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Mental Health Law Policy Suite

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Type of document	Guidance
Target audience	All staff
Document purpose	To provide staff with guidance in relation to the implementation of mental health law including the Mental Health Act 1983 and Mental Capacity Act 2005.

Approving meeting	Clinical Practice and Standards Sub-Committee	Date 12-Dec-19
Implementation date	12-Dec-19	

CWP documents to be read in conjunction with	
MH8	Missing persons' policy inc Section 18 MHA 1983
CP53	Policy and procedure for Multi-Agency Public Protection Arrangements (MAPPA) notification duty
CP42	Care Planning (CPA and Standard Care) Policy
MH16	Section 135 and Section 136 Mental Health Act 1983 Police arrest in public place

Document change history	
What is different?	Section 17 leave forms updated
Appendices / electronic forms	
What is the impact of change?	

Training requirements	Yes - Training requirements for this policy are in accordance with the CWP Training Needs Analysis (TNA) with Education CWP.

Document consultation	
Clinical services	Via policy discussion forum
Corporate services	Via policy discussion forum and Patient Safety and Effectiveness Sub Committee
External agencies	N/A

Financial resource implications	Low

External references
1. Mental Health Act 1983 (as amended in 2007)

2. Mental Capacity Act 2005
3. Mental Health Act Code of Practice 2015
4. Mental Health Act Code of Practice Easy Read 2015
5. Mental Capacity Act Code of Practice 2005
6. Mental Capacity Act Code of Practice Easy Read Guide 2005
7. Mental Capacity Act Deprivation of Liberty Safeguards Code of Practice 2005
8. Mental Health Act Manual, Richard Jones, 23rd Edition, 2020
9. Mental Capacity Act Manual, Richard Jones, 8th Edition, 2018.

Equality Impact Assessment (EIA) - Initial assessment	**Yes/No**	**Comments**
Does this document affect one group less or more favourably than another on the basis of:		
- Race	No	
- Ethnic origins (including gypsies and travellers)	No	
- Nationality	No	
- Gender	No	
- Culture	No	
- Religion or belief	No	
- Sexual orientation including lesbian, gay and bisexual people	No	
- Age	No	
- Disability - learning disabilities, physical disability, sensory impairment and mental health problems	No	
Is there any evidence that some groups are affected differently?	No	
If you have identified potential discrimination, are there any exceptions valid, legal and/or justifiable?		
N/A		
Is the impact of the document likely to be negative? - If so can the impact be avoided? - What alternatives are there to achieving the document without the impact? - Can we reduce the impact by taking different action?	No N/A N/A N/A	
Where an adverse or negative impact on equality group(s) has been identified during the initial screening process a full EIA assessment should be conducted. If you have identified a potential discriminatory impact of this procedural document, please refer it to the human resource department together with any suggestions as to the action required to avoid / reduce this impact. For advice in respect of answering the above questions, please contact the human resource department.		
Was a full impact assessment required?	No	
What is the level of impact?	Low	

Contents

1. Introduction

The Mental Health Act 1983 (MHA) applies to England and Wales. It provides a legal framework giving health professionals the power, under specific circumstances, to assess, detain and treat people with mental disorders in the interests of their health and safety and for public protection. The structure also includes safeguards for detained patients in order to protect them from inappropriate use. In 2007, the MHA was amended; the most significant change being the introduction Community Treatment Orders, enabling a more structured approach to treatment within the community and the ability to recall a patient to hospital if necessary.

The MHA continues to be a complex piece of legislation which has over time become innately linked with other pieces of legislation; case law continuing to provide ongoing guidance on its implementation. However, the current primary source of guidance is the MHA Code of Practice 2015 (CoP). This comprehensive statutory guide is the benchmark for implementation of the MHA for mental health services and the Care Quality Commission when carrying out reviews. Professionals should be familiar with the CoP, giving regard to its contents when implementing the MHA. Departures from the CoP may give rise to legal challenge and so the reasons for departure should be clearly recorded. The CoP, therefore, forms the basis of all Mental Health Act policies.

2. The Five Guiding Principles

Chapter 1 of the CoP sets out the overarching principles which should always be considered when making decisions in relation to the care, support and treatment of patients under the MHA.

1. Least restrictive option and maximising independence
Where it is possible to treat a patient safely and lawfully without detaining them under the Act, the patient should not be detained. Wherever possible a patient's independence should be encouraged and supported with a focus on promoting recovery wherever possible.
2. Empowerment and involvement
Patients should be fully involved in decisions about care, support and treatment. The views of families, carers and others, if appropriate, should be fully considered when taking decisions. Where decisions are taken which are contradictory to views expressed, professionals should explain the reasons for this.
3. Respect and Dignity
Patients, their families and carers should be treated with respect and dignity and listened to by professionals.
4. Purpose and Effectiveness
Decisions about care and treatment should be appropriate to the patient, with clear therapeutic aims, promote recovery and should be performed to current national guidelines and/or current, available best practice guidelines.
5. Efficiency and Equity
Providers, commissioners and other relevant organisations should work together to ensure that the quality of commissioning and provision of mental healthcare services are of high quality and are given equal priority to physical health and social care services. All relevant services should work together to facilitate timely, safe and supportive discharge from detention.

3. Related Legislation

The MHA has become intrinsically linked to other pieces of legislation (link to CoP Chapter 3) which must also be considered:

The **Mental Capacity Act 2005** specifically impacts upon decisions regarding consent to admission and treatment, the capacity test incorporated in day-to-day practice. This is extended to include the Deprivation of Liberty Safeguards (DoLS).

The **Human Rights Act 1998** incorporates the fundamental rights of individuals as set out in the European Convention on Human Rights and Freedoms. The 'Articles' within are designed to safeguard the individual, and often form the basis of challenges in court in respect of potential unlawful detention.

The **Care Act 2014** should be considered, particularly when considering the care and treatment of patients in the community.

The **Children Acts of 1989 and 2004** may provide alternative options for the admission for children and young people.

4. Glossary of Terms

Term	Definition
Absent without leave (AWOL)	A person who has absconded from legal custody i.e.: when a detained patient leaves hospital without permission, or who does not return to hospital when required to do so.
Appropriate Treatment Test	The requirement in some sections that appropriate medical treatment for mental disorder is available for the patient, taking into account the nature and degree of the person's mental disorder and any other relevant circumstances. Medical treatment is defined in Section 145 of the MHA and includes nursing, therapies, habilitation and rehabilitation, as well as care and treatment given by doctors. (MHA CoP Chapter 23).
Approved Clinician	A mental health professional approved by the Secretary of State to act as an approved clinician for the purposes of the MHA. Some decisions under the MHA can only be made by an approved clinician. A responsible clinician must be an approved clinician (MHA CoP Chapter 36).
Approved Mental Health Professional (AMHP)	A social worker or other trained professional, approved by a local authority to carry out specific functions under the MHA.
Capacity	The ability to make a decision about a particular matter at the time the decision needs to be made. There is an assumption of capacity. However, some people may lack capacity to make decisions for themselves because they cannot understand, retain, use or weight up the information given to them that tis relevant to the decision. See Mental Capacity Act Section 2 for a definition of capacity. Applies to people aged 16 or over.
Community Treatment Order (CTO)	The legal authority for the discharge of a patient from detention in hospital, subject to the possibility of recall to hospital if further in-patient treatment is necessary. CTO patients are expected to comply with specified conditions.
Consent	Agreeing to allow someone to do something to or for you, e.g.: consent to treatment. To obtain valid consent the person must have capacity to make the decision.
Court of Protection	A specialist court set up under the Mental Capacity Act 2005 to deal with

Term	Definition
	issues relating to people who lack capacity to make decisions for themselves.
Deprivation of Liberty	Circumstances in which a person's liberty is taken away.
Deprivation of Liberty Safeguards (DoLS)	A framework of safeguards under the MCA 2005 (as amended by the MHA 2007) for people who need to be deprived of their liberty in their best interests for care or treatment to which they lack capacity to consent to themselves. A DoLS (MHA CoP Chapter 13) authorisation under MCA is given by a supervisory body to authorise a deprivation of liberty in a care home or hospital.
Electro-convulsive therapy (ECT)	Form of medical treatment for mental disorder in which a small electric current is introduced into the brain.
European Convention on Human Rights (ECHR) Human Rights Act 1998 (HRA)	The European Convention for the Protection of Human Rights and Fundamental Freedoms (ECHR) – the substantive rights are largely incorporated into the Human Rights Act 1998
First-tier Tribunal (Mental Health) (FTT)	A judicial body which has the power to discharge patients from detention and CTOs.
Gillick competent	A child who is considered to have sufficient understanding and intelligence to enable them to understand fully what is involved in a proposed intervention, including admission to hospital and treatment. A lack of Gillick competency may be due to their mental condition or because they do not have the maturity to make the decision. See Gillick for more information.
Guardianship	The appointment of a guardian to help and supervise a patient aged 16 or over in the community.
Holding powers	Powers under the MHA which allows patients, in specific circumstances, to be detained in a place of safety temporarily so that a decision can be made about whether an application for detention should be made.
Hospital Managers	The organisation (MHA CoP Chapter 37) responsible for the operation of the MHA e.g.: CWP. This includes various functions which are delegated to specific groups of staff e.g.: clinical staff, Mental Health Law Team.
Hospital Managers' Panels	A group of people (MHA CoP Chapter 38) who have the delegated power to review detention, and discharge most detained patients, including CTOs.
Independent Mental Capacity Advocate (IMCA)	An advocate who can support patients who lack capacity with regards to arrangements under the MCA.
Independent Mental Health Advocate (IMHA)	An advocate who can support patients with their detention under the MHA.
Informal in-patient	Someone who has agreed to admission and treatment in hospital.
Liable to be detained	People who are actually detained, e.g.: people subject to detention under MHA in hospital. It does not apply to those subject to CTO.
Mental Capacity Act 2005 (MCA)	An Act of Parliament which governs decision making on behalf of people aged 16 or over who are unable to make decisions for themselves.
Mental Disorder	Any disorder or disability of the mind – A definition of recognised conditions can be found in Section 1 MHA
Mentally Disordered	A person who has a mental disorder and who has committed a criminal

Term	Definition
Offender	offence.
Nearest Relative	A person defined by Section 26 of the MHA who has certain rights and powers under the MHA in respect of a patient for whom they are nearest relative. This person must not be confused with next-of-kin.
Next-of-kin	A person chosen by a patient who they wish information to be shared with about their care and treatment.
Nominated deputy	The MHA allows the AC to nominate a deputy to exercise the powers of Section 5(2). In CWP this is the junior doctor on-call.
Nurse of the prescribed class	A nurse registered to practice in the field of: a) Mental health nursing b) Learning disability nursing
Part 2 MHA	A part of the MHA which deals with detention, guardianship and CTO for civil patients.
Part 3 MHA	A part of the MHA which deals with Mentally Disordered Offenders which allows courts to detain people in hospital, rather than impose a custodial sentence. E.g.: Section 37
Part 4 MHA	A part of the MHA which deals with medical treatment for mental disorder for patients detained in hospital. Often referred to as Section 58 or 58A treatment where special rules apply for the administration of medication and ECT.
Part 4A	A part of the MHA which deals with medical treatment (MHA CoP Chapter 24/25) for mental disorder for CTO patients who have not been recalled to hospital
Place of Safety	A place in which people may be temporarily detained under Sections 135 or 136 (MHA CoP Chapter 16).
Responsible Clinician (RC)	An approved clinician with overall responsibility for a detained patient's care. Certain decisions may only be made by the RC.
Responsible hospital	The hospital whose managers are responsible for a community patient – this is usually the hospital in which the patient was detained prior to discharge on a CTO.
Restricted patient	A patient who has been through criminal proceedings may be made subject to a restriction order where it appears that it is necessary to protect the public from serious. This is usually attached to a section under MHA (MHA CoP Chapter 22). e.g.: Section 37/41
Second Opinion Appointed Doctor (SOAD)	An independent doctor (MHA CoP Chapter 25) appointed by the CQC to provide a second opinion on whether certain types of treatment for mental disorder should be given without a patient's consent.
Section 12(2) approved doctor	A doctor who has been approved under the MHA by the Secretary of State for Health as having special experience in the diagnosis or treatment of mental disorder. Some medical recommendations and medical evidence to courts can only be provided by a Section 12(2) approved doctor. Approved clinicians are automatically Section 12(2) approved,
Statutory consultees	Professionals that a SOAD is required to consult with prior to issuing a certificate to approve treatment, who are involved in a patient's care and treatment.

Term	Definition
Victim	A person who has been subject to serious violent or sexual offence by a mentally disordered offender who has subsequently been detained under the MHA. A victim has certain rights (MHA CoP Chapter 40) under the Domestic Violence, Crime and Victims Act 2004.

5. Useful Contacts

Mental Health Law Team:
MHL Manager
01244 393167

General Team contact
01244 393162
cwp.mhlteam@nhs.net

MHL intranet page
http://nww.cwp.nhs.uk/TeamCentre/SafeServices/mha_mca/Pages/home.aspx

CHAPTER ONE – SECTION INFORMATION

6. MHA Part 2 - Civil Sections

6.1 Sections 5(4) and 5(2)

Section 5(4)	
Purpose	To allow a nurse of the prescribed class to detain an informal in-patient for a limited period of time. Often referred to as the nurses' holding power.
Criteria	The nurse considers that: - The patient is suffering from mental disorder to such a degree that it is necessary for the patient to be immediately prevented from leaving the hospital either for the patient's own health or safety or the protection of other people, and - It is not practicable to secure the attendance of a doctor or AC who can submit a report under Section 5(2). Section 5(4) can only be implemented when a patient is still on the hospital premises. **MHA Code of Practice 2015**
Duration	Up to 6 hours
Treatment	Part 4 of the MHA does not apply to Section 5(4). Treatment for mental disorder may only be given if: - the patient has capacity and consents to the proposed treatment **or** - under the MCA if the patient lacks capacity to consent to the proposed treatment and it is in their best interests
Right of Appeal	A patient does not have the right to appeal under Section 5(4).
Leave of Absence	The RC has no powers to authorise Section 17 leave for a patient detained under Section 5(4).
Ending Section 5(4)	During the six hour period the AC or nominated deputy must assess the patient to consider whether further detention under Section 5(2) is necessary. Section 5(4) ends upon the arrival of the doctor. If Section 5(2) is implemented by the doctor, the duration of the Section 5(2) is calculated from the start of the Section 5(4). Section 5(4) cannot be renewed.
Paperwork	The following form must be completed to implement Section 5(4): **H2** - completed by nurse of the prescribed class. Following detention the patient should be provided with the Section 5(4) Patient Information Leaflet and their rights explained.

Section 5(2)	
Purpose	To allow a doctor to detain an in-patient for a limited period of time in order to undertake a further formal assessment. May only be implemented by the AC or nominated deputy.
Criteria	The AC or nominated deputy is of the opinion that an application ought to be made under Part 2 of the MHA for the patient's continued detention in hospital. The reasons why informal treatment is no longer appropriate must be provided. **MHA Code of Practice 2015**

Duration	Up to 72 hours
Treatment	Part 4 of the MHA does not apply to Section 5(2). Treatment for mental disorder may only be given if: - the patient has capacity and consents to the proposed treatment or - under the MCA if the patient lacks capacity to consent and it is in their best interests
Right of Appeal	A patient does not have the right to appeal under Section 5(2).
Leave of Absence	The RC has no powers to authorise Section 17 leave for a patient detained under Section 5(2).
Ending Section 5(2)	As soon as practicable during the 72 hour period the AC must assess the patient and determine the outcome: - End the 5(2), the patient becoming informal - Make a recommendation for Section 2 or 3. **Please Note:** - If two medical recommendations are completed for further detention, but the AMHP decides not to make an application, section 5(2) ends at this point. - Section 5(2) cannot be renewed. - A patient cannot be transferred to another hospital on Section 5(2), as this will end once the patient leaves the building. If a patient requires urgent transfer for medical treatment then they must either consent to it, or the MCA is used if the patient lacks capacity and it is in their best interests.
Paperwork	The following form must be completed: **H1** – Part 1 completed by the AC or nominated deputy Part 2 completed by the nurse-in-charge Following detention the patient should be provided with the Section 5(2) Patient Information Leaflet and their rights explained.

6.2 Section 4

Section 4	
Purpose	To allow compulsory admission to hospital where only one doctor is available.
Criteria	An application for Section 4 may only be made in limited circumstances: • The patient is suffering from a mental disorder warranting detention in hospital for a limited period of time. • The patient's detention is required as a matter of urgent necessity, **and** • Obtaining a second medical recommendation would cause undesirable delay. Section 4 should only be used where there is urgent necessity and the patient's need for admission outweighs waiting for a second doctor. **Please Note: Section 4 should never be used for administrative convenience (see MHA CoP para 15.7)**
Duration	72 hours
Treatment	Part 4 of the MHA does not apply to Section 4.

	Treatment for mental disorder may only be given if: - the patient has capacity and consents to the proposed treatment or - under the MCA if the patient lacks capacity to consent and it is in their best interests
Right of Appeal	A patient does have the right to appeal to the First-tier Tribunal under Section 4. In practice, this rarely happens due to the limited timeframe available. However, if a patient appeals whilst detained under Section 4, which is subsequently converted to Section 2, the hearing process will continue.
Leave of Absence	The RC may grant Section 17 within the time limits of Section 4, the patient being liable to be detained.
Ending Section 4	The RC must assess the patient during the 72 hours. Although the section may be discharged, it is usual for it to be converted to Section 2 by the completion of a second medical recommendation. In such cases the duration of section 2 would be then calculated from the start date of the section 4. If the RC decides to implement Section 3, Section 4 cannot be converted - a full MHA assessment must be undertaken within the 72 hour period.
Paperwork	The following forms must be completed: **A11** – medical recommendation **and** **A10** – AMHP application **or** **A9** – Nearest relative application (see section 22 below for further details on powers of nearest relative) **and** **H3** - acceptance form completed by nurse in charge. To convert to section 2 the following forms must be completed: **A4** – medical recommendation and **H3 – Part 2** of the original form used for Section 4 to be completed by nurse in charge Following detention the patient should be provided with the Section 4 Patient Information Leaflet and their rights explained.

6.3 Section 2

Section 2	
Purpose	To allow compulsory admission to hospital for assessment and treatment.
Criteria	The person is suffering from a mental disorder warranting their detention in hospital for at least a limited period of time, **and** requires detention in the interests of their own health or safety, or with a view to the protection of others. Before it is decided that admission to hospital is necessary, consideration should be given to alternative options for providing the care and treatment a patient requires. Medical recommendations should include reasons why informal admission is not appropriate. **MHA Code of Practice 2015**
Duration	Up to 28 days.

	Extension of Section 2 may be permitted only in the following circumstances: - When an application for Section 3 is being considered and the nearest relative objects. Section 2 may be extended if the process of displacing the nearest relative has commenced (i.e.: it has been lodged with the court) - If the patient has been AWOL and returns during the final week of the 28 day period, Section 2 may be extended for one week only from the date of the patient's return to allow the RC time to assess. If a patient is AWOL when Section 2 runs out there is no authority to return the patient to hospital.
Treatment	**Medication for mental disorder –** Section 63 allows a patient to be treated whilst detained on Section 2, with or without their consent. No form of authority is required; however, the patient's capacity to consent to treatment must be fully documented on first administration. **ECT –** A form of authority must be in place at all times when ECT is being administered, regardless of the patient's capacity to consent. - Form **T4** completed by RC if patient has capacity and is consenting - **Section 62** – trust form to be completed if patient lacks capacity to consent to ECT and a SOAD has been requested (subject to the criteria being met). A new form must be completed for each administration of ECT until the SOAD arrives. - Form **T6** – Completed by the SOAD for a patient who lacks capacity to consent to ECT or has capacity and is refusing. **NB** - Capacity must be assessed on each administration of ECT. If a patient has capacity and is refusing, ECT cannot be given.
Right of Appeal	For guidance on ensuring patients are aware of their rights under Section 132 and 130D see section 12 below. Patients on Section 2 have the following rights of appeal: **First-tier Tribunal (Mental Health)** A section 2 patient may appeal to the FTT within the first 14 days of detention only. The appeal must be received by the Tribunal office within this timeframe in order to qualify. A hearing will be scheduled within 7 days of the date of appeal. **Hospital Managers' Panel** A Section 2 patient may appeal to the Hospital Managers at any point during their detention. There is no limit to the number of appeals which can be submitted; however, the Hospital Managers will use their discretion when considering multiple appeals. See section 21 below for further information on the appeal process and copies of the appeal forms.
Leave of Absence	Patients detained under Section 2 may be granted leave within the hospital grounds at the discretion of the Responsible Clinician and clinical team.

	Section 17 leave – only the RC may grant Section 17 leave, subject to risk assessment, for patients who wish to go outside the hospital grounds. See MHA CoP Chapter 27 for further information on Section 17 and Appendix 3 for a copy of the leave form.
Ending Section 2	Section 2 may be ended at any time within the 28 days by: - The RC - The First-tier Tribunal (Mental Health) - The Hospital Managers' Panel - The patient's nearest relative (see section 22 below for details) - An application for detention under Section 3 Section 2 cannot be renewed. However, it may be extended if an application to displace the nearest relative has been lodged with the Court, resulting from a nearest relative objection to the implementation of Section 3. The period of extension will end when the Court has reached a decision.
Paperwork	The following forms must be completed: **A4** – single medical recommendation (two required) **or** **A3** – joint medical recommendation **and** **A2** – application by the AMHP **or** **A1** – application by the nearest relative (see section 22 for further details on powers of nearest relative) **and** **H3** – acceptance form completed by nurse in charge. **H7** – RC discharge In order to complete form H3 the trust wide section checklist (add link) should be used as guidance. Following detention the patient should be given a copy of the Section 2 Patient Information Leaflet and their rights explained. For further guidance on completing section paperwork see section 9 below.

6.4 Section 3

Section 3	
Purpose	To allow compulsory admission to hospital for treatment of a mental disorder.
Criteria	The person is suffering from a mental disorder of a nature or degree which makes it appropriate for them to receive treatment in a hospital, **and** it is necessary for the health or safety of the person or for the protection of other persons that they should receive such treatment, **and** such treatment cannot be provided unless they are detained under this section, **and** appropriate treatment is available to them. **MHA Code of Practice 2015**
Duration	Up to 6 months initially. May be renewed for up to 6 months, and thereafter annually.
Treatment	**Medication for mental disorder** Section 63 allows a patient to be treated during the first three months of detention

	(including Section 2 if in place immediately prior to Section 3). No form of authority is required. However, the patient's capacity to consent to treatment must be fully documented on first administration, and regularly reviewed/documented. After three months in order to continue the administration of medication for mental disorder appropriate authority must be in place: - ***T2*** completed by the RC if the patient has capacity and is consenting - ***Section 62*** – Trust form completed by the RC if the patient lacks capacity to consent to treatment and a SOAD has been requested (subject to the criteria being met for emergency treatment). - ***T3*** completed by the SOAD to authorise treatment when a patient lacks capacity to consent **Please note:** - Medication should be reviewed regularly by the RC. If there is a change in medication or in a patient's consent status, a new form of authority must be completed before medication can be administered. - If a patient changes ward and there is a Form T2 in place the new RC must review and complete a new Form T2 (the SOAD form will remain valid) as soon as possible. - When Section 3 is renewed, the RC must review medication. If a SOAD certificate is in place (T3) the RC must submit a report under Section 61 to the CQC. **ECT** – A form of authority must always be in place when ECT is being administered, regardless of the patient's capacity to consent: - ***T4*** completed by the RC if patient has capacity and is consenting - ***Section 62*** – Trust form completed by the RC if the patient lacks capacity to consent to ECT and a SOAD has been requested (subject to the criteria being met). A new form must be completed for each administration of ECT until the SOAD arrives. - ***T6*** – Completed by the SOAD for a patient who lacks capacity to consent to ECT or has capacity and is refusing. **NB** - Capacity must be assessed on each administration of ECT. If a patient has capacity and is refusing, ECT cannot be given.
Right of Appeal	For guidance on ensuring patients are aware of their rights under Section 132 and 130D see section 12 below. Patients on Section 3 have the following rights of appeal – **First-tier Tribunal (Mental Health)** A section 3 patient may appeal to the FTT once with any period of detention, i.e.: once in the first 6 months, once in the second 6 months. If a patient has not appealed during the first 6 months of detention CWP has a duty to submit a referral under Section 68 to the FTT for review. Also, if a patient is detained long-term and does not appeal within a three year period, a referral must be submitted to the FTT. Hearings are usually heard 6 – 8 weeks following an application.

	Hospital Managers' Panel A Section 3 patient may appeal to the Hospital Managers at any point during their detention. There is no limit to the number of appeals which can be submitted; however, the Hospital Managers will use their discretion when considering multiple appeals. The Hospital Managers' Panel also have a duty to hold a review of detention following renewal. See section 21 below for further information on the appeal process and copies of the appeal forms.
Leave of Absence	Patients detained under Section 3 may be granted leave within the hospital grounds at the discretion of the Responsible Clinician and clinical team. **Section 17 leave** – only the RC may grant Section 17 leave, subject to risk assessment, for patients who wish to go outside the hospital grounds. See section 16 for further information on Section 17 leave and Appendix 2 for a copy of the leave form. **NB** - When deciding upon Section 17 leave for 7 or more consecutive days the RC should consider whether a CTO is a more suitable option. The rationale behind the decision made should be recorded.
Ending Section 3	Section 3 may be ended at any time by: - The RC - The First-tier Tribunal (Mental Health) - The Hospital Managers' Panel - The patient's nearest relative (see section 22 for further details)
Paperwork	The following forms must be completed: **A8** – single medical recommendation (two required) **or** **A7** – joint medical recommendation **and** **A6** – application by the AMHP **or** **A5** – application by the nearest relative (see section 22 for further details on powers of nearest relative) **and** **H3** – acceptance form completed by nurse in charge. **H5** – to renew detention **H7** – RC discharge In order to complete form H3 the trust wide section checklist (see Appendix1) should be used as guidance. Following detention the patient should be given a copy of the Section 3 Patient Information Leaflet and their rights explained. See MHA CoP Chapter 14 for further guidance. For further guidance on completing section paperwork see section 9 below.

6.5 Section 17A - Community Treatment Order, including recall

CTO	
Purpose	To allow suitable patients to be treated safely in the community rather than in hospital and to provide a way to help prevent relapse and any harm this may cause. It is intended to help patients maintain stable mental health outside hospital and to promote recovery. The framework allows the RC to recall a patient to hospital, if necessary, for treatment.
Criteria	Only patients who are detained under Sections 3, 37, 47 and 48 (unrestricted) may be considered for CTO. The criteria being that: The person is suffering from a mental disorder of a nature or degree which makes it appropriate for them to receive treatment, **and** It is necessary for the health, or safety of the person, or for the protection of other persons that they should receive such treatment, **and** Subject to the patient being liable to be recalled, such treatment can be provided without the patient continuing to be detained in a hospital, **and** It is necessary that the RC should be able to exercise the power under section 17E(1) of the Act to recall the patient to hospital, **and** Appropriate medical treatment is available for the patient. **MHA Code of Practice 2015** The effect of a CTO is that the section the patient was detained on immediately prior to its implementation remains suspended in the background. See below for information on the power of recall and revocation.
Conditions	Two mandatory conditions apply: - Patient to make themselves available for examination when considering extension of CTO - Patient to make themselves available for examination to enable a certificate of consent to treatment to be issued. Discretionary conditions: Further conditions may be identified by the clinical team which may be necessary or appropriate to – - Ensure the patient receives medical treatment for mental disorder - Prevent a risk of harm to patient's health or safety as a result of mental disorder - Protect other people from a similar risk of harm Discretionary conditions may be varied by the RC by completing form **CTO2**.
Duration	Up to 6 months initially. May be renewed for up to 6 months, and thereafter annually.
Treatment	**Medication for mental disorder** Part 4A provides the authority to treat a patient subject to CTO; Section 64, A-K, specifically dealing with treatment. The MHA CoP providing detailed guidance in chapter 25. **Please Note: Compulsory treatment cannot be given to a CTO patient who has not been recalled, has capacity/competence to consent to or refuse treatment**

and who refuses treatment.

A certificate of consent does not need to be in place immediately upon implementation. The 3 month/1month rule applies, i.e.: either 3 months after the commencement of detention under the MHA, or 1 month after the start of the CTO – whichever is the later.

Examples of the 3 month/1 month rule:

Section 3 implemented 10/04/2017 (3 month rule = 09/07/2017).
CTO implemented 20/08/2017 (1 month rule = 19/09/2017).
Consent to treatment is required by 19/09/2017 as this is the later date.

Section 3 implemented 10/04/2017 (3 month rule = 09/07/2017).
CTO implemented 18/05/2017 (1 month rule – 17/06/2017).
Consent to treatment is required by 09/07/2017 as this is the later date.

Examples:

1. Section 3 implemented 10/04/2017 (3 month rule = 09/07/2017)
   CTO implemented 20/08/2017 (1 month rule = 19/09/2017)
   Consent to treatment required by 19/09/2017 as this is the later date.
2. Section 3 implemented 10/04/2017 (3 month rule = 09/07/2017)
   CTO implemented 18/05/2017 (1 month rule – 17/06/2017)
   Consent to treatment required by 09/07/2017 as this is the later date.

After this date in order to continue the administration of medication for mental disorder appropriate authority must be in place:

- ***CTO12*** completed by the RC if the patient has capacity and is consenting
- ***Section 64G (medication)*** – Trust form completed by the RC if the patient lacks capacity to consent to treatment and a SOAD has been requested (subject to the criteria being met for emergency treatment).
- ***CTO11*** completed by the SOAD to certify that the proposed treatment is appropriate when a patient lacks capacity to consent

Please note:

- Medication should be reviewed regularly by the RC. If there is a change in medication or in a patient's consent status, a new form must be completed as appropriate.
- If a patient changes RC and there is a Form CTO12 in place the new RC must review and complete a new Form CTO12 (the SOAD form will remain valid)
- When a CTO is extended, the RC must review medication.

ECT – A form of authority must always be in place when ECT is being administered, regardless of the patient's capacity to consent:

	- ***CTO12*** - completed by the RC if patient has capacity and is consenting - ***Section 64G (ECT)*** – Trust form completed by the RC if the patient lacks capacity to consent to ECT and a SOAD has been requested (subject to the criteria being met). A new form must be completed for each administration of ECT until the SOAD arrives. - ***CTO11*** – Completed by the SOAD for a patient who lacks capacity to consent to ECT or has capacity and is refusing. **NB** - Capacity must be assessed on each administration of ECT. If a patient has capacity and is refusing, ECT cannot be given. It is not common for CTO patients to be administered ECT treatment; however, this is sometimes given on a maintenance basis.
Right of Appeal	For guidance on ensuring patients are aware of their rights under Section 132 and 130D see section 12 below. Patients on CTO have the following rights of appeal - **First-tier Tribunal (Mental Health)** A CTO patient has the same right of appeal as a Section 3 patient. **Hospital Managers' Panel** A CTO patient may appeal to the Hospital Managers in the same way as a Section 3 patient. The Hospital Managers' Panel also have a duty to hold a review of detention following renewal. See section 21 for further information on the appeal process and copies of the appeal forms.
Ending CTO and underlying Section 3	A CTO may be ended at any time by: - The RC - The First-tier Tribunal (Mental Health) - The Hospital Managers' Panel - The patient's nearest relative (see section 22 below for details) - Revocation by the RC (see below)
Paperwork	The following form must be completed: **CTO1** – completed by the RC and an AMHP to implement CTO **CTO7** – completed by the RC and an AMHP to extend CTO **Section 23 Trust form** – RC discharge of CTO and underlying section Following detention the patient should be given a copy of the CTO Patient Information Leaflet and their rights explained. For further guidance on completing section paperwork see section 9 below.
CTO Recall and Revocation	
Recall	The power of recall is intended to enable a response to relapse or high-risk behaviour relating to mental disorder before the situation becomes critical or leads to

	harm. It may also be used if a patient has broken one of the mandatory conditions. Only the RC may recall a patient to hospital if, on the information provided by the clinical team, the patient needs to receive treatment in hospital for mental disorder, and there is a risk of harm to the patient or others if not recalled. See Share Learning Bulletin SL17 for guidance on CTO recall. Practical elements to consider when recalling patients: - If the recall notice (**CTO3**) has not been served and, following further discussion/sharing of information, less restrictive options are considered more appropriate and the patient is in agreement, the RC may retract the recall notice. The proposed alternative intervention must be fully documented. - Once the recall notice has been served on the patient the process must be carried out i.e.: the patient must attend the hospital named on the recall notice, as this provides the authority to convey if necessary. - If a patient is admitted to another hospital the recall becomes invalid. Occasionally the allocated bed may change; this may be because the patient does not present themselves within the required timeframe. In such cases, to ensure the validity of the recall notice, the following steps should be taken: • The patient must present at the hospital named on the recall notice • Form **CTO4** must be completed by a member of staff to acknowledge their arrival and the start of the 72 hour recall period • The patient may be transferred to another hospital within the trust where the bed is now available – no transfer form is required • If the patient is transferred to a hospital outside CWP form **CTO6** must be completed to authorise the transfer If a recalled patient is admitted to a hospital which is not named on the CTO3 recall notice, the holding powers of Sections 5(4) and 5(2) cannot be used as the patient is already liable to be detained. The options are then informal admission, if the patient has capacity to agree to the admission and proposed treatment, or consideration of the in-patient RC completing a new CTO3 recall notice.
Duration of Recall	Recall is for up to 72 hours from the time the patient presents in hospital. The timeframe cannot be extended.
End of Recall - Revocation	During the recall period the RC must assess the patient and decide whether or not continued detention in hospital is required. Ending recall – the RC must complete the trust form, following which the patient may remain in hospital as an informal patient, or may be discharged from hospital. Continued detention – the RC, in consultation with the clinical team, may decide that further treatment is required in hospital. The RC may revoke the CTO using form **CTO5**, with the agreement of an AMHP. The original section will be reinstated as if the patient was detained on that day e.g.: if Section 3 was in place prior to CTO, this will be reinstated with the 6 month period starting on the day of revocation.
Consent to Treatment on recall and revocation	There are several possible options to authorise treatment on recall. **NB** – authority to consent to treatment must be in place as soon as possible following revocation.

Right of Appeal	There is no right of appeal on recall. Following revocation: - An automatic referral will be submitted to the First-tier Tribunal (Mental Health) by the MHL Team. - The patient has the right of appeal as per Section 3 above.
Paperwork	**CTO3** – completed by the RC to recall a patient to hospital **CTO4** – completed by nursing staff on the patient's arrival at hospital **CTO5** – completed by RC and an AMHP to revoke a CTO **CTO6** – transfer authority of a recalled patient to another Trust.

6.6 Sections 135 and 136

Due to multiagency involvement a stand-alone policy remains and can be located by following this link.

7. Part 3 – Forensic Sections

7.1 Section 35

Section 35	
Purpose	Remand to hospital to obtain a report on the individual's mental condition, if the court has reason to suspect that the accused is suffering from a mental disorder. The report will inform the court on whether the accused is fit to plead. May be implemented by either a Crown Court or a Magistrates' Court.
Duration	For up to 28 days at a time. It may be extended for up to a maximum of 12 weeks.
Implementation	The court will require written or oral evidence from a registered medical practitioner, and evidence that arrangements have been made for admission to hospital within 7 days of remand.
Consent to treatment	Part IV of the MHA does not apply. However, if necessary, Section 2 or Section 3 may be implemented alongside Section 35 to enable treatment to be given. Dual detention may be open to challenge and should be carefully considered.
Leave	There is no right to leave. If the accused absconds whilst in hospital he may be arrested by the police without a warrant and taken before the court. The remand may then be terminated, and alternative court powers implemented.
Right of appeal	There is no right of appeal. The patient information leaflet explains this.
Outcome	Following written evidence from the registered medical practitioner the court will determine the most appropriate course of action. If the conclusion is that the accused suffers from a mental disorder Section 36 or 37 may be imposed. However, if there is no mental disorder the court case will resume.

7.2 Section 36

Section 36	
Purpose	Instead of remand to custody the Crown Court may remand the accused to hospital while awaiting trial for an offence punishable with imprisonment, if satisfied that he suffers from a mental disorder and that appropriate treatment is available. This section does not apply to someone charged with murder.
Duration	For up to 28 days at a time. It may be extended for up to a maximum of 12 weeks.
Implementation	The court will require written or oral evidence from two registered medical

	practitioners (one of which must be Section 12(2) approved) and evidence that arrangements have been made for admission to hospital within 7 days of remand.
Consent to treatment	Part IV of the MHA applies as the patient is considered liable to be detained.
Leave	There is no right to leave. If the accused absconds whilst in hospital he may be arrested by the police without a warrant and taken before the court. The remand may then be terminated, and alternative court powers implemented.
Right of appeal	There is no right of appeal. The patient information leaflet explains this.
Outcome	Following written evidence from the registered medical practitioner the court will determine the most appropriate course of action. If the conclusion is that the accused suffers from a mental disorder Section 37 may be imposed. However, if there is no mental disorder the court case will resume.

7.3 Section 37 (with or without restrictions)

Section 37 (with or without restrictions)	
Purpose	An alternative to a custodial sentence where the Crown or Magistrates' Court have found that the offender suffers from a mental disorder at the time of sentencing. This section is not applicable for a person who has been convicted of murder. Section 37 ends the Courts' involvement in the case. However, the court may impose restrictions under S41 'for the protection of the public from serious harm'.
Duration	S37 - Up to 6 months, renewable for 6 months, and 12 months thereafter, in the same way as Section 3. S37/31 – There is no time limit, however the RC must report annually to the Secretary of State.
Implementation	The court will require written or oral evidence from two registered medical practitioners (one of which must be Section 12(2) approved). The patient must be admitted within 28 days of the Order.
Consent to treatment	Part 4 of the MHA applies whether or not a restriction is in place.
Leave	S37 - The RC may grant leave without informing the court. S37/41 – The RC cannot authorise leave without permission from the Secretary of State
Right of appeal	S37 - The patient may appeal to the court within 21 days of the order being made. The patient cannot appeal to the FTT within the first 6 months but may appeal during subsequent periods if detention is renewed by the RC. The patient may appeal to the Hospital Managers' panel at any time. S37/41 – The patient may appeal to the FTT only after the first 6 months have passed. He may appeal to the Hospital Managers' panel at any time; however the Hospital Managers may only exercise their power to discharge with the agreement of the Secretary of State. Patient information leaflets contain more explanation for service users.
Outcome	S37 - The patient may be discharged by the RC, Hospital Managers' Panel, FTT or nearest relative in the same way as Section 3. The court does not need to be informed of the outcome. S37/41 – The Secretary of State may end the restriction at any time. However, the patient will not become informal - S37 will remain in place and the patient

	should be treated as such. The FTT may grant either an absolute or conditional discharge.

7.4 Section 38

Section 38	
Purpose	An interim hospital order where a person is convicted before the Crown Court, but not sentenced, and the court requires further information regarding the person's response to treatment before making a final decision on whether Section 37 is appropriate.
Duration	An initial period of up to 12 weeks. Further periods up to 28 days may be authorised by the court, up to a maximum of 12 months in total.
Implementation	Evidence from two approved clinicians (one who must be on the staff of the hospital specified in the order) that the offender is suffering from a mental disorder and that it may be appropriate for a hospital order (S37) to be made.
Consent to treatment	Part 4 of the MHA applies.
Leave	The RC cannot authorise leave without the court's agreement.
Right of appeal	There is no right of appeal. patient information leaflet
Outcome	The RC cannot discharge. The court may end S38 at any time - this may be following evidence from the RC. The court may renew or convert to S37, or deal with the offender through the court process.

7.5 Section 47 (with or without restrictions under Section 49)

Section 47 (with or without restrictions under Section 49)	
Purpose	Transfer of a sentenced prisoner suffering from a mental disorder to hospital under the direction of the Secretary of State. In the majority of cases a restriction is applied – Section 47/49. The rare occasion when no restriction is imposed is usually when the person is reaching the end of the early release date of their sentence.
Duration	S47 without restrictions - the same as a hospital order i.e.: initially up to 6 months, thereafter renewable for 6 months, then 12 month. S47/49 – there is no time limit
Implementation	Two medical recommendations (one being from a Section 12(2) approved doctor) and an application from the prison medical officer is made to the Secretary of State to request transfer. Admission to hospital must be within 14 days of the transfer direction. A report must be sent to the Secretary of State once a year.
Consent to treatment	Part 4 of the MHA applies whether or not there is a restriction in place.
Leave	S47 - The RC may grant leave. S47/49 – The RC cannot grant leave without permission from the Secretary of State.
Right of appeal	S47 - The patient may appeal to the FTT within the first six months of the transfer order, and then during each period following renewal. S47/49 - The patient may appeal to the FTT once within the first six months, once within the next six months and then once every year thereafter. patient information leaflets

Outcome	S47 - The RC, FTT or Hospital Managers' panel may discharge the transfer direction – even if this is before the expiry of the sentence imposed by the court. S47/49 – If the RC believes that the patient no longer requires treatment for mental disorder, the Secretary of State may direct that he returns to prison or release him on parole. If the restrictions end (i.e.: the patient remains in hospital on the date he would have been released from prison) then he does not become an informal patient - S47 remains in place. This is often known as a 'notional 37', however technically the patient is on S47 and should be treated as such.

7.6 Section 48 (with or without restrictions under Section 49)

Section 48 (with or without restrictions under Section 49)	
Purpose	Transfer of an un-sentenced prisoner to hospital, who is in need of urgent treatment for mental disorder. In practice, as the court proceedings have not ended, the Secretary of State will always impose a restriction.
Duration	The transfer order will end when the patient returns to court.
Implementation	As per S47 above. Admission to hospital must be within 14 days of the transfer direction.
Consent to treatment	Part 4 of the MHA applies whether or not there is a restriction
Leave	The RC cannot grant leave without permission from the Secretary of State
Right of appeal	The patient may appeal to the FTT once during the first 6 months, and once during each period following renewal thereafter. However, the FTT has no power to direct the discharge of the patient but may notify the Secretary of State of his eligibility for absolute or conditional discharge. In such cases the Secretary of State may direct the patient's return to prison or other institution (S74) patient information leaflets
Outcome	With or without restrictions – The order will end if court proceedings are completed. S48 – the period of remand set by the court may end, unless the patient is committed to Crown Court. The FTT may discharge the order – in which case the court would decide the next step under the criminal justice system. S48/49 – The restrictions will end if the RC concludes that there is no mental disorder. In such cases the Secretary of State may return the patient to prison, or release on parole (if eligible).

7.7 Absolute and conditionally discharged patients (Section 73)

A restricted patient may appeal to the First-tier Tribunal (Mental Health) who may direct:

- An *Absolute discharge*, if it is not satisfied that the criteria apply and that it is not appropriate for the patient to remain liable to be recalled to hospital for further treatment. The patient then ceases to be liable to be detained as a result of the hospital order, and the restriction order will also cease. There is no power to defer absolute discharge – it is effective immediately the decision is made.
- A *Conditional discharge*, where conditions may be imposed at the time of discharge by the FTT or at any subsequent time by the Secretary of State. The patient may be recalled to hospital by the Secretary of State (although this is not an automatic power if conditions are not complied with).

Conditional discharge may be deferred by the FTT until it is satisfied that appropriate arrangements are in place in the community to enable the conditions to be met.

If a patient is recalled by the Secretary of State to hospital the Ministry of Justice must refer the case to the FTT within one month of admission. Upon recall the patient will become subject to the original section (i.e.: S37/41) starting from the original date. Part 4 of the MHA applies, the three month rule applying from the date of re-admission.

For further guidance on Part III of the MHA which relates to 'patients concerned with criminal proceedings or under sentence' refer to Chapter 22 of the MHA Code of Practice 2015.

CHAPTER 2 – GUIDANCE ON THE IMPLEMENTATION OF THE MENTAL HEALTH ACT

8. AWOL detained patients

The Missing Persons' policy applies to all patients, including those detained under the MHA. The guidance below is specific to the provisions of the MHA.

This guidance will refer to the provisions of MHA in relation to AWOL i.e.: timeframes for retaking, and cross-referencing the main policy

9. Factors to consider when completing section paperwork

The following guidance applies to both Section 2 and Section 3.

Status of two doctors completing recommendations:

- At least one of the doctors must be Section 12(2) approved.
- Where practicable to the second recommendation must be completed by a doctor with previous acquaintance i.e.: someone who has personally treated the patient or has some previous knowledge of the patient's case.
- If the second doctor does not have previous acquaintance it is preferable that they are section 12(2) approved
- If neither doctor has previous acquaintance the AMHP must state the reason for this on their application.

Conflicts of interests:

Specific scenarios considered to be a conflict of interest may restrict which professionals are able to complete medical recommendations. Guidance relating to conflicts may be found in the MHA CoP in Chapter 39.

Time limits for medical recommendations:

Where individual medical recommendations are completed there must be no more than five clear days between the dates of examination, e.g.: if the first doctor examined the patient on 01/09/2017, the second doctor must examine the patient no later than 07/09/2017.

Time limits for applications:

The applicant (AMHP or nearest relative) must have personally seen the patient within 14 days ending on the date of signing the application.

Acceptance of section papers

The nurse in charge of the ward must accept the section papers on behalf of CWP as described above for each section, using the Trust checklist (see Appendix 1) to ensure papers are lawful. Any correctable errors identified must be actioned as soon as possible. Section 15 of the MHA allows certain errors to be rectified within 14 days of the date the patient was admitted to hospital.

Errors as described on the checklist which would invalid the section cannot be rectified and appropriate action must be taken.

Example Scenario:
If the application completed by the AMHP has been made out to the wrong hospital the section is invalid and should be identified when using the checklist to accept papers. The AMHP service must be contacted immediately to complete a new application. The patient must be informed of the error and a Datix completed (Category B to enable a 72 hour review and learning). Whilst waiting for the AMHP to complete a new application, consideration may be given to the use of Sections 5(4) or 5(2) to ensure the patient remains on the ward safeguarded by an appropriate framework. Throughout this process the MHL Team must be kept informed.

Following acceptance on the ward the papers must be scanned and e-mailed to the MHL Team for further scrutiny, both administratively and medically. The original papers must be sent as soon as possible to the MHL Team.

10. Section renewal (3, 37 & CTO)
All parts of the H5 form must be completed in consecutive order to ensure the process has been appropriately followed. If Part 3 of the form is dated prior to Part 2, then the section renewal may be challenged as it would appear that the RC has authorised renewal without the agreement of another professional as per legislation.

11. Authority to consent to treatment
In all cases when a form of consent has been completed, either by the RC or a SOAD, the original must be sent to the MHL Law Team. A copy must first be taken, scanned and e-mailed to the MHL Team, and then attached to the prescription chart.

For CTO patients who are administered medication by the community team, a copy must also be kept with the prescription chart.

Example regarding administration of medication:
Prior to administrating medication for mental disorder nursing staff must check that the prescription matches the form of authorisation. If the medication is not authorised, it cannot be given until appropriate authority is given by the RC or SOAD. Likewise, a junior doctor who may be asked to prescribe some prn medication should also check to ensure that it is appropriately authorised. Administering medication for mental disorder which is not authorised under the MHA would be a serious matter and considered to be in contravention of patients' rights not to be treated inhumanely (HRA Article 3).

12. Patient rights
All patients subject to the MHA, whether in hospital or in the community, on a civil section or a section imposed by the courts, are entitled to specific rights. CWP has a duty under the MHA to ensure all patients are informed of their rights, and that effective communication is maintained with their families, carers and other relevant persons with the consent of the patient.

As soon as practicable following detention patients must be made aware of their rights and what the section, they are detained under means to them. Patient Information Leaflets are available for all sections; a copy should be offered to all detained patients and the implications explained. It is not always possible to do this following admission if a patient is particularly unwell or lacks capacity to understand the information. It is essential, therefore, that further attempts are made to inform patients of their rights.

The method of communicating rights should be considered carefully and barriers to effective communication overcome. Patient Information Leaflets are available in many languages, and if a particular language is not readily available the MHL Team will attempt to source rom external partners. Easy Read leaflets have been developed; picture boards, interpreters and sign language may be considered.

Trust guidance has been issued for staff on the frequency of explaining rights to patient. This can be found by clicking here.

13. Independent Mental Health Advocate (IMHA)

IMHAs are a valuable resource in assisting patients to understand the section they are subject to, commissioned by local authorities. They are an additional safeguard for patients with specialist knowledge of the MHA, and can assist patients to participate in decision making, communicate their views to staff, and in the appeal process.

CWP has a duty under Section 130D to inform patients of their right to support from an IMHA and how to obtain that support. The MHA Code of Practice advises that if a patient lacks capacity to understand this information, then a referral should be made to the IMHA service (Ch. 6.16).

IMHAs may also assist patients with the hearing process, specifically Hospital Managers' hearings. As soon as staff are aware of a hearing steps should be taken to ensure the patient is offered this support, and if accepted a referral made.

NB: All attempts to explain rights to a detained patient must be documented as a clinical note in the patient's electronic record. See section 26.2 for further clarification on what should be documented.

Example:
Jo is admitted on Section 2 to Pine ward. He is particularly unwell and is not receptive to staff attempts at explaining what the section means and his right of appeal/support. The nurse documents on the electronic patient record that this attempt has been made but due to his current presentation and lack of capacity to understand this information a further attempt will be made the next day.

The following day a further attempt is made and as Jo is more settled on the ward, he is willing to listen to the information given. However, there are concerns regarding his capacity to understand the information provided, and it is clear that he is not happy to be on the ward. The nurse submits a referral to the IMHA service and documents the interaction with Jo in the electronic patient record. She clearly documents why she is concerned about his capacity to understand, that he is not happy being detained on the ward, and that she had made a referral to the IMHA service. She also documented that further attempts will be made to explain to Jo his rights, particularly as he may wish to exercise his right of appeal.

See section 26.2 for good examples of clinical notes when documenting rights.

14. Transfer of detained patients

Detained patients may be transferred under Section 19.

Detained In-Patients	
Transfers within the trust	• No formal authorisation required. • When detained patients move wards the MHL Team must be informed as there will be a change of RC which may affect consent to treatment provisions and hearing arrangements.
Transfers to another trust	• Agreement must be sought from the receiving trust and arrangements made for transfer • The MHL Team MUST be informed as soon as possible to ensure a copy of the MHA paperwork goes with the patient. Where this is not possible a copy of the MHA paperwork must be sent with the patient and the MHL Team will arrange with the receiving trust for the papers to be sent recorded delivery. • Part 1 of Form H4 is to be completed by the nurse-in-charge and given to the receiving trust who will complete Part 2 to accept the transfer. • A copy of the completed Form H4 must be sent to the MHL Team who will update the electronic patient record.
Transfers from another trust	• On acceptance of the transfer, the nurse-in-charge must clarify the patient's legal status and request the original MHA paperwork. If this is not possible a copy by be received. • Check the MHA papers are correct and all present using the checklist (see Appendix 2). • Complete Part 2 of Form H4 to formally accept the transfer. • Inform the MHL Team as soon as possible of the transfer; scan and e-

	mail a copy of the papers to the MHL Team; post the originals to the MHL Team.

CTO Transfers	
Transfers to another trust	• Care co-ordinator to ensure agreement for the transfer is obtained in writing from the clinical team at the receiving trust. • On receipt of this agreement the MHL Team are to be informed. • MHL Team will complete Form CTO10 to formally transfer the responsibility of care to the new trust. • MHL Team will ensure all relevant MHA paperwork is sent to the new responsible trust and will update the electronic patient record.
Transfers from another trust	• The receiving CMHT must accept the transfer of care. • The MHL Team must be informed of the transfer. • Original MHA paperwork must be obtained from the transferring trust, including the completed CTO10. Where appropriate the MHL Team will liaise with the referring trust to obtain paperwork.

15. Transfer to/from Guardianship

Patients may be transferred from section 3 to section 7 (guardianship). Once agreed the local authority will complete Form G6. The MHL Team must be informed of this transfer and will ensure the original paperwork is sent to the relevant LA. The period of guardianship will expire on the date on which section 3 was due to expire, but may be renewed if appropriate

A patient may be transferred from guardianship to hospital. However, in this case there is a requirement for the completion of two medical recommendations and an application to accompany Form G8 which authorises the transfer. All MHA paperwork must be sent to the MHL Team.

16. Section 17 leave

There are two types of leave which may be granted to detained patients and these should not be confused:

- *Discretionary leave within the hospital grounds* – agreed by the clinical team to enable patients to have access to the hospital grounds only, following risk assessment.

For the purposes of Section 17 leave, hospital grounds are defined as the perimeter of the hospital, or health park sites in situations where there are multi-trust sites:

Perimeter of health park site	Countess of Chester Health Park	Ancora House Bowmere Hospital Eastway Assessment and Treatment Unit
	Clatterbridge Hospital Health Park	Springview
	Macclesfield District General Health Park	Silk Ward
Perimeter of individual site	Soss Moss Site	Alderley Unit Saddlebridge Unit
	Rosemount Site	Greenways Assessment and Treatment Unit
	CWP site boundary, including Jocelyn Solly	Mulberry Ward

- *Section 17 leave* – leave for detained patients that can only be authorised by the RC (in conjunction with the Secretary of State if the patient is restricted) for patients who wish to leave the hospital grounds e.g.: to visit local shops. Most patients detained under the MHA are entitled to Section 17 leave (see individual sections above for entitlement). Leave may be granted for varying timeframes dependent upon individual circumstances.

Leave is an important aspect of a detained patient's care plan but can also be a time of risk. Therefore, it is essential that a risk assessment is undertaken and fully documented prior to granting leave, and prior to the patient taking leave. Guidance on what should be considered can be found in the MHA CoP, page 317.

The Trust Section 17 leave form (see Appendix 3) must be fully completed to include the following:

- The duration of the leave i.e.: date and time of start and finish
- Whether any conditions are attached, e.g.: the address where a patient is staying if leave is overnight, specific places leave is restricted to
- Whether the leave authorised is unescorted, escorted, or accompanied. If escorted the ratio/gender and number of escorts must be documented. If accompanied, the names of carers/relatives must be documented.

The form must be signed by the RC to authorise leave and staff must ensure that the patient is aware of the conditions of the leave authorised. A copy must be offered to the patient, their care co-ordinator, relatives, carers and any other relevant person, and this should be indicated on the form.

Guidance on completion can be found on the back page of the Section 17 leave form.

On return from leave it is good practice for staff to discuss with the patient how leave went and document this as a clinical note. Such discussions may inform future plans for leave.

There is now a requirement for the RC to consider a CTO when authorising leave for 7 or more consecutive days. The Code of Practice states that leave should be of short duration, however it is not unlawful to authorise longer-term leave. The use of CTO is an option, as is Guardianship, and if this is not considered to be the appropriate course of action, the reasons should be documented on the Section 17 leave form. Further guidance on deciding between Section 17 leave, CTO and Guardianship can be found in Chapter 31 of the MHA Code of Practice.

Exceptions to the above are:

- If a patient is to receive treatment from a different trust within the same healthcare park, then Section 17 leave would be required.
- If a patient requires urgent treatment then, in the best interests of the patient, they must be taken to the general hospital immediately without seeking Section 17 leave authorisation. The RC, and Secretary of State (if the patient is restricted), must subsequently be informed so that discussions can take place to ensure appropriate care plan/conditions are in place whilst the patient is receiving urgent treatment and to ascertain whether or not authorisation is required for further leave to allow non-urgent treatment.
- If the Order for a restricted patient states that he is detained to a specific unit then any leave outside that unit, even if within the same healthcare park, would require authorisation from the Secretary of State. However, if the Order states that the patient is detained to the site, section 17

would not be required. This may cause confusion and staff should be clear regarding the conditions of the Order.

Scenario:
Tom has been placed on a Section 37/41 by the court, the Order stating that he is to be detained at Alderley Unit. However, he wishes to attend York House within the hospital site but is unable to do so unless the Secretary of States authorises leave.

Peter, on the other hand, is also on Section 37/41 but his Order states that he is detained to the Soss Moss site. He is, therefore, able to attend York House without the Secretary of State authorisation.

If considered necessary, by the RC and/or the Secretary of State, a patient's leave may be revoked at any time in the interests of the patient's health or safety or for the protection of others. A refusal to take medication would not be sufficient grounds to revoke leave. This must be made in writing to the patient, fully explaining the reasons, and this must be given to the patient, or whoever is in charge of the patient at that time.

If a patient does not return to hospital as stated in the conditions of their leave, the Trust's Missing Persons policy must be followed.

17. Patients Absent without Leave
Patients who do not return to the ward as required following the authorisation of leave, who leave the ward without authorisation, or who do not attend the hospital stated on the CTO3 recall notice within the required timeframes, are regarded as AWOL.

Detained patients may be taken into custody and returned to hospital by an AMHP, any member of the hospital staff, a police officer, or anyone authorised in writing by the hospital managers, under Section 18 MHA. Trust policy should be followed regarding missing persons; however, consideration must be made of the timeframes for returning a detained patient to hospital. These timeframes are determined by the specific section:

Example:
Sections 5(4) and 5(2) – patient may be retaken up to the end of the period of detention i.e.: 6 hours or 72 hours respectively.

Section 2 – patient may be retaken up to the end of the period of detention i.e.: 28 days following implementation.

Section 4 – patient may be retaken up to the end of the period of detention i.e.: 72 hours.

Section 3 – patient may be retaken up to the end of the current period of detention, or up to six months starting with the day he went absent whichever is the later.

E.g.: Section 3 implemented 02/05/18, patient went AWOL on 24/06/18. The section is due to expire midnight on 01/11/18, six months from the date he went AWOL is 23/12/18. Therefore he may be retaken up to midnight on 23/12/18.

If a patient is AWOL when a deadline for renewal is approaching but a section 20 renewal report has not been completed, special arrangements apply if the patient returns prior to the date of expiry. In such cases the period of detention is treated as not expiring until the end of the week starting from when the patient returned. During this time the RC may renew the section.

For detailed clarification of the timeframes, refer to Chapter 25 of the MHA Reference Guide.

18. Return of patients AWOL outside England and Wales

The MHA only has jurisdiction in England and Wales. Reciprocal arrangements are in place with Scotland, Northern Ireland, the Isle of Man and the Channel Islands. For guidance on repatriation of patients see Chapters 34 to 38 of the MHA Reference Guide.

19. Treatment of physical disorders

Consent to treatment provisions in the MHA are applicable only for treatment of mental disorder. Treatment for physical disorders may be given if:

- the patient has capacity and has consented to the treatment, or
- the patient lacks capacity to consent and the treatment is deemed to be in the patient's best interests - the Mental Capacity Act may be used

There are occasions when a patient's physical condition and mental disorder are interlinked, in which case treatment for a physical intervention may be authorised by the RC under Section 63.

Example:
Sue is suffering from severe depression and the RC has decided that ECT is the most appropriate treatment. As she lacks capacity a SOAD has authorised a course of 12 ECT treatments. However, the anaesthetist is not happy to proceed as Sue has a loose tooth which requires extraction as it would pose a high risk of potentially choking Sue during the anaesthetic. Sue is unable to give consent to the extraction and so following a best interests meeting it was agreed that the RC would authorise the extraction under Section 63 so that the course of ECT could proceed. Sue's family were involved in the discussion and agreed that this was the best way forward.

20. Patient's correspondence

The MHA does not allow patient's incoming personal correspondence to be withheld, unless they are detained in a high security hospital.

However, in exceptional circumstances, if concern is raised as to the content of incoming mail arrangements may be made for the patient to open the mail in the presence of staff. This must be agreed and fully documented. For further guidance refer to Chapter 5 of the MHA Reference Guide.

Section 134 allows a postal packet addressed to any person by a detained patient to be withheld if that person has specifically requested that they do not want to receive such correspondence. Any correspondence that is withheld must be clearly documented in the electronic clinical record, together with the reasons why.

21. Appeal process, including representation

Detained patients have the right to appeal against their detention under the MHA; please refer to the section information above to ascertain the rules for when a patient may appeal to the FTT and Hospital Managers' panel.

The hospital managers have a duty to refer cases to the Tribunal at specific times (MHA CoP pg. 382 – Figure 20), and the Secretary of State may also refer a case if considered appropriate.

Example of a referral:
Polly had been detained on Section 2 for three weeks when the clinicians agreed that Section 3 was required for further treatment in hospital. Unfortunately, Polly's nearest relative, Fred, did not agree with this decision and so objected. The AMHP believed that his objection was not in Polly's best interests and so applied to the Court of Protection under Section 29 to displace him as nearest relative. The Court had not made a decision before the Section was due to end, resulting in Section 2 being extended until the proceedings have been completed.

Six weeks later the Court proceedings are still ongoing, but Polly is unable to challenge her continued detention as she can only appeal with the first 14 days of a Section 2. The MHL Administrator believes that this is a violation of her human rights under Article 5(4) of the ECHR as she is unable to have her case heard in a timely manner by the Tribunal, and so asks the Secretary of State to make a reference.

21.1 First-tier Tribunal (Mental Health)

The Tribunal is an independent judicial body which reviews cases of detained and conditionally discharged patient, and patients subject to CTOs. The Tribunal may direct the discharge of detained patients where it thinks it appropriate. This process provides a significant safeguard for patients who have had their liberty removed or restricted.

Written reports submitted to the panel should be clear, concise and relevant, and should have regard for the patient's wishes. Reports must be submitted, using the template provided, within the specified timeframe. Failure to do so will result in the receipt of Directions. Follow this link for further guidance on completion of reports. Professionals are expected to attend the hearing to present their reports and provide an update. If a report author is unable to attend, they must ensure that a representative who has a working knowledge of the patient attends. This evidence is crucial as it is for the professionals who believe detention is necessary who must prove this, not for the patient to disprove it.

Patients are entitled to free representation from a legal representative, who will meet with them to obtain their views and provide support throughout the process. At the hearing the legal representative will ensure the panel is aware of the patient's views.

In certain cases, patients may ask to be examined prior to the hearing by the medical member of the panel. Staff should ensure that appropriate arrangements are in place to facilitate this. For further guidance on prior examination follow this link.

Having heard all the evidence, the Tribunal panel will make their decision, informing the patient (if in attendance), legal representative and professionals. This is followed by a written decision giving a full explanation of the reasons for their decision.

21.2 Hospital Managers' Panels

The Hospital Managers' panel are a group of people appointed by the trust to consider the cases of detained patients. They have the power to discharge if it is felt the criteria for detention is not met.

Patients may appeal to the Hospital Managers' panel (see individual section information for details). The Panel also has a duty to review detention or CTO following renewal.

Although not a judicial body, the process for Hospital Managers' hearings is the same as that for Tribunal hearings with regards to submission of reports from appropriate professionals, and attendance at the hearing to provide oral evidence.

Ward staff or the care co-ordinator must ensure that patients are aware that they may be supported by an advocate, a legal representative or family member/carer, and ensure this in place prior to the hearing, if requested.

An additional function of the Hospital Managers' panel is to review cases where the RC has barred a nearest relative's application for discharge. In such cases an additional criteria must be considered by the panel when deciding whether or not the patient should be discharged.

22. The role of the nearest relative, including powers of discharge

The nearest relative is defined in Section 26 of the MHA and should not be confused with next-of-kin (see Glossary of Terms above). When considering implementing a section the AMHP will determine who is the nearest relative in accordance with the hierarchy. If a relative who would normally be nearest relative ordinarily resides outside the UK, they are excluded from this role.

A nearest relative may:

- Delegate their role to another person. This must be in writing and the nominated person must sign to acknowledge their acceptance.
- Request the discharge of their relative if they are subject to section 2, 3, guardianship or a CTO.
- Stop the AMHP from making an application for section 3 or guardianship.
- Make an application to detain their relative on section 2, 3 or 4.
- Receive information about their relative's treatment (unless the patient objects)
- Attend a First-tier Tribunal or Hospital Managers' hearing
- Be informed if their relative is transferred to another hospital
- Be informed of their relative's discharge

NB: Patients remanded to hospital under section 35 and 36, are subject to interim hospital orders under section 38, or who are restricted, do not have nearest relatives as defined by the MHA.

A nearest relative may be displaced by the court in specific circumstances (MHA CoP Ch 5.7). The application may be made by the patient, any relative of the patient, anyone living with the patient, or an AMHP. In such cases if the court agrees and a suitable proposed replacement is willing to act in this role, the court will appoint the nearest relative.

Process for a nearest relative application for discharge:

- Nearest relative application is received in writing by ward/community staff.
- The date and time of receipt must be written on the application and the MHL Team informed.
- The MHL Team will liaise with the patient's RC.
- During the 72 hour period from the time of receipt the RC must assess the patient and if applicable make a report barring the request for discharge.
- If a barring report is completed, the patient remains detained and a Hospital Managers' hearing will be arranged.
- If a barring report is not completed, the patient becomes informal at the end of the 72 hour period.

The RC, when considering a barring report must address additional criteria, which is whether 'the patient, if discharged, would be likely to act in a manner dangerous to other persons or himself'. The MHA does not define 'dangerousness'; however the Code of Practice provides guidance at chapter 32.23.

Following completion of a barring report the nearest relative is disqualified from making a further application for discharge for six months. However, if unhappy with the barring report, the nearest relative may apply for discharge to the First-tier Tribunal within 28 days of the barring report.

23. Section 117 aftercare

Section 117 is an enforceable duty requiring clinical commissioning groups (CCGs) and local authorities to provide or arrange for the provision of aftercare to patients who have been detained in hospital under sections 3, 37, 45A 47 or 48. This provision applies to all ages, and includes patients granted section 17 leave, and those on a CTO.

Aftercare means "services which have the purposes of meeting a need arising from or related to the patient's mental disorder and reducing the risk of a deterioration of the patient's mental condition (and, accordingly, reducing the risk of the patient requiring admission to hospital again for treatment for mental disorder" (MHA CoP Ch 33.3).
Aftercare can encompass healthcare, social care and employment services, supported accommodation and services to meet the person's wider social, cultural and spiritual needs.

Care planning should commence as soon as possible following admission, appropriate aftercare services being identified in good time prior to discharge. The duty of aftercare continues for as long as the person is in need of services in respect of their mental disorder and is delivered via the Care Programme Approach (CPA).
Patients are under no obligation to accept the aftercare offered. This does not mean that patients have no need for such services, nor does it preclude them from services if they change their mind.

A joint section 117 review should take place at least annually, with periodic reviews in accordance with the CPA. Refer to CP42 Care Planning (CPA and Standard Care) Policy for further guidance on CPA.

Procedure for discharging Section 117:

- Convene a section 117 discharge meeting inviting all relevant professionals, family/carers and patient.
- If it is agreed that aftercare is no longer required print the S117 discharge form from the electronic patient record. This must be signed by a representative from each authority.
- Send the completed form to the MHL Team who will update the electronic patient record.
- Inform the GP of the decision.

24. Victims

Victims of serious violent and sexual offences have specific rights with regards to the treatment and discharge of Part 3 patients (mentally disordered offenders). The Domestic Violence, Crime and Victims Act 2004, together with the Mental Health Act (as amended in 2007) allow victims the right to receive certain information about key stages of a Part 3 patient's progress. A victim may engage with the Victim Contact Scheme (VCS) for support - a Victim Liaison Officer (VLO) appointed.

An eligible victim is entitled to:

- know whenever a discharge is being considered, either by the Secretary of State, the Tribunal service (restricted patients), the Responsible Clinician or the Hospital Managers (unrestricted patients).
- make representations to the decision-maker about conditions to be attached to a discharge or CTO for their protection. However, cannot make representations as to the appropriateness of discharge.
- know whether the patient was discharged, or a CTO made. If a CTO was implemented, they are further entitled to know what conditions, if any, are in place for the protection of the victim or the victim's family; when those arrangements end and why.

A victim does not have a statutory right to know where the patient is being detained, when the patient is on leave from the hospital, or where the patient lives on discharge. However, depending upon risk, there is a presumption that victims will be informed of leave.

For further details on the rights of victims please refer to Chapter 40 of the MHA Code of Practice. A flow chart for the Victim Contact Scheme (VCS) may be found in the CP53 Policy and Procedure for multi-agency Public Protection Arrangements (MAPPA) notification duty on page 14.

25. Mental Capacity Act and Deprivation of Liberty Safeguards.

The Mental Capacity Act 2005 (MCA) empowers individuals to make their own decisions where possible and protects the rights of those who lack capacity. Where an individual lacks capacity to make a specific decision, the MCA provides a legal framework for others to make a decision, in their best interests, on their behalf.

The MCA applies to individuals aged 16 and over.

At the heart of the MCA are five statutory principles:

1. A person must be assumed to have capacity unless it is established that they lack capacity.
2. A person is not to be treated as unable to make a decision unless all practicable steps to help them to do so have been taken without success.
3. A person is not to be treated as unable to make a decision merely because they make an unwise decision.
4. An act done, or decision made, on behalf of a person who lacks capacity, must be done, or made, in their best interests.
5. Before the act is done, or the decision is made, regard must be had to whether the purpose of the act or the decision can be as effectively achieved in a way that is less restrictive of the person's rights and freedom of action.

Capacity is decision and time specific and should be central to the approach when caring for individuals in a mental health setting. It is important to note that individuals with a mental disorder, including those liable to be detained under the MHA, do not necessarily lack capacity.

A person lacks capacity to make a specific decision if, at the material time, the person is unable to make a decision for themselves in relation to the matter because of an impairment of, or a disturbance in the functioning of, the mind or brain.

In order to determine whether or not a person lacks capacity two tests must be considered:

Diagnostic Test: this determines whether the person has an impairment or disturbance in the functioning of the mind or brain.

Functional Test: this determines whether the individual is unable to make the specific decision themselves because of an impairment or disturbance of the mind or brain. This may be temporary or permanent; if temporary the decision-maker should justify why the decision cannot wait until there is a change in circumstances.

Having considered both the diagnostic and functional tests a patient may be deemed unable to make a decision for themselves if they are unable to do any one of the following:

- Understand information which is relevant to the decision to be made
- Retain that information in their mind
- Use or weight that information as part of the decision-making process, or
- Communicate their decision (whether by talking, sign language or any other means)

This is known as the Capacity Test and forms the basis of all assessments of capacity.

The MCA can be relied upon to treat mental disorder where the individual lacks capacity to make a specific decision, if it is in his best interests and the treatment is not regulated by Part 4 of the MHA. It

also offers protection from legal liability for certain acts of restraint in specific circumstances ie: the person taking action reasonably believes that restraint is necessary to prevent harm to the person who lacks capacity, and the amount or type of restraint used and the amount of time it lasts is a proportional response to the likelihood and seriousness of that harm.

The MCA may be used for the treatment of physical conditions where an individual is liable to be detained under the MHA. This may include treatment of a physical condition that is intended to alleviate or prevent a worsening of a symptom or manifestation of the mental disorder, or where treatment is ancillary to treatment for mental disorder.

> Example of using MCA for patients liable to be detained under the MHA:
>
> Polly's medication regime includes Clozapine, requiring regular blood tests. However, she lacks capacity to agree to these tests. Blood tests are a physical health intervention and so do not come under the MHA regime. However, they are part of/ancillary to, treatment for mental disorder and so the MCA may be used in her best interests.

25.1 Advance Statements/Decisions and Lasting Power of Attorney

Advance Statements allow an individual to document their wishes when they have capacity in preparation for a time when they may not be able to make decisions for themselves. Although not legally binding, and Advance Statement may identify an individual's preferences for domestic arrangements, treatment preferences, finance arrangements and childcare arrangements. Professionals should take the wishes expressed in an Advance Statement into account when making decisions on behalf of an incapacitated patient.

Advance Decisions (AD) may be made orally or in writing by anyone over 18 years of age who has capacity at the time of its creation. The AD has the effect of enabling a person to refuse specific treatment when they lose capacity to give or refuse that treatment. Therefore, it only becomes effective when the individual loses capacity.

- An AD may be varied or withdrawn at any time as long as the individual has capacity to do so.
- An AD cannot refuse basic/essential care i.e.: warmth, shelter, hygiene measures, offer of food/water (not artificial nutrition and hydration).
- An AD can be overridden by Part 4 of the MHA – i.e.: a decision to refuse a specific treatment may be rendered ineffective if a person is detained under the MHA and it is within the scope of Part 4. An exception to this rule is s.58A with regards to ECT – a patient's decision to refuse ECT cannot be overridden if they have capacity to refuse (including in advance).
- If an AD is in relation to life sustaining treatment there are specific requirements which must be followed: it must be in writing, signed and witnessed, and must expressed state that it is to apply where life is at risk.
- Consideration should be given to advances in treatment that the individual was not aware of at the time of making the AD. If the individual had known, would this have affected the decision to refuse treatment?
- An AD must be **valid** and **applicable** to the decision being made.

For further information on Advance Decisions refer to the Mental Capacity Act Code of Practice, chapter 9.

Lasting Powers of Attorney (LPA) empowers relatives not just to express their views in relation to the care of incapable relatives, but to make decisions for them. They can only be made when an individual has capacity and is aged 18 years and over.

There are two types of LPA: Property and Affairs and Welfare.

- An LPA is a legal document allowing the named attorney to make decisions on behalf of the individual once they lose capacity. The individual may choose one, or several, attorneys.
- An LPA must be registered with the Office of Public Guardian (OPG) at any time prior to its use. If the LPA is not registered it is not valid. Any changes in advance of its use must also be reported to the OPG once registered.
- For an LPA to be valid it must be written and set out in the statutory form; it must be signed by the individual and the appointed attorney(s). The document must include a certificate completed by an independent third party confirming that they believe the individual understands the purpose of the LPA and that there has been no coercion in it making.

Decisions regarding health care and treatment fall under the Welfare LPA. It is essential, therefore, to ascertain what type of LPA is in place. In such cases the attorney(s) has specific duties, including following the MCA statutory principles, and making decisions in the best interests of the individual.

If there are doubts that the attorney is acting in the individual's best interests the OPG must be informed, who may refer to the Court of Protection for investigation.

For further details on LPAs refer to the MCA Code of Practice chapter 7.

NB: For the purposes of those detained under the MHA, the attorney(s) may be different to the identified nearest relative.

If it is known that there is an Advance Statement, Advance Decision or Lasting Power of Attorney in place the validity of these documents must initially be ascertained. An alert must be recorded on the patient's electronic record and a copy attached to the Doc tab.

All relevant professionals must be informed, including the MHL Team who have a duty to provide welfare attorneys information at specific times if the individual is detained under the MHA.

Documentation of Capacity

When documenting a Capacity Assessment, the decision-maker must first establish what the decision is that is being made. The Capacity Test, as outlined above, must be addressed in order to provide the rationale behind the decision made, and the outcome must be clearly stated. See section 26.2 for examples of how to document capacity.

25.2 Deprivation of Liberty Safeguards

The Deprivation of Liberty Safeguards (DoLS) introduced in the MCA 2005, and amended by the MHA 2007, provides a framework for those who need to be deprived of their liberty in their best interests for care or treatment who which they lack capacity to consent themselves.

- DoLS only applies to individuals who lack capacity to consent to accommodation in a care home or hospital where the care and/or treatment provided is, or is likely to, amount to deprivation of liberty.
- DoLS does not in itself authorise care or treatment, only the deprivation that results from the implementation of a care plan. Therefore, any necessary care or treatment is provided in accordance with MCA.
- Decision-makers should first assess the individuals' capacity to consent to the proposed arrangements, whether these arrangements are likely to result in a deprivation of liberty and whether changes to the care plan may avoid this potential deprivation.

The definition of a 'deprivation of liberty' is not fixed; clarification being provided in case law. The Supreme Court, on 19th March 2014,[1] clarified that there is a deprivation of liberty in circumstances where an individual is under continuous control and supervision, is not free to leave and lacks capacity to consent to these arrangements. This is known as the 'acid test'.
The Supreme Court also noted factors which are not relevant when determining a deprivation of liberty, including the individual's compliance or lack of objection, the reason or purpose behind the placement and the relative normality of that placement.

Urgent DoLS Authorisations may be self-authorised by the relevant hospital by completing the statutory form. Urgent authorisations are time-limited, initially lasting for up to 7 days with a potential extension of a further 7 days if agreed by the relevant local authority. When completing an Urgent Authorisation an application for a Standard Authorisation must also be submitted to the local authority (LA) from the area in which the patient normally resides.

Standard DoLS Authorisations may only be authorised by the relevant LA following a series of assessments to ensure eligibility and that the criteria is met. The LA states the period of authorisation and may attach conditions to the authorisation. A Standard Authorisation may be extended following further assessments by the LA.

A DoLS authorisation cannot be transferred from one authority to another. Therefore, if a person is discharged from a ward to a care home, the care home must apply for a new DoLS authorisation ideally prior to arrival on their premises.

MHA v MCA/DoLS

Individuals are ineligible for DoLS if:

- They are detained under sections 2, 3, 4, 35 – 38, 44, 45A, 47, 48 or 51 of the MHA.
- They are liable to be detained under one of the aforesaid sections, but are not currently in hospital (ie: they are on leave) and the proposed care/treatment plan would conflict with a requirement imposed upon them; or the relevant care/treatment plan consists, in whole or in part, of treatment for mental disorder.

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[1] P v Cheshire West and Chester Council and another and P & Q v Surrey County Council, 2014.
https://www.supremecourt.uk/decided-cases/docs/UKSC_2012_0068_Judgment.pdf

- They are subject to a CTO and the proposed care and treatment plan would conflict with the conditions of the CTO
- They are subject to guardianship and the proposed care and treatment plan would conflict with the conditions of the guardianship.

When considering which framework to use an options grid in chapter 13 of the MHA Code of Practice summarises the availability of MHA and DoLS, providing a good starting point. There are circumstances when potentially both regimes are available; in which case the choice of regime should not be based upon a preference for one over the other. Both regimes are based on the need to impose as few restrictions on the liberty and autonomy of patients as possible.

Decision makers should not proceed on the basis that one regime is less restrictive than the other, as both provide safeguards for individuals. Decisions should be made on the circumstances of the particular individual.

Each individual case is unique and should be assessed on its merits, taking into account all necessary factors. The proposed care plan and deprivation of liberty should be discussed with family/carers, and clearly documented to evidence the rationale behind the deprivation and whether alternative interventions have been considered.

For further guidance on Deprivation of Liberty Safeguards refer to:

The MHA Code of Practice, chapter 13.
The Deprivation of Liberty Code of Practice (however this should be with caution as case law has superseded some aspects of this guidance)
The Law Society Guidance on Deprivation of Liberty Safeguards

Monitoring Applications for a Deprivation of Liberty Authorisation, and escalation of delays in assessment, should be undertaken in accordance with SL102.

26. MHA Documentation

26.1. MHA Paperwork

All original paperwork completed (including new sections/CTOs, renewals/extensions, consent to treatment and section discharge) must be sent to the MHL Team as follows:

- Scan and e-mail original forms to: cwp.mhlteam@nhs.net
- Post original forms direct to: MHL Team, Redemere, Countess of Chester Health Park, Liverpool Road, Chester, CH2 1BQ.

The MHL Team will ensure that administrative scrutiny is undertaken for all MHA paperwork and, where applicable, medical scrutiny is undertaken. Any correctable errors identified on section papers must be completed within 14 days as per Section 15 of the MHA. Should errors be identified which render the section unlawful (eg: the application does not state the hospital to where the patient was actually admitted), the MHL Team will ensure appropriate steps are taken. For guidance on correctable and non-correctable errors refer to the section acceptance checklist (Appendix 1)

The MHL Team will scan and upload all MHA paperwork to the electronic patient record, once administrative and medical scrutiny has been completed. Wards are advised to keep a paper copy of section papers until this process has been completed as this is the authority to detain a patient lawfully on the ward.
However, a copy of consent to treatment forms must always be attached to the patient's prescription card. On administration of medication nursing/community staff should check that the medication being given is authorised in accordance with the consent provisions as described above for each section. If authorisation is required, but the specific medication is not identified on the consent form, it cannot be given until appropriate authority is in place.

27. Clinical notes

It is essential that clinical notes are documented accurately and fully reflect the current situation. Specific areas of importance with regards to MHA are documenting that a patient has been explained their rights and an assessment of capacity has taken place. Clinical notes should be appropriately headed to ensure ease of reference. i.e.: Capacity Assessment / Patient's Rights.

Below are some good examples of documentation:

Documenting an Explanation of Rights

Patient's Rights
'I have discussed rights with Rupert under section 3 MHA. He told me understands his rights, therefore I asked him to confirm what he understands. He told me he is detained under section 3 for up to 6 months, needs section 17 leave to go out of hospital grounds, and can be brought back to hospital if he leaves without leave granted. He is aware that he has to take treatment for his mental health, and if he refuses this can be given against his will. He was unsure of role of IMHA, therefore I explained this. He was then offered support from them, which he has declined. He is aware of right to appeal, which he has previously exercised. He has legal representation and does not want any further help at this time.'

Documenting an Assessment of Capacity

Capacity Assessment
Roger was able to understand some of the information, particularly issues around side effects that he had previously experienced and was able to recount some of this conversation today though he had not retained all the information. He was not able to weigh up the information to make an informed choice. Hence it is my opinion that Roger does not have the capacity to consent to his treatment.

Capacity
Holly is able to understand information regarding her admission, retain it, weight up the pros and con and communicate her decision. She recognises she is not well, is a danger to herself and that she may benefit from admission and medication. She agreed to stay and comply with treatment; therefore, I feel an informal admission would be most appropriate for Holly.

Appendix 1 **Checklist for receiving section papers**

Name of patient:	DOB:	Ward:
Is the admission a FORMAL TRANSFER from another Trust? (section 19)		If yes, see checklist for receiving formal transfers

THE FOLLOWING ERRORS CANNOT BE RECTIFIED SECTION CANNOT BE ACCEPTED	TICK IF APPLICABLE	ACTION TAKEN
Wrong forms completed		
Forms not signed		
Application is made out to the wrong hospital		A new application is required, the same medical recommendations may be used
Application is written before the date on the medical recommendations		A new application is required, the same medical recommendations may be used
The applicant (AMHP) saw the patient PRIOR TO 14 days before making the application		A new application is required, the same medical recommendations may be used
THE FOLLOWING ERRORS CAN BE RECTIFIED WITHIN 14 DAYS. IMMEDIATE ACTION REQUIRED	**TICK IF APPLICABLE**	**ACTION TAKEN**
Dates completed incorrectly, or omitted.		
Differences in the patient's name and address		
There should be no more than FIVE CLEAR DAYS between the two dates of examinations on the medical recommendations for Section 2 & 3.		
At least 1 recommendation must be from a Section 12(2) approved doctor. (Please note for a Section 4, the recommendation does not have to be completed by a Section 12(2) doctor)		
If a continuation sheet is indicated on a medical recommendation check that this is present		
Check that the medical recommendations have the correct hospital named where appropriate medical treatment is available – Section 3 only		
Check that the two doctors completing the recommendations are not both from the same hospital		
In all cases is there an AMHP report with the section papers?	YES / NO	

NB – If there is any discrepancy noted, please inform MHA Team as soon as possible regarding rectification.

PAPERS CHECKED BY

Name:	Ward:	Date:

MHA ADMINISTRATOR CHECK

Name:	Date:

WHEN COMPLETING FORM H3 (only for Section 2, 3 and 4), WRITE IN THE NAME OF THE TRUST & HOSPITAL; SIGN, AND RECORD DATE AND TIME OF ACCEPTANCE. Attach the checklist to Form H3.

Errors which will invalidate a section

- Forms not signed by someone who is empowered under the Act to do so or the forms are not signed at all
- The wrong forms have been completed
- The Application is written out to the wrong hospital (A fresh application must be made)
- The Application is written before the date of the medical recommendations
- The date of the Application is MORE THAN 14 days from the date that the Applicant first examined the patient

If such errors are found, and the patient is already in hospital, consideration should be given to the implementation of 5(4) or 5(2) until a fresh application is made.

Errors which can be rectified within 14 days

- Blank spaces on the form, **other than a signature**, eg: dates
- Failure to delete one or more alternatives in places where only one can be correct
- The patient's forename, surname or address can be amended if they do not agree in all places
- Where each individual medical recommendation is valid but taken together they do not comply with the Act – e.g.
    - two doctors from the same hospital
    - none of the doctors is Section 12 (2) approved
    - there are more than five clear days between the recommendations

  Then one of the recommendations can be replaced by another within 14 days. This will be valid if, together, the 2 recommendations comply with the Act other than the timescales.

RELEVANT FORMS FOR DETENTION

Section 2

Medical Recommendations:	Form A4 (2 of these forms) or Form A3 (1 form)
Application:	Form A1 or Form A2

Section 3

Medical Recommendations:	Form A8 (2 of these forms) or Form A7 (1 Form)
Application	Form A5 or A6

Section 4

Medical Recommendations:	Form A11 (1 Form)
Application:	Form A9 or A10

Please note that Applications to detain patients are only made by Approved Mental Health Professionals or patients' Nearest Relatives

Appendix 2 **Checklist for receiving formal transfers under Section 19**

Name of patient		**DOB**	
Ward			

Areas to check for Section 2 & 3	Actions to be taken	Comment *Tick box if correct*
Check that the relevant section papers are present and correct	If not present, transfer cannot be accepted. Originating hospital to be contacted for copies	
Check that all section renewal forms are present (if applicable) Form H5	If not present, transfer cannot be accepted. Originating hospital to be contacted for copies	
Check that consent to treatment forms are present (if applicable)	If not present, transfer cannot be accepted. Originating hospital to be contacted for copies	
Check Form H4 (transfer authority) is present and Part 1 completed correctly by the original hospital	If not present, ensure this is completed before staff from originating hospital leave the ward	
If all the above are present and correct, complete Part 2 of Form H4 to accept transfer	If not present, ensure this is completed before staff from originating hospital leave the ward	
	A copy of Form H4, together with the section papers is to be faxed to MHA Team immediately	
	Original section papers to be sent direct to MHA Team	

NB – If possible, request that a copy of the section papers are faxed prior to transfer to ensure paperwork is correct. Although it is good practice to receive the original section papers on transfer, this is not always possible. In these cases, copies may be accepted and the MHA Team will arrange for the original papers to be forwarded as soon as possible by the originating hospital.

Areas to check for part 3 patients (forensic sections)		**Tick Box**
Ensure all relevant paperwork is present:		
Sec 37	Hospital order from court. Form H4 authority for transfer only to be completed if patient transferred from another Trust.	
Sec 37/41	Hospital order (with restriction) including transfer authority from Ministry of Justice and Form H4 from originating hospital, if applicable	
Sec 38	Interim Hospital order from court	
Sec 47	Transfer authority for sentenced prisoner from court	
Sec 47/49	Transfer authority for sentenced prisoner (with restriction)	
Sec 48	Transfer authority for un-sentenced prisoner from court	
Sec 48/49	Transfer authority for un-sentenced prison (with restrictions) from Ministry of Justice	

Papers checked by	Print Name		**Date**	
Ward				
MHA Administrator check:	**Name**		**Date**	

Errors which will invalidate a section

- Forms not signed by someone who is empowered under the Act to do so or the forms are not signed at all;
- The Application is written out to the wrong hospital (a fresh application must be made);
- The Application is written before the date of the medical recommendations (except Section 4);
- The date of the Application is MORE THAN 14 days from the date that the Applicant first examined the patient;

If such errors are found, and the patient is already in hospital, consideration should be given to the implementation of 5(4) or 5(2) until a fresh application is made.

Errors which can be rectified within 14 days

- The leaving blank of any spaces on the form **other than a signature**;
- Failure to delete one or more alternatives in places where only one can be correct;
- The patient's forename, surname or address can be amended if they do not agree in all places;
- Where each individual medical recommendation is valid but taken together they do not comply with the Act – e.g.
    - 2 doctors from the same hospital
    - None of the doctors is Section 12 (2) approved
    - There are more than five clear days between the recommendations.

  Then one of the recommendations can be replaced by another within 14 days. This will be valid if, together, the 2 recommendations comply with the Act other than the timescales.

Relevant forms for detention

Section 2	
Medical Recommendations:	Form A4 (2 of these forms) **or** Form A3 (1 form)
Application:	Form A1 or Form A2

Section 3	
Medical Recommendations:	Form A8 (2 of these forms) or Form A7 (1 Form)
Application:	Form A5 or A6

Section 4	
Medical Recommendations:	Form A11 (1 Form)
Application:	Form A9 or A10

Please note that Applications to detain patients are only made by approved Mental Health Professionals or patients' Nearest Relatives

Appendix 3 **Section 17 Leave of Absence Form**

Patient Name:	NHS No:	DOB:
Legal Status:	Date section commenced:	

I [full name]_____am the responsible Clinician (RC) / covering RC* in charge of the treatment of the above named patient *delete as applicable

☐ I confirm that I have consulted with the appropriate staff, relatives, carers and community services regarding authorisation of this period of leave.

☐ I confirm that an up-to-date risk assessment has been completed and is documented in the clinical record.

☐ If applicable, I confirm that Ministry of Justice authorisation has been received (s.48 or s.49).

Start date of Leave:		**Review date:**	
Date/ Time of Leave	Where is leave to? (Inc. address if overnight)	Escorted/ unescorted/ accompanied/emergency) Please state ratio/name & gender of escorts if	Conditions/ Restrictions
From / To			

Ward contact number during period of	
A copy of this leave plan (if applicable) has been given to:	☐ Patient ☒ Family/ carer ☐ Care co-ordinator ☐ Other state:_____

I_____[patient] agree with this leave plan and have been offered / given a copy.*

Signed:_____Date:_____

☐ Refused to sign Lacks capacity to understand and sign *Delete as applicable

Initial route of authorisation if RC not available to sign: Telephone Email ☒

Signed:_____Responsible Clinician/covering RC

Printed:_____Date:_____

Section 17 leave may only be authorised by the patient's Responsible Clinician (RC), or covering RC.

Section 17 leave only applies to leave outside the hospital boundary eg: outside the Health Park site if it is a multi- trust site, or the footprint of individual sites such as Mulberry ward. For further guidance, please refer to the MHL Policy Suite.

Risk Assessment

The RC must complete an up-to-date risk assessment prior to granting s.17 leave and any necessary safeguards put in place. A record of this risk assessment must be documented in the patient's electronic record. This may be as a clinical note, in CARSO or CPA meeting notes and must correspond with the leave granted.
(MHA Code of Practice ch 27.10)

Discretionary/ground leave must not be documented on this form.

"No formal procedure is required to allow patients to move within a hospital or its grounds. Such 'ground leave' within a hospital may be encouraged or, where necessary, restricted, as part of each patient's care plan."
(MHA code of Practice ch 27.5)
"*What constitutes a particular hospital for the purpose of leave is a matter of fact which can be determined only in the light of the particular case. Where one building, or set of buildings, includes accommodation under the management of different bodies (eg; two different NHS trusts), the accommodation used by each body should be treated as forming separate hospitals. Facilities and grounds shared by both can be regarded as part of both hospitals.*"
(MHA Code of Practice ch 27.7)

Local processes should be in place to record and monitor the use of this type of leave.

Emergency Treatment

If a detained patient requires emergency treatment for a physical disorder or injury, legal authority is present if either

a) The RC has granted leave in anticipation of the event occurring, or
b) The RC has granted leave over the telephone at the time of the emergency.

However, if there is no time to seek formal authority from the RC (either verbally or in writing), the patient may be moved to a general hospital under the remit of the Mental Capacity Act 2005, if they lack capacity to consent to the move/treatment, or with the capable patient's consent. In such cases, the RC must grant leave at the earliest opportunity, as technically the patient is absent without leave until appropriate authority has been granted.

Escorted Leave

The RC may direct that the patients remain in custody while on leave of absence, either in their own interests or for the protection of other people. Patients may be kept in the custody of any officer on the staff of the hospital or any person authorised in writing by the hospital managers. Such an arrangement is often useful, eg to enable patients to participate in escorted trips or to have compassionate home leave.
(MHA Code of Practice ch 27.27)

Accompanied Leave

While it may often be appropriate to authorise leave subject to the condition that a patient is accompanied by a friend or relative (eg on a pre-arranged day out from the hospital), RCs should specify that the patient is to be in the legal custody of a friend or relative only if it is appropriate for that person to be legally responsible for the patient, and if that person understands and accepts the consequent responsibility.

(MHA Code of Practice ch 27.29)