called. Officers should also consider the risks of leaving the individual alone at AED e.g. Risk of the individual walking out of AED and harming themselves, or the risk to AED staff.
- Contact the Local Authority to request Duty AMHP attendance or MHA 83 assessment
- Consider any offences disclosed (a mental health assessment can take place in custody)

Entry to premises in these instances can only be with consent, unless entry is justified under PACE or Breach of the Peace etc.

Where the circumstances are not as serious or critical and entry to the premises cannot be justified as lawful, in these circumstances the options are:

- Refer the person to the Local Authority for a mental health assessment
- Pass on the details of the incident to their G.P. (if known)
- Persuade the owner of the premises (quite possibly the person with the mental illness) to permit police to enter the premises and request the AMHP or their mental health worker (if applicable) to attend urgently.

It is unreasonable in most circumstances, if there is no other policing purpose, for officers to remain for a long period waiting for an AMHP to arrive.

#### **Escalation**

	<p>If officers encounter any issues with partner agencies at any incident involving an individual with a mental health condition that cannot be resolved at the time</p> <p>e.g. patrols being engaged with the incident longer than is necessary or patrols having to convey due to NWS resourcing issues. Details of the issue should be recorded on the Storm log. The log should then be brought to the attention of the BCU Mental Health SPOC</p> <p>The Mental Health SPOC should then engage with strategic managers within the relevant agency to ensure the situation is resolved.</p>	
<b>MAGISTRATES COURTS: CONTACT DETAILS</b>	Liverpool (and Knowsley) ((Magistrates Court	Queen Elizabeth II Law Courts Derby Square <b>Liverpool</b> Merseyside L2 1 Tel. 0151-24305500
	South Sefton Magistrates Court	Merton Road Bootle Merseyside, L20 3XX Tel. 0151-285-6231
	St. Helens (Knowsley) Court House, Corporation Street	As per Liverpool Magistrates Court above
<b>Section/Holding Power</b>	<b>Section 135 Warrant to search for and remove patients</b>	
Code of Practice	Ch.16, paras 16.1 – 16.16, pp.139/141	
Details	See 6.8.13 above – <b>Police and Crime Act 2017</b>	
<b>Section/Holding Power</b>	<b>Section 136 Mentally disordered people found in public places</b>	
Code of Practice	Ch. 16, paras 16.17 – 16.29, pp.141/143	
Details	Refer to Trust Policy MH16 and see 6.8.13 above – <b>Police and Crime Act 2017</b>	

## 6.09 Leave of Absence under the Mental Health Act 1983

6.09.1 MHA 1983 Section 17

6.09.2 MHA Code of Practice

Chapter 27, paras. 27.1-27.7, 27.18-27.21, 31.4-31.5, Annexe A (p.411)

See also:-

(a) Accompanied Leave	Paragraphs 27.9
(b) Aftercare (s.117)	Paragraph 33.2
(c) Care and treatment	Paragraphs 27.24-27.26
(d) Safeguards	Paragraphs 31.8-31.11
(e) Escorted leave	Paragraphs 27.27-27.28 & 28.9
(f) Power to grant s.17	Paragraphs 27.8-27.14
(g) Recall	Paragraphs 27.32-27.36
(h) Record keeping	Paragraphs 27.22-27.23
(i) To reside in other hospitals	Paragraphs 27.30-27.31
(j) Restricted patients	Paragraphs 27.39-27.42
(k) CTO as an alternative	Paragraphs 31.4-31.7
(l) Short-term leave	Paragraphs 27.15-27.17

6.09.3 *Additional Guidance*  
Mersey Care NHS Trust

(a) Section 17 Leave of Absence Forms

- (i) High, Regional and Low Secure Units use a Ministry of Justice compliant leave of absence form
- (ii) The remaining services use a standardised form but with minor variations to meet the needs of patients (specific to given services)
- (iii) Responsible Clinicians should consider the viability of granting routine escorted leave in excess of one hour at a time (ie if two or more patients on a given ward are separately granted 2 hours escorted leave daily, then how will this impact upon the safety of the ward?)

(b) Leave of Absence beyond England and Wales

- (a) The Mental Health Act 1983 has no powers outside of England and Wales although there are reciprocal agreements that exist with both Scotland and Northern Ireland.
- (b) If leave of absence is to be granted to any other country the Responsible Clinician must be able to justify why it is considered safe to authorise such leave to a place where s/he is no longer under the powers of the Act but on her/his return they will still need to be detained.
- (c) In any event, where leave is granted, the Responsible Clinician must review the patient on their return to determine whether or not continued detention under the Act is still necessary.

**6.10 Absence Without Leave**

6.10.1 MHA 1983 Sections 18, 21,21A,21B, 22, 137 and 138

6.10.2 MHA Code of Practice

- (a) General Chapter 28; pp.324-328
- (b) Eligibility for IMHA Services Paragraph 6.8, p.55
- (c) Disclosure of Confidential Information Paragraph 10.9, p.80
- (d) Section 135(2) Warrant Paragraph 16.14, p.141
- (e) Transport between Hospitals Paragraph 17.30, p.157
- (f) Community Treatment Orders (CTO) Paragraphs 28.8, 28.11-28.12, 28.21
- (g) Detained Patients Paragraphs 28.4-28.6, 28.11-28.12
- (h) Guardianship Patients Paragraphs 28.7, 28.13, 28.21
- (i) Local Policies Paragraphs 28.2, 28.11-28.23
- (j) Patients in Legal Custody 28.9-28.10
- (k) Examination of Returned Patients (s.21B) 28.21

**6.11 Formal Transfers**

6.11.1 Section 19(1) **Transfer of Patients to a hospital managed by different Hospital Managers in England & Wales**

6.11.3 *Additional Guidance*

- (a) Section 19(1) transfer requires the completion of Form H4
- (b) Part A is completed by the transferring hospital
- (c) Part B is completed by the receiving hospital
- (d) The form should arrive at the receiving hospital either with the patient or in advance of their transfer
- (e) If a patient goes absent without leave en route then the transfer papers may still be delivered to the receiving hospital. If the patient is retaken s/he may be either returned to the transferring hospital or may be taken into custody at the receiving hospital (on receipt of written instruction from the transferring hospital). Once received into custody the transfer can be completed (guidance received from Hill Dickinson Solicitors, 2013)
- (f) The decision to return a patient absent without leave to the transferring hospital or the receiving hospital must be based on grounds of necessity, patient best interests, proportionality and the least restriction principle (guidance received from Hill Dickinson Solicitors, 2013)

6.11.4 **Section 19(3) Transfer of Patients to a hospital managed by the same Hospital Managers in England & Wales**6.11.5 *Additional Guidance*

- (a) The transfer details must be documented in the patient's case notes but there are no forms to complete.
- (b) **Patients cannot be transferred under section 19 if they are detained under sections 5(2) or 5(4) of the MHA 1983**

6.11.6 **The transfer to and from countries outside England and Wales**

MHA Section	TITLE
s.80	Removal of in-patients TO Scotland
s.80ZA	Transfer of responsibility for community patients TO Scotland
s.80A	Transfer of conditionally discharged patients TO Scotland
s.80B	Removal of detained patients FROM Scotland
s.80C	Removal of community patients FROM Scotland
s.80D	Transfer of conditionally discharged patients FROM Scotland
s.81	Removal of in-patients TO Northern Ireland
s.81ZA	Transfer of responsibility for community patients TO Northern Ireland
s.81A	Transfer of conditionally discharged patients TO Northern Ireland
s.82	Removal of detained patients FROM Northern Ireland
s.82A	Transfer of conditionally discharged patients FROM Northern Ireland
s.83	Removal of in-patients TO Channel Islands or Isle of Man
s.83ZA	Transfer of responsibility for community patients TO Channel Islands or Isle of Man
s.83A	Transfer of conditionally discharged patients TO Channel Islands or Isle of Man
s.84	Removal of detained patients FROM Channel Islands or Isle of Man
s.85	Patients (Offenders) removed from Channel Islands or Isle of Man
s.85ZA	Removal of community patients FROM Channel Islands or Isle of Man
	Transfer of conditionally discharged patients FROM Channel Islands or Isle of Man

s.85A	Responsibility for patients transferred FROM Channel Islands or Isle of Man
s.86	Removal of foreign patients FROM England and Wales

## 6.12 Discharge

6.12.1 Discharge takes on several meanings and it is important to clarify just what is meant when a person is 'discharged'.

(a) Discharge from detention under s.23 of the Act (Code of Practice):-

- |  |                        |
|--|------------------------|
| (i) Not holding a review before detention expire | Paragraph 32.10        |
| (ii) Community Treatment Orders                  | Paragraphs 32.11-32.16 |
| (iii) Nearest Relative's Discharge Power         | Paragraphs 32.20-32.25 |
| (iv) Hospital Managers and Tribunal: Discharge   | Paragraphs 32.26       |

(b) Discharge from hospital

(c) Discharge from Mental Health Act Aftercare services (eg. Section 117 aftercare, Community Treatment Orders)

(d) Discharge from service

## 6.13 Aftercare

6.13.1 Section 117 Aftercare

Please refer to the joint inter-agency section 117 Policy on the Trust web site

6.13.2 MHA Code of Practice Chapter 33, pp. 357-361, 27, pp.250-259

6.13.3 *Additional Guidance*

(a) **What is Covered by Section 117 Aftercare?**

*R v LB Camden, [2013] EWHC 1637, 13<sup>th</sup> June 2013*

A recent court judgment has clarified further what is covered by S.117 Aftercare. *R v LB Camden, [2013] EWHC 1637, 13<sup>th</sup> June 2013*, concerned a man, Mr Tewodros Afework, who had been detained under Sec.3 MHA in 1992 & 1993. He had then lived in a number of local authority flats with his sister, for which they received housing benefit.

In 2000, he was assaulted and incurred significant brain damage. As a consequence he was no longer able to live independently and had to live in specialist accommodation. S.21 National Assistance Act 1948 applied, but he was not charged for his accommodation on the grounds of low income.

It would appear that the application arose as a result of Mr Afework being awarded a considerable sum of money in Criminal Injuries compensation, which it was likely the local authority providing accommodation would take into account when assessing his contribution to his accommodation charges.

Mr Justice Mostyn, the judge in the case, reiterated a number of previous cases which looked at issues of accommodation and S.117 Aftercare. In particular, the case of *R (Stennett) v Manchester City Council [2002] 2 AC 1127*, looked at three cases



where people who had been detained under Sec.3 had then been charged for residential accommodation. It was affirmed that residential accommodation came within the remit of S.117 aftercare, and could not therefore be charged for. This decision was upheld by the House of Lords.

He also referred to Mwanza, which I have looked at before (*R v Greenwich London Borough Council and Bromley London Borough Council, ex parte Michael Mwanza (2010) [2010] EWHC 1462 (Admin) QBD (Admin) (Hickinbottom J) 15th June 2010*, to give it its full title.)

This case involved a Zambian national who was in this country on the basis that his wife had a student visa. He was subsequently detained under Sec.3. He and his wife stayed in this country for several years, during which time his wife's student visa ran out and they were then considered to be residing in this country unlawfully, so they were unable to work.

They applied for accommodation and financial support. When this was refused, he applied for judicial review on the basis that S117 aftercare covered both eventualities, as they could be considered to be necessary in order to prevent a deterioration in his mental health.

The Court found that a local authority's duty to provide aftercare was limited to the services necessary to meet a need arising from a person's mental disorder. As his mental disorder had not been the cause of his homelessness or destitution, then there was no requirement on the local authority to meet this need.

The judge also examined the case of R (Gary Baisden) v Leicester City Council [2011] EWHC 3219 (Admin). In this case, a man called Gary Blaisden, who had paranoid schizophrenia and who had been detained under Sec.3 MHA in 2010, was being evicted from his accommodation on the grounds of his antisocial behaviour. This antisocial behaviour had arisen not by his mental illness but by his drug abuse. It was argued that the local authority should provide him with accommodation under S.117 aftercare provisions were he to become homeless.

The judge in this case rather sensibly concluded:

"If the mental condition does not require specialised accommodation with elements of support, then the duty to provide bare accommodation is under section 21 of the National Assistance Act. In any event, in respect of both duties the defendant says that the assessment of the consultant psychiatrist is that it is his voluntary drug taking that is the cause of his predicaments rather than his underlying schizophrenia that can respond to medication. Therefore what he needs to do is to stop taking drugs and to co-operate with his Outreach team in that respect, at which point he will be able, if he so chooses, to manage independent living, look after himself, abide by the conditions of his tenancy and not be a nuisance with his neighbours."

Based on these cases, Mr Justice Mostyn therefore held that:

"As a matter of law s117(2) is only engaged vis-à-vis accommodation if:

- i) The need for accommodation is a direct result of the reason that the ex-patient was detained in the first place ("the original condition");
- ii) The requirement is for enhanced specialised accommodation to meet needs directly arising from the original condition; and
- iii) The ex-patient is being placed in the accommodation on an involuntary (in the sense of being incapacitated) basis arising as a result of the original condition."

As he found that the applicant's need for residential care arose entirely from his head injury, and was not the result of his underlying mental illness, then S.117 aftercare did not apply.

The conclusion to be drawn from these cases therefore could not be clearer:

- Residential care is certainly covered by S.117 aftercare, but only if the need for that care arises from the patient's mental condition which resulted in their detention under Sec.3 MHA.
- Ordinary accommodation, eg a flat or house, is not under any circumstances covered by S.117.

## 6.14 **Community Treatment Orders (also referred to as CTO, Supervised Community Treatment, SCT)**

### 6.14.1 MHA Code of Practice

TITLE	Chapter	Paragraph
Absence without leave and SCT	28 & Ann B	28.3, 28.8, 28.11-28.12, 28.21, & Ann B
Accommodation for hearings	12	12.38
Advance Decisions and CTOs	9	9.8-9.10
After Care (s.117 entitlement and CTOs)	29	29.21, 29.77, 33.2, 33.6
AMHP (Approved Mental Health Professional) role in CTOs	29	29.10, 29.22-29.25, 29.40, 29.64-29.68,
As an Alternative to s.17 Leave	27	27.11-27.14, 27.37, 31.5
Application of CTO (ie making the order)	29	29.26
Appropriate medical treatment test and CTOs	23	23.7-23.8
Assessment of Patient suitability for CTO	29	29.10-29.18, 29.19, 29.22, 29.25
Attorney, deputy or agent of patient on a CTO	7	7.6, 7.7
Capacity to consent to treatment and SCT (See Mental Capacity Act & CTOs below)	-	-
Care planning and CTO	29	29.20-29.21
Children, Young People & CTO	19	19.82, 19.113-19.114
Communication with patients on CTO	4	4.2, 4.9
Concerns raised by relatives or carers	29 & Ann B	29.4 and Ann B
Conditions attached to CTOs	29	29.27-29.33, 29.38
Conflicts of interest and CTO	39	39.16
Deprivation of Liberty and CTO (See Mental Capacity Act & CTOs below)	-	-
Discharge from CTO	4	4.13, 4.21, 4.33
	29	29.75-29.77
	32	32.17-32.19
	38	38.1-38.9
Documentation	4	4.16
	35	35.16-35.17, 35.18-35.20
Duty to provide information (See Information below)	-	-
Eligibility criteria for CTO	29	29.28-29.18
Emergency applications for detention (eg s.136) & pre-existing CTOs	15	15.16-15.17
Emergency Treatment under s.64G for Part 4A patients	24	24.24-24.28
	25	25.26, 25.84

Expiry of CTO	4	4.28
	32	32.1, 32.2, 32.11, 32.18-32.19
	38	38.15
Extension (Renewal) of CTO	4	4.28, 4.34
	32	32.1-32.10, 32.11-32.16, 32.19
	38	38.41-38.46
Extension (Renewal) of CTO – Uncontested Renewals	38	38.41-38.46
Guardianship, Leave of Absence or CTO	13	13.1-13.11
IMHA Services and CTOs	6	6.6, 6.8, 6.12
Information (for Nearest Relatives)	4	4.30-4.35
	37	37.22
Information (for Patients)	4	4.9-4.30
	29	29.34-29.35
	Ann B	Annexe B
Information (for Recall)	4	4.18-4.19, 4.28
Information (for Seeking a Review)	4	4.21
	38	38.11
Medical Treatment and Part 4A Certificates	24	24.23
	25	25.3, 25.27-25.32, 25.33-25.36, 25.47, 25.53-25.54, 25.83
	29	29.27, 29.47,
	34	34.13
Medical Treatment and Patients NOT recalled to hospital (Part 4A patients)	24	24.14-24.23
Medical Treatment and Positive Behaviour Support Care Plans	21	21.13-21.14
Medical Treatment and SOAD visits	25	25.45-25.46
Medical Treatment and the Three Month (s.58) Rule	25	25.16, 25.31
Medical Treatment without consent	9	9.8-9.9
	19	19.82
Mental Capacity Act (MCA) and CTOs	13	Ch.13 generally. Specific: 13.56
	24	24.54
	31	31.8-31.11
Monitoring Patients in receipt of CTO	29	29.36-29.39
Personality Disorders	21	21/13-21.14
Recall (and Hospital)	15	15.17
	24	24.10
	29	29.9, 29.45-29.62
	31	31.6
Recall Process	29	29.52-29.62
Recall (Transportation of patients)	17	17.33-17.35
Revoking the CTO	4	4.24, 4.28
	29	29.63,-29.72,
	37	37.42
	Ann A	Annexe A
Reviews	29	29.73-29.74
	38	38.11-38.14, 38.18, 38.19-38.24 & 38.24-38.40
Second Professional	32	32.13
Section 135(2) Warrants (See Police and Crime Act 2017, para. 6.8.13 above)	16	16.15
	29	29.57
Sexual and Violent Offenders	37	37.34-37.36

Transfer and Assignment of Responsibility	37	37.30-37.31
Tribunals and CTO - Purpose	12	12.3-12.5
Tribunals and CTO - Recommendations	29	29.19
Tribunals and CTO – Representation at	12	12.26
Tribunals and CTO – Rights to apply to	4	4.21, 4.21-4.24,
	12	12.2, 12.6-12.9
	38	38.11
Use of Force on Part 4A patients	24	24.19, 24.20, 24.27-24.28
Varying and Suspending Conditions	29	29.40-29.43

## 6.15 Treatment

- 6.15.1 Please refer to the Department of Health Policy on Consent to Treatment which includes additions with respect to mental health. Policy accessed through the Trust web site (Policy Reference SD06).
- 6.15.2 Key guidance regarding Consent to Treatment can be found within the Mental Health Act Code of Practice:- Chapters 23-26
- 6.15.3 Consent to Treatment and Capacity related guidance can, additionally be found in Chapters 13 and 14.

## 6.16 Appeals, Renewals and Extensions of In-patient Detention and Community Treatment Orders

- 6.16.1 Mental Health Tribunal Appeals against Detention and Community Treatment orders  
MHA Code of Practice Chapter 12, Paragraphs 12.1-12.43, pp.87-94  
**Nb. The Code refers to these as *Mental Health Review Tribunals (The Mental Health Act 2007 revised this to First-tier Tribunal (Mental Health))*.**
- 6.16.2 Appeals against and Renewals of Detention and Community Treatment Orders by the Hospital Managers  
MHA Code of Practice Chapter 38, Paragraphs 38.1-38.50, pp.385-393

## 6.17 The Hospital Managers (Also referred to as *The Managers* or *The Mental Health Act Managers*)

- 6.17.1 Code of Practice Chapter 37, paragraphs 37.1-37.47, pp.376-384
- 6.17.2 The Trust has a statutory duty to ensure that it applies the Mental Health Act correctly and in accordance with law. This duty is met by way of delegation to the Hospital Managers.
- 6.17.3 They have a range of statutory functions.
- 6.17.4 Most of these functions are delegated to personnel within the Trust but the power of discharge can only be delegated to those Members of the Trust and others who are not employees.
- 6.17.5 The Trust Board keeps and maintains a formal Scheme of Delegation of Hospital Managers' Functions

## 6.18 The Mental Health Act 1983 and the Health and Social Care Act 2012

6.18.1 The following sections of the Health and Social Care Act 2012 have amended the Mental Health Act 1983:-

*Functions relating to mental health matters*

**s.38 Approval functions**

(1) After section 12 of the Mental Health Act 1983 insert—

***“12ZA Agreement for exercise of approval function: England***

(1) The Secretary of State may enter into an agreement with another person for an approval function of the Secretary of State to be exercisable by the Secretary of State concurrently—

(a) with that other person, and

(b) if a requirement under section 12ZB has effect, with the other person by whom the function is exercisable under that requirement.

(2) In this section and sections 12ZB and 12ZC, “approval function” means—

(a) the function under section 12(2), or

(b) the function of approving persons as approved clinicians.

(3) An agreement under this section may, in particular, provide for an approval function to be exercisable by the other party—

(a) in all circumstances or only in specified circumstances;

(b) in all areas or only in specified areas.

(4) An agreement under this section may provide for an approval function to be exercisable by the other party—

(a) for a period specified in the agreement, or

(b) for a period determined in accordance with the agreement.

(5) The other party to an agreement under this section must comply with such instructions as the Secretary of State may give with respect to the exercise of the approval function.

(6) An instruction under subsection (5) may require the other party to cease to exercise the function to such extent as the instruction specifies.

(7) The agreement may provide for the Secretary of State to pay compensation to the other party in the event of an instruction such as is mentioned in subsection (6) being given.

(8) An instruction under subsection (5) may be given in such form as the Secretary of State may determine.

(9) The Secretary of State must publish instructions under subsection (5) in such form as the Secretary of State may determine; but that does not apply to an instruction such as is mentioned in subsection (6).

(10) An agreement under this section may provide for the Secretary of State to make payments to the other party; and the Secretary of State may make payments to other persons in connection with the exercise of an approval function by virtue of this section.

**12ZB Requirement to exercise approval functions: England**

(1) The Secretary of State may impose a requirement on the National Health Service Commissioning Board (“the Board”) or a Special Health Authority for an approval function of the Secretary of State to be exercisable by the Secretary of State concurrently—

(a) with the Board or (as the case may be) Special Health Authority, and

(b) if an agreement under section 12ZA has effect, with the other person by whom the function is exercisable under that agreement.

(2) The Secretary of State may, in particular, require the body concerned to exercise an approval function—

(a) in all circumstances or only in specified circumstances;

(b) in all areas or only in specified areas.

(3) The Secretary of State may require the body concerned to exercise an approval function—

(a) for a period specified in the requirement, or

(b) for a period determined in accordance with the requirement.

(4) Where a requirement under subsection (1) is imposed, the Board or (as the case may be) Special Health Authority must comply with such instructions as the Secretary of State may give with respect to the exercise of the approval function.

(5) An instruction under subsection (4) may be given in such form as the Secretary of State may determine.

(6) The Secretary of State must publish instructions under subsection (4) in such form as the Secretary of State may determine.

(7) Where the Board or a Special Health Authority has an approval function by virtue of this section, the function is to be treated for the purposes of the National Health Service Act 2006 as a function that it has under that Act.

(8) The Secretary of State may make payments in connection with the exercise of an approval function by virtue of this section.

**12ZC Provision of information for the purposes of section 12ZA or 12ZB**

(1) A relevant person may provide another person with such information as the relevant person considers necessary or appropriate for or in connection with—

(a) the exercise of an approval function; or

(b) the exercise by the Secretary of State of the power—

(i) to enter into an agreement under section 12ZA;

- (ii) to impose a requirement under section 12ZB; or
- (iii) to give an instruction under section 12ZA(5) or 12ZB(4).
- (2) The relevant persons are—
  - (a) the Secretary of State;
  - (b) a person who is a party to an agreement under section 12ZA; or
  - (c) if the Secretary of State imposes a requirement under section 12ZB on the National Health Service Commissioning Board or a Special Health Authority, the Board or (as the case may be) Special Health Authority.
- (3) This section, in so far as it authorises the provision of information by one relevant person to another relevant person, has effect notwithstanding any rule of common law which would otherwise prohibit or restrict the provision.
- (4) In this section, “information” includes documents and records.”
- (2) In section 54(1) of that Act (requirement for certain medical evidence etc. to be from practitioner approved under section 12 of the Act), after “the Secretary of State” insert “, or by another person by virtue of section 12ZA or 12ZB above,”.
- (3) In section 139(4) of that Act (protection for acts done in pursuance of the Act: exceptions), at the end insert “or against a person who has functions under this Act by virtue of section 12ZA in so far as the proceedings relate to the exercise of those functions”.
- (4) In section 145(1) of that Act (interpretation), in the definition of “approved clinician”, after “the Secretary of State” insert “or another person by virtue of section 12ZA or 12ZB above”.
- (5) In each of the following provisions, after “the Secretary of State” insert “, or by another person by virtue of section 12ZA or 12ZB of that Act,”—
  - (a) in section 8(2) of the Criminal Procedure (Insanity) Act 1964 (interpretation), in the definition of “duly approved”,
  - (b) in section 51(1) of the Criminal Appeal Act 1968 (interpretation), in the definition of “duly approved”,
  - (c) in section 6(1) of the Criminal Procedure (Insanity and Unfitness to Plead) Act 1991 (interpretation), in the definition of “duly approved”,
  - (d) in section 157(6) of the Criminal Justice Act 2003 (mentally disordered offenders: definition of “medical report”),
  - (e) in section 172(1) of the Armed Forces Act 2006 (fitness to stand trial etc: definition of “duly approved”),
 and
  - (f) in section 258(5) of that Act (mentally disordered offenders), in the definition of “medical report”.

**s.39 Discharge of patients**

- (1) In section 23 of the Mental Health Act 1983 (discharge of patients), omit subsections (3) and (3A).
- (2) In section 24 of that Act (visiting and examination of patients), omit subsections (3) and (4).
- (3) In Schedule 1 to that Act (application of certain provisions of that Act to patients subject to hospital and guardianship orders)—
  - (a) in Part 1, in paragraph 1, omit “24(3) and (4),” and
  - (b) in Part 2, in paragraph 1, omit “24(3) and (4),”.
- (4) In consequence of the repeals made by this section—
  - (a) in the National Health Service and Community Care Act 1990, in Schedule 9—
    - (i) omit paragraph 24(3)(a) and the “and” following it, and
    - (ii) omit paragraph 24(4),
  - (b) in the Health Authorities Act 1995, in Schedule 1, omit paragraph 107(2)(a) and (3),
  - (c) in the Care Standards Act 2000, in Schedule 4, omit paragraph 9(3),
  - (d) in the Health and Social Care (Community Health and Standards) Act 2003, in Schedule 4, omit paragraphs 53(a) and 54,
  - (e) in the Domestic Violence, Crime and Victims Act 2004—
    - (i) omit sections 37A(5), 38A(3), 43A(5) and 44A(3),
    - (ii) in section 37A(7)(a), omit “, (5)”, and
    - (iii) in section 43A(7), omit “, (5)”, and
  - (f) in the Mental Health Act 2007, in Schedule 3, omit paragraphs 10(5) and (6) and 11(3) and (4).

**s. 40 After-care**

- (1) Section 117 of the Mental Health Act 1983 (after-care) is amended as follows.
- (2) In subsection (2)—
  - (a) after “duty of the” insert “clinical commissioning group or”,
  - (b) omit “Primary Care Trust or” in each place it appears, and
  - (c) after “such time as the” insert “clinical commissioning group or”.
- (3) After subsection (2C) insert—

“(2D) Subsection (2), in its application to the clinical commissioning group, has effect as if for “to provide” there were substituted “to arrange for the provision of”.



(2E) The Secretary of State may by regulations provide that the duty imposed on the clinical commissioning group by subsection (2) is, in the circumstances or to the extent prescribed by the regulations, to be imposed instead on another clinical commissioning group or the National Health Service Commissioning Board.

(2F) Where regulations under subsection (2E) provide that the duty imposed by subsection (2) is to be imposed on the National Health Service Commissioning Board, subsection (2D) has effect as if the reference to the clinical commissioning group were a reference to the National Health Service Commissioning Board.

(2G) Section 272(7) and (8) of the National Health Service Act 2006 applies to the power to make regulations under subsection (2E) as it applies to a power to make regulations under that Act.”

(4) In subsection (3)—

(a) after “section “the” insert “clinical commissioning group or”,

(b) omit “Primary Care trust or” in each place it appears, and

(c) after “means the”, in the first place it appears, insert “clinical commissioning group or”.

(5) In section 275 of the National Health Service Act 2006 (interpretation) after subsection (4) insert—

“(5) In each of the following, the reference to section 3 includes a reference to section 117 of the Mental Health Act 1983 (after-care)—

(a) in section 223K(8), paragraph (a) of the definition of “relevant services”,

(b) in section 244(3), paragraph (a)(i) of the definition of “relevant health service provider”,

(c) in section 252A(10), the definition of “service arrangements”,

(d) section 253(1A)(d)(ii).”

(6) In section 48 of the Health and Social Care Act 2008 (special reviews and investigations), in subsection (2)(ba), after “the National Health Service Act 2006” insert “or section 117 of the Mental Health Act 1983 (after-care)”.

(7) In section 97 of that Act (general interpretation of Part 1), in subsection (2A), after “section 7A of that Act)” insert “or section 117 of the Mental Health Act 1983 (after-care)”.

(8) In consequence of the repeals made by subsections (2)(b) and (4)(b), omit paragraph 47 of Schedule 2 to the National Health Service Reform and Health Care Professions Act 2002.

#### **s.41 Provision of pocket money for in-patients**

(1) Section 122 of the Mental Health Act 1983 (provision of pocket money for in-patients) is amended as follows.

(2) In subsection (1)—

(a) for “Secretary of State may” substitute “Welsh Ministers may (in relation to Wales)”,

(b) for “he thinks fit” substitute “the Welsh Ministers think fit”,

(c) for “their” substitute “those persons”,

- (d) for “him” substitute “the Welsh Ministers”, and
- (e) for “they” substitute “those persons”.
- (3) In subsection (2)—
  - (a) omit “the National Health Service Act 2006 and”, and
  - (b) for “either of those Acts” substitute “that Act”.
- (4) In section 146 of that Act (application to Scotland), omit “122,”.

**s.42 Transfers to and from special hospitals**

- (1) Omit section 123 of the Mental Health Act 1983 (transfers to and from special hospitals).
- (2) In section 68A of that Act (power to reduce periods after which cases must be referred to tribunal), in subsection (4)—
  - (a) after paragraph (c), insert “or”,
  - (b) omit the “or” following paragraph (d), and
  - (c) omit paragraph (e).
- (3) In section 138 of that Act (retaking of patients escaping from custody), in subsection (4)(a), omit “or under section 123 above”.
- (4) In consequence of the repeal made by subsection (1), omit paragraph 67 of Schedule 4 to the Health Act 1999.
- (5) This section does not affect—
  - (a) the authority for the detention of a person who is liable to be detained under the Mental Health Act 1983 before the commencement of this section,
  - (b) that Act in relation to any application, order or direction for admission or removal to a hospital made under that Act before that commencement, or
  - (c) the authority for the retaking of a person who, before that commencement, escapes while being taken to or from a hospital as mentioned in section 138(4)(a) of that Act.

**s.43 Independent mental health advocates**

- (1) In section 130A of the Mental Health Act 1983 (independent mental health advocates: England), in subsection (1)—
  - (a) for “The Secretary of State” substitute “A local social services authority whose area is in England”, and
  - (b) at the end insert “for whom the authority is responsible for the purposes of this section”.
- (2) In subsection (4) of that section, for “the Secretary of State” substitute “a local social services authority”.
- (3) In section 130C of that Act (provision supplementary to section 130A), after subsection (4) insert—

“(4A) A local social services authority is responsible for a qualifying patient if—

(a) in the case of a qualifying patient falling within subsection (2)(a) above, the hospital or registered establishment in which he is liable to be detained is situated in that authority's area;

(b) in the case of a qualifying patient falling within subsection (2)(b) above, that authority is the responsible local social services authority within the meaning of section 34(3) above;

(c) in the case of a qualifying patient falling within subsection (2)(c), the responsible hospital is situated in that authority's area;

(d) in the case of a qualifying patient falling within subsection (3)—

(i) in a case where the patient has capacity or is competent to do so, he nominates that authority as responsible for him for the purposes of section 130A above, or

(ii) in any other case, a donee or deputy or the Court of Protection, or a person engaged in caring for the patient or interested in his welfare, nominates that authority on his behalf as responsible for him for the purposes of that section.

(4B) In subsection (4A)(d) above—

(a) the reference to a patient who has capacity is to be read in accordance with the Mental Capacity Act 2005;

(b) the reference to a donee is to a donee of a lasting power of attorney (within the meaning of section 9 of that Act) created by the patient, where the donee is acting within the scope of his authority and in accordance with that Act;

(c) the reference to a deputy is to a deputy appointed for the patient by the Court of Protection under section 16 of that Act, where the deputy is acting within the scope of his authority and in accordance with that Act.”

(4) In Schedule 1 to the Local Authority Social Services Act 1970 (social services functions), in the entry for the Mental Health Act 1983, at the appropriate place insert—

“Section 130A Making arrangements to enable independent mental health advocates to be available to help qualifying patients”.

#### **s.44 Patients' correspondence**

(1) In section 134 of the Mental Health Act 1983 (patients' correspondence), in subsection (1)—

(a) before “the approved clinician” insert “or”, and

(b) omit “or the Secretary of State”.

(2) Subsection (1) of this section does not affect the validity of any requests made to the Secretary of State under section 134(1) of that Act and having effect immediately before the commencement of this section.

#### **s.45 Notification of hospitals having arrangements for special cases**

(1) In section 140 of the Mental Health Act 1983 (notification of hospitals having arrangements for special cases)—

- (a) after “the duty of” insert “every clinical commissioning group and of”,
  - (b) omit “every Primary Care Trust and of”,
  - (c) after “the area of the” insert “clinical commissioning group or”,
  - (d) omit “Primary Care Trust or” in the first place it appears,
  - (e) after “available to the” insert “clinical commissioning group or”, and
  - (f) omit “Primary Care Trust or” in the second place it appears.
- (2) In consequence of the repeals made by this section, in the National Health Service Reform and Health Care Professions Act 2002, in Schedule 2, omit paragraph 48(a) and (c).

## 7 CONSULTATION

- 7.1 The Mental Health Act and related legislation such as the Mental Capacity Act are the Trust’s Core Business.
- 7.2 Consultation with all services is a seamless process that is continuously being developed.
- 7.3 This process will continue after ratification and without time-limit.
- 7.4 Any recommendations for change, at any time, will be seriously considered although it must be recognised that much of this policy is bound by statutory requirement.

## 8 TRAINING AND SUPPORT

- 8.1 The Mental Health Act and related legislation such as the Mental Capacity Act are the Trust’s Core Business
- 8.2 Training, advice, guidance and support is continuously provided year on year and includes Code of Practice training.

## 9 MONITORING

- 9.1 The process for monitoring compliance with the standards outlined in this policy is detailed below:

System for the Monitoring of Compliance with the Policy and Procedure for the Development, Ratification, Implementation, Review and Archive of Procedural Documents.	
Monitoring of compliance with this policy will be undertaken by:	Monitoring of the outcomes of MHA monitoring visits undertaken and through annual audit.
Should shortfalls be identified the following actions will be taken:	Action plans will be developed for implementation and monitoring through the MHA managers committee
The results of monitoring will be reported to:	MHA managers committee

**10 EQUALITY AND HUMAN RIGHTS ANALYSIS**  
**(See Overleaf)**

# 10 Equality and Human Rights Analysis

**Title:** MH01 OVER-ARCHING POLICY AND PROCEDURE OF THE MENTAL HEALTH ACT 1983

**Area covered:** All aspects of Trust compliance with the Mental Health Act 1983

**What are the intended outcomes of this work?**

**To review the policy in relation to the previous Equality and Human Rights Analysis Undertaken 22<sup>nd</sup> January 2014**

This corporate policy and procedure sets out the Trust's policy and procedure for applying and monitoring the Mental Health Act 1983

**Who will be affected?**

This policy and procedure is applicable in part and/or whole to:-

1. All patients who are detained in hospital under the MHA
2. All patients who have given their informed consent to in-patient hospital admission for assessment, care and/or treatment of mental disorder
3. All patients who or in receipt of supervised community treatment within the meaning of the MHA
4. All patients who are in receipt of section 117 After care
5. The Nearest Relative (within the meaning of the MHA) of any patient identified in 1.3, 1-4 above
6. The Trust's Mental Health Act Managers (Hospital Managers)
7. All staff working with the patient group identified in 1.3, 1-4 above and their respective Nearest Relative.
8. The Trust's Mental Health Law Administrators
9. The Trust's Legal Team

## Evidence

**What evidence have you considered?**

The previous equality and human rights assessment  
 The policy

**Disability (including learning disability)**

Action. Need to include reference to information being provided in a format understandable by recipient (Completed).

**Sex**

No issues identified following discussion

**Race**

Action. Need to include reference to information being provided in a format understandable by recipient (Completed).

**Age** No issues identified following discussion

<b>Gender reassignment (including transgender)</b> No issues identified following discussion
<b>Sexual orientation</b> No issues identified following discussion
<b>Religion or belief</b> No issues identified following discussion
<b>Pregnancy and maternity</b> No issues identified following discussion
<b>Carers</b>
<b>Other identified groups</b>
<b>Cross Cutting</b> <p style="text-align: center;">Actions from last assessment</p> <ol style="list-style-type: none"> <li>1. Policy Standards – requires reference to compliance with Equality standards (Action Completed).</li> <li>2. 'Equality and Human Rights Analysis' wording to be added in policy (Action completed).</li> <li>3. Appendix 3 – Need to replace with current Equality and Human Rights Analysis Tool (Action Completed).</li> <li>4. Old version of Equality and Human Rights Screen – to be deleted (Action Completed).</li> </ol>

<b>Human Rights</b>	<b>Is there an impact? How this right could be protected?</b>
<b>Right to life (Article 2)</b>	Human Rights-based approach supported.
<b>Right of freedom from inhuman and degrading treatment (Article 3)</b>	Human Rights-based approach supported.
<b>Right to liberty (Article 5)</b>	Human Rights-based approach supported. Deprivation of Liberty Safeguards (DoLS) considered in that context.
<b>Right to a fair trial (Article 6)</b>	Human Rights-based approach supported.
<b>Right to private and family life (Article 8)</b>	Human Rights of Service Users have been considered in relation to Advance Statements
<b>Right of freedom of religion or belief (Article 9)</b>	Human Rights-based approach supported.
<b>Right to freedom of expression</b> <b>Note: this does not include insulting language such as racism (Article 10)</b>	Human Rights-based approach supported.

<b>Right freedom from discrimination (Article 14)</b>	Human Rights-based approach supported.
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## Engagement and Involvement .

This policy will be placed in the public domain via the Trust website for the benefit of Service Users, Carers, the Public and Staff.

Section 3 of Implementation Plan (Involving Service Users and Carers) – Recommend use of Trust-wide channels of communication to ensure staff are aware of existence of Policy and resources gathered therein. Ensure Service Users and Carers Forum are advised that staff have been made aware of existence and correct use of Policy.

Consultation with all services is a seamless process that is continuously being developed.

## Summary of Analysis

### Eliminate discrimination, harassment and victimisation

No discrimination, harassment or victimisation detected.

### Advance equality of opportunity N/A

### Promote good relations between groups

N/A

### What is the overall impact?

Overall impact re. Equality is neutral.

### Addressing the impact on equalities

## Action planning for improvement

See below

## For the record

### Name of persons who carried out this assessment:

George Sullivan  
Jayne Bridge  
Jim Wiseman

### Date assessment completed:

March 03 2017

### Name of responsible Director:

Medical Director

### Date assessment was signed:

March 2017



# Action plan template

This part of the template is to help you develop your action plan. You might want to change the categories in the first column to reflect the actions needed for your policy.

Category	Actions	Target date	Person responsible and their area of responsibility
<b>Monitoring</b>	Collation of information on outcomes of MHAM Panels and Mental Health Review Tribunals broken down by protected characteristics. Collation of information on admissions and detentions broken down by protected characteristics.  Full monitoring plan contained in section 9 above.		
<b>Engagement</b>	Consultation and engagement with all services is a seamless process that is continuously being developed.		
<b>Increasing accessibility</b>	Policy to be placed on Trust Website with the new equality and human rights analysis/ review. (Action completed).		

## 11 REFERENCES

All procedural documents must include details of the evidence base upon which they are based, with clearly cited references (in full) using the Harvard referencing style.

References in relation to the development of this policy include:

- (a) The Mental Health Act 1983
- (b) The Mental Health Act Code of Practice, 2008 edition
- (c) The Reference Guide to the Mental Health Act, 2008 edition
- (d) The Mental Capacity Act 2005
- (e) The Mental Capacity Act Code of Practice, 2007 edition
- (f) The Deprivation of Liberty Safeguards Code of practice, 2008 edition
- (g) The Mental Health Act Manual, 22<sup>nd</sup> edition, Richard Jones 2019
- (h) Sex Discrimination (gender Reassignment) Regulations 1999.
- (i) Police and Crime Act 2017

## 12 SUPPORTING INFORMATION

## Appendix 1 – Implementation Plan

# IMPLEMENTATION PLAN for the OVER-ARCHING POLICY AND PROCEDURE OF THE MENTAL HEALTH ACT 1983

DOCUMENT NUMBER	MH...
RATIFYING COMMITTEE	Corporate document review group
DATE RATIFIED	
NEXT REVIEW DATE	

**ACCOUNTABLE DIRECTOR: Medical Director**

**DOCUMENT AUTHOR: Mental Health Law Facilitator**

	<b>Issues identified / Action to be taken</b>	<b><i>Time-Scale</i></b>
<p><b>1. Co-ordination of implementation</b></p> <ul style="list-style-type: none"> <li>• How will the implementation plan be co-ordinated and by whom?</li> </ul> <p><i>Clear co-ordination is essential to monitor and sustain progress against the implementation plan and resolve any further issues that may arise.</i></p>	<p>Working within the framework of mental health is core business and training consistent with this policy and procedure has been (and will remain) in place since the Trust's inception.</p> <p>Delivered via the role specific mandatory training programme via e-learning platform.</p> <p>Ad hoc training and guidance can be provided via the Mental Health Legislation Lead.</p>	3 yearly rolling programme
<p><b>2. Engaging staff</b></p> <ul style="list-style-type: none"> <li>• Who is affected directly or indirectly by the policy?</li> <li>• Are the most influential staff involved in the implementation?</li> </ul> <p><i>Engaging staff and developing strong working relationships will provide a solid foundation for changes to be made.</i></p>	<p>All Clinical Staff and clinical support staff Mental Health Law Administrators</p> <p>This policy and procedure has been devised on the back of consultation with staff and consistent with requests for advice received</p>	n/a  n/a
<p><b>3. Involving service users and carers</b></p> <ul style="list-style-type: none"> <li>• Is there a need to provide information to service users and carers regarding this policy?</li> <li>• Are there service users, carers, representatives or local organisations who could contribute to the implementation?</li> </ul> <p><i>Involving service users and carers will ensure that any actions taken are in the best interest of services users and carers and that they are better informed about their care.</i></p>	No	

	<b>Issues identified / Action to be taken</b>	<b><i>Time-Scale</i></b>
<p><b>4. Communicating</b></p> <ul style="list-style-type: none"> <li>• What are the key messages to communicate to the different stakeholders?</li> <li>• How will these messages be communicated?</li> </ul> <p><i>Effective communication will ensure that all those affected by the policy are kept informed thus smoothing the way for any changes. Promoting achievements can also provide encouragement to those involved.</i></p>	<p>Compliance with Mental Health Law.</p> <p>The use of the Mental health Act is monitored (statutory requirement) by the Hospital Managers and relayed back through the Mental Health Law Governance Group</p>	On-going
<p><b>5. Resources</b></p> <ul style="list-style-type: none"> <li>• Have the financial impacts of any changes been established?</li> <li>• Is it possible to set up processes to re-invest any savings?</li> <li>• Are other resources required to enable the implementation of the policy eg. increased staffing, new documentation?</li> </ul> <p><i>Identification of resource impacts is essential at the start of the process to ensure action can be taken to address issues which may arise at a later stage.</i></p>	Not applicable.	n/a

	<b>Issues identified / Action to be taken</b>	<b>Time-Scale</b>
<p><b>6. Securing and sustaining change</b></p> <ul style="list-style-type: none"> <li>• Have the likely barriers to change and realistic ways to overcome them been identified?</li> <li>• Who needs to change and how do you plan to approach them?</li> <li>• Have arrangements been made with service managers to enable staff to undertake e-learning sessions, attend briefing and training sessions?</li> <li>• Are arrangements in place to ensure the induction of new staff reflects the policy?</li> </ul> <p><i>Initial barriers to implementation need to be addressed as well as those that may affect the on-going success of the policy</i></p>	<p>The major changes occurred in 2008-2009 and staff have been supported through this time by the Mental Health Act and Mental Capacity Act lead for the Trust. This is an on-going process.</p>	On-going
<p><b>7. Evaluating</b></p> <ul style="list-style-type: none"> <li>• What are the main changes in practice that should be seen from the policy?</li> <li>• How might these changes be evaluated?</li> <li>• How will lessons learnt from the implementation of this policy be fed back into the organisation?</li> </ul> <p><i>Evaluating and demonstrating the benefits of new policy is essential to promote the achievements of those involved and justifying changes that have been made.</i></p>	<p>Improved Mental Health law compliance.</p> <p>Through the Quality Review Visits (QRV) and the Hospital managers' audits and reviews.</p>	On-going
<p><b>8. Other considerations</b></p>	None	

Stage 1

Appendix 2

## Single Equality and Human Rights Screen

Name of Document

Who does it relate to	Staff		Service Users		Carers	
-----------------------	-------	--	---------------	--	--------	--

Area of Trust it covers  
Trust-wide

Names of people completing screen (Minimum of 3)


**What is the purpose of policy / service change /strategy. what is your this document trying to achieve**

--

The screening of any document is completed to ensure that it does not have either a **Direct** or **Indirect** impact on any members from particular protected Equality Groups.

Equality Strand	Y	N	Reasoning
Age			
Disability inc Learning Disability			
Gender			
Race Inc Gypsies and travellers and Asylum Seekers			
Religion and Belief			
Sexual Orientation			
Transgender			
Cross cutting			
<b>Total</b>			

### **Accessibility**

Is it clear that this document is available in other formats:	Yes	No	comment
Other comments noted from the assessment.			

Any areas highlighted by the EIA assessors must be put into an action plan. This must record all areas noted even when it can be rectified immediately. The document with the assessment, which includes the action plan, must be available for scrutiny and be able to show:-

- What has been highlighted
- What has been done to rectify immediately
- What time frame has been agreed to rectify in the future



## HUMAN RIGHTS IMPACT ASSESSMENT

<b>Right of freedom from inhuman and degrading treatment (Article 3)</b>	
Does this policy ensure people are treated with dignity and respect	
Could this policy lead to degrading or inhuman treatment (eg lack of dignity in care, excessive force in restraint) How could this right be protected?	
<b>Right to life (Article 2)</b>	
Does this policy help protect a persons right to life?	
Does this policy have the potential to result in a persons loss of life?	
How could this right be protected?	
<b>Right to a fair trial (Article 6)</b>	
Does this policy support the right to a fair trial?	
Does this policy threaten the right to a fair trial? (eg no appeals process)	
How could this right be protected?	
<b>Right to liberty (Article 5)</b>	
Does this policy support the right to liberty?	
Does this policy restrict the right to liberty?	
Is the restriction prescribed by law?	

Right to private and family life (Article 8)	
Does this policy support a persons right to private and family life	
Does this policy have the potential to restrict the right to private and family life	
How could this right be protected?	
Is it prescribed by law?	
Is it necessary?	
Is it proportionate?	
Right to freedom of expression Note: this does not include insulting language such as racism (Article 10)	
Does this policy support a persons ability to express opinions and share information	
Does this policy interfere with a person's ability to express opinions and share information?	
Is it in pursuit of legitimate aim?	
Is it prescribed by law?	
Is it necessary?	
Is it proportionate?	
Right of freedom of religion or belief (Article 9)	
Does this policy support a person's right to freedom of religion or belief?	
Does this policy interfere with a person's right to freedom of religion or beliefs? (eg prevention of a person practising their religion Is it in pursuit of legitimate aim? Is it prescribed by law? Is it necessary? Is it proportionate?	
Right freedom from discrimination (Article 14)	
If you have identified an impact, will this discriminate against anyone group in particular?	
NO	

Is the Document:

Compliant

 Y/N

Non compliant -  
With actions immediately taken  
to make compliant

 Y/N

Action Plan completed

 Y/N

Full Impact Assessment Required

Y/N

Lead Assessor \_\_\_\_\_

Date \_\_\_\_\_

**ACTION PLAN**

<b>Age</b>	<b>Impact Noted</b>	<b>Action Required</b>	<b>Action Taken</b>	<b>Date to be completed.</b>
Disability				
Gender				
Race				
Religion and Belief				
Sexual Orientation				
Transgender				

Cross cutting				
Human Rights				