Leicestershire Partnership NHS
NHS Trust

# Mental Health Act
# Procedural Document

**Statement/Key Objectives:**
This document provides for the procedures required under the requirements of the Mental Health Act 1983 within Leicestershire Partnership NHS Trust.

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|---|---|---|
| Key Words: | Mental Health Act, Code of Practice | |
| Version: | Version 3 | |
| Approved by: | MHA Governance Delivery Group (MHAGDG) | |
| Ratified by: | Quality and Safety Committee | |
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| Type of Procedural document (tick appropriate box) | Clinical √ | Non-Clinical |

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## 1.0 Quick Look Summary

This policy will remain subject to version control, assurance and monitoring details as stated within its content.

The purpose of this policy and related procedural documents is to provide all permanent employees of LPT, together with those on bank, agency or honorary contracts with clear guidance in their application of '*the Act'* (Mental Health Act 1983) in order that the Board may be assured of their responsibilities in terms of compliance with the legislative requirements of the Act.

Employees as described above are expected to work within the guidance provided here and within the associated documentation.

## 1.1 Version Control

| Version number | Date | Comments (description change and amendments) |
|---|---|---|
| 1 | May 2016 | |
| 2 | April 2018 | Revision following policy expiry date |
| 2.1 | October 2019 | No changes |
| 3 | January 2023 | Review following expiry date and changes to Trust Delegation Document |

1.2 Key individuals involved in developing and consulting on the document:

- Dr Saquib Muhammad – Interim Medical Director/Chair MHAGDG
- Alison Wheelton – Senior Mental Health Act Administrator
- Members of the MHAGDG with responsibility for service distribution

1.3 Governance

Level 2 or 3 approving delivery Group - Mental Health Act GDG
Level 1 Committee to Ratify Procedure - Quality and Safety Committee

1.4 Equality Statement

Leicestershire Partnership NHS Trust (LPT) aims to design and implement policy documents that meet the diverse needs of our service, population, and workforce, ensuring that none are placed at a disadvantage over others.

It takes into account the provisions of the Equality Act 2010 and promotes equal opportunities for all. If you require this document in another format please contact the Corporate Governance Team.

This document has been assessed to ensure that no one receives less favourable treatment on the protected characteristics of their age, disability, sex (gender), gender reassignment, sexual orientation, marriage and civil partnership, race, religion or belief, pregnancy and maternity.

1.5 Due Regard

LPT will ensure the Due Regard for equality is taken and as such will undertake an analysis of equality (assessment of impact) on existing and new polices/procedures in line with the Equality Act 2010. This process will help to ensure that:

- Strategies, policies and procedures and services are free from discrimination
- LPT complies with current equality legislation
- Due regard is given to equality in decision making and subsequent processes
- Opportunities for promoting equality are identified

Please refer to due regard assessment in the appendices to this document.

1.6 Definitions that apply to this procedure

| | |
|---|---|
| **The Act** | The Mental Health Act 1983 (as amended, including by the Mental Health Act 2007, the Health and Social Care Act 2012 and the Care Act 2014). |
| **Detained patient** | Unless otherwise stated, a patient who is detained in hospital under the Act, or who is liable to be detained in hospital but who is(for any reason) currently out of hospital. |
| **Detention (and detained)** | Unless otherwise stated, being held compulsorily in hospital under the Act for a period of assessment or medical treatment. Sometimes referred to colloquially as 'sectioning'. |
| **CQC** | The CQC (Care Quality Commission) look after the rights and concerns of all those who are held under the Act and aim to ensure the Act is being properly used. The CQC is also responsible for the provision of **SOADs** (see below under 'Second Opinion Appointed Doctors) when required. |
| **CTO** | Community Treatment Order - Power under sections 17A-17G that enables a patient to be discharged from detention in hospital but to remain subject to recall. |
| **IMHA** | Independent Mental Health Advocate **–** Specialist advocates who support detained patients and those on CTO, ensuring that the safeguards laid out in the legislation are followed, commissioned in Leicester, Leicestershire and Rutland by POWhER. |
| **NR** | Nearest Relative - Not to be confused with 'Next of Kin', a patient cannot choose their Nearest Relative. It is a term specific to the Act and the Nearest Relative has a legally defined role (see section 26 of MHA). The Nearest Relative has certain powers and is entitled to receive certain information regarding a patient who is subject to the Mental Health Act unless the patient objects. |
| **SOAD** | Second Opinion Appointed Doctor - The CQC retain responsibility for the provision of SOADs in response to requests from clinicians when ensuring that a patient who does not or cannot consent to certain treatment that it is only given if it is medically necessary. Also required to ratify the treatment provided to CTO patients irrespective of whether consent is forthcoming. In this role they are acting independently of the detaining hospital on behalf of the CQC. |
| **RC** | Responsible Clinician – Clinician in charge of the patient's care and treatment under the requirements of the Act |

## 2 Purpose and introduction

This Procedural Document sits within the series of Mental Health Act related documents, and sets out the procedures for compliance with the both good practice and statutory requirements of the Act.

The aim of the procedural documents is to provide clear guidance to staff when undertaking their duties on behalf of the Trust as detailed in the Trust's Delegation document for use by those who have responsibility for the care and treatment of person(s) subject to the relative provision of the Mental Health Act to which this document applies.

## 3. Policy requirements

This procedure will remain subject to version control, assurance and monitoring details as stated in the over-arching policy.

The Mental Health Act 1983 remains primary legislation, the Code of Practice (revised in 2015) provides for the good practice by which the Act is implemented.

The Guiding Principles, set out at the front of the Code, provide for its statutory status, the following therefore provides for both primary legislation and good practice, and the local procedures that are written in accordance with them.

## 4. Duties within the Organisation

The Trust Board has a legal responsibility for Trust policies and for ensuring that they are carried out effectively.

Trust Board Sub-committees have the responsibility for ratifying policies and protocols.
Directors and Heads of Service are responsible for:

- ensuring that comprehensive arrangements are in place regarding adherence to this policy and how this policy is applied within their own department.
- ensuring that team managers and other management staff are given clear instruction about the policy arrangements so that they in turn can instruct staff under their direction.

These arrangements will include:

- Distributing information about the policy in a timely manner throughout the Directorate/Department or Service to a distribution list which will be agreed in advance with local managers.
- Ensuring all staff has access to the up-to-date policy, either through the intranet, or if policy manuals are maintained that the resources are in place to ensure these are updated as required.
- Maintaining a system for recording that the policy has been distributed and received by staff within the department/service and for having these records available for inspection upon request for audit purposes.

Senior Managers, Matrons and Team leaders are responsible for:

- Providing this information to all new (applicable) staff on induction. It is the responsibility of local managers and team leaders to have in place a local induction that includes this policy.

- Ensure that their staff know how and where to access the current version of this policy; via intranet.

Consent

- Clinical staff must ensure that consent has been sought and obtained before any care, intervention or treatment is delivered. Consent can be given orally and/or in writing. Someone could also give non-verbal consent as long as they understand the treatment or care about to take place. Consent must be voluntary and informed and the person consenting must have the capacity to make the decision.

- In the event the patient's capacity to consent is in doubt, clinical staff must ensure that a mental capacity assessment is completed and recorded. Someone with an impairment or a disturbance in the functioning of the mind or brain is thought to lack the mental capacity to give informed consent if they cannot do one of the following:

    - Understand information about the decision
    - Remember that information
    - Use the information to make the decision
    - Communicate the decision

5. Monitoring compliance and effectiveness

The MHA Code of Practice 2015 at Chapter 37 states the following:

> *37.11 The 'Trust' should put in place appropriate governance arrangements to monitor and review the way that functions under the Act are exercised on its behalf. Many organisations establish a Mental Health Act steering or scrutiny group especially for that task, and whilst recognising that the Act is a legal framework for the delivery of care, also monitor and review via clinically focussed forums. Ideally, such forums should have representation from the Board or registered manager.*

The MHAGDG monitors the reporting of risk through established Trust procedures i.e. the Risk Register.

The CQC will test application of the Code of Practice Trust-wide as part of their Inspection Programmes and as part of their focused MHA Reviewer visits for detained patients, which are broader than the remit of this overarching policy document.

Monitoring compliance will be recorded through the monthly MHA Census which is reported through the Service Reports to the MHAGDG.

## 6. Mental Health Act 1983 – The Guiding Principles

The MHA provides a legal framework within which clinicians can intervene where necessary to protect people with mental disorder themselves and, sometimes, to protect other people as well. However, with the power to intervene compulsorily comes the responsibility to do so only where it is right and to the highest possible standards.

The Trust remains responsibility for the delivery of care and treatment for all patients in receipt of its services. Where those patients remain subject to the provisions of the Act, the Trust has a statutory responsibility to ensure those provisions are met.

The principles that guide the application of the Act are set out at the front of the accompanying Code of Practice. Compliance with the statutory requirements of the Act is also very much reliant on compliance with those principles and with the guidance contained in the Code itself.

As such the Trust writes all relevant policy and procedural documents in accordance with the Code (and Guiding Principles). These documents can be found as appendices to this Policy.

The Guiding Principles are as follows:

- **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

- **Empowerment and involvement**
  Patients should be given the opportunity to be involved in planning, developing and reviewing their own care and treatment to help ensure that it is delivered in a way that is as appropriate and effective for them as possible.

- **Respect and dignity**
  Patients and carers should be treated with respect and dignity. Practitioners performing functions under the Act should respect the rights and dignity of patients, and their carers while also ensuring their safety and that of others.

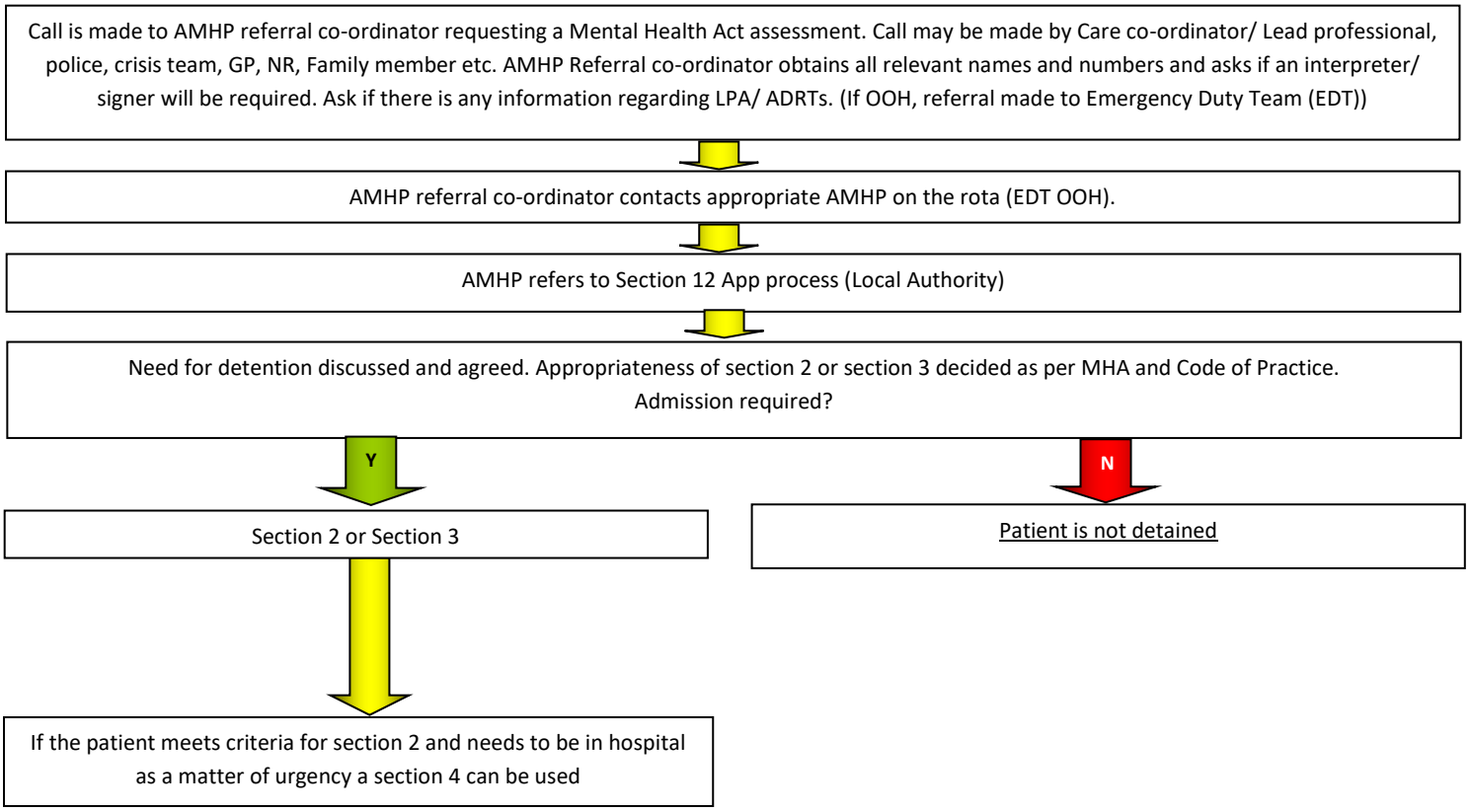
- **Purpose and effectiveness**
  Care, support and treatment under the Act should be given in accordance
  with up-to-date national guidance and/or current best practice from professional bodies where this is available.

- **Efficiency and equity**
  Commissioners and providers, including their staff, should give equal priority to mental health as they do to physical conditions.

## 7. The Procedures

The following suite of procedures form the basis of this document and provide for the guidance staff require different scenarios when applying the Mental Health Act 1983 and associated Code of Practice.

## 7.1 Overall Assessment



## 7.2 – Section 2 Application

Most senior Section 12 doctor conducting assessment arranges for a bed or can delegate but retains responsibility.

Doctors complete 1 x **Form A3** or 2 x **Form A4**

AMHP completes Form **A2** ensuring correct address of hospital including name of Trust. AMHP informs NR of application and their rights (including right to refer to IMHA). AMHP discusses the IMHA service with the patient. AMHP should check all forms for consistency and correctness.

Appropriate transport arranged by AMHP (Police to be contacted if high risk) in accordance with Multi-Agency Joint Conveyance Agreement

AMHP (and others dependant on risk assessment) goes with patient to hospital and personally delivers application for admission and accompanying medical recommendations to hospital ward staff. Delivery of papers can be delegated in exceptional circumstances. The reasons for this must be appropriately recorded. If the AMHP does not accompany should phone the hospital later to confirm admission.

## 7.3 – Section 2 Admission & Maintenance

Nurse completes Form H3 and MHA1 Scrutiny Form and Section 132 Rights Form on SystmOne, giving patient a copy of the relevant DoH information leaflet – scans and emails copies of the statutory papers and the above forms to the MHA Office immediately, sending the originals in the internal post using the 'pink' envelope system.

The admitting nurse, or named nurse, continues to inform patient of their rights in accordance with section 132 of the MHA recording each attempt (and where the patient hasn't understood) on SystmOne

The MHA Administrators scrutinise statutory papers in accordance with MHA2 Scrutiny form and write to the patient further informing them of their rights, following local procedures for medical scrutiny of forms.

Consent to Treatment - Patient can be detained for 28 days & is subject to Part IV consent rules. For the purposes of obtaining a **Form T2 or Form T3** it will be assumed that treatment commences on the first day of detention. RC should inform MHA Administrators of the date treatment starts if it is later than the first day of detention.

Section 17 leave may be granted.

At each MDT the necessity for the patient to remain under section should be reviewed and documented.

At day 14 MHA Administrators email RC and Ward Matron reminding date of expiry

By day 21 a decision should be made regarding the need for section 3. Section 3 required?

2nd reminder sent after 21 days if no response received.

**Y**

RC completes first medical recommendation.

RC (which could be delegated to NIC) arranges for AMHP & second medical recommendation.

**See process 7.4 below**

**N**

RC completes MHA7 End of Section Form sends to MHA Office ASAP.

RC informs patient that they are an informal patient and what this means and documents conversation in the healthcare record.

MHA Office writes to patient

## 7.4 – Section 3 Application

Appropriateness of section 3 agreed by all assessors

Most senior Section 12 doctor conducting assessment arranges for a bed or can delegate to Crisis teams but retains responsibility.

Doctors agree what is the appropriate treatment and where this can be given and complete 1 x **Form A7** or 2 x **Form A8**, documenting all the various alternatives on the paperwork.

AMHP consults with NR. If this is not appropriate or possible reasons must be documented. If the NR objects to the use of section 3 the section cannot be applied. If NR maintains objection AMHP should consider displacement under s 29 if grounds are met. AMHP consults own legal department.

AMHP completes **Form A6** ensuring correct address of hospital including name of Trust. AMHP informs NR of their rights (including right to refer to IMHA). AMHP should check all forms for consistency and correctness.

Appropriate transport arranged by AMHP (Police to be contacted if high risk) in accordance with agreed Multi Agency Conveyance document.

AMHP (and others dependant on risk assessment) goes with patient to hospital and personally delivers application for admission and accompanying medical recommendations to hospital ward staff. Delivery of papers can be delegated in exceptional circumstances. The reasons for this must be appropriately recorded. If the AMHP does not accompany should phone the hospital later to confirm admission.

## 7.5 – Section 3 Admission & Maintenance

Nurse completes **Form H3 and MHA1 Scrutiny Form and Section 132 Rights Form on SystmOne** giving patient a copy of the relevant DoH information leaflet – scans and emails copies of the statutory papers and the above forms to the MHA Office immediately, sending the originals in the internal post using the 'pink' envelope system.

The admitting nurse, or named nurse, continues to inform patient of their rights in accordance with section 132 of the MHA recording each attempt (where the patient hasn't understood) or reminder on SystmOne

The MHA Administrators scrutinise statutory papers in accordance with MHA2 Scrutiny form and write to the patient further informing them of their rights, following local processes to comply with medical scrutiny requirements

Consent to Treatment - Patient can be detained for 6 months initially & is subject to Part IV consent rules. For the purposes of obtaining a **Form T2** or **Form T3** it will be assumed that treatment commences on the first day of detention (under section 2 or 3). RC should inform the MHA admin team of the date treatment starts if it is later than the first day of detention.

Section 17 leave may be granted

At each MDT the necessity for the patient to remain under section should be reviewed.

By 4 months a decision needs to be made regarding the continuing need for section 3

If RC believes continued detention necessary, then RC completes part 1 of **Form H5** and sends to 2nd Professional by the 5 month date. If RC does not consider continued detention necessary completes Form End of Section Form and returns to MHA Office

After 4 months MHA Admin Team email the RC and ward to ascertain if the patient is to be discharged or for **Form H5** and **CQC s61** (if **Form T3** in situ), if section 3 to be renewed (or potentially **Form CTO1** if patient is to be discharged onto CTO).

If no response with 2 weeks MHA Office emails RC and Ward manager again

2nd Professional agrees with the RC that there is a continued need for detention under section 3?

**Y**

2nd professional completes Part 2 of **Form H5** and returns to RC at least 4 weeks before expiry of section.

RC completes Part 3 of **Form H5** and returns to MHA Office ASAP. **CQC s61** also completed if patient had a **Form T3** in situ.

Patient can be detained for a further 6 months at their initial renewal and then annually. MHA Office will co-ordinate Managers Panel Review and/or referral to Tribunal

**N**

**End of Section form** completed by RC and sent to MHA Office ASAP.

Where applicable patient informed by RC that they are an informal patient and what this means (including section 117 aftercare) and this is documented in the healthcare record.

MHA Admin team write to patient and advise of informal status

## 7.6 – Section 4 Application & Admission Process

If the patient meets criteria for section 2 and needs to be in hospital as a matter of urgency a section 4 can be used . Preference should always be given to using two doctors from the admitting hospital to complete a section 2, rather than using a section 4.

Doctor conducting assessment arranges for a bed.

Doctor completes **Form A11**.

AMHP completes **Form A10** ensuring correct address of hospital including name of Trust. AMHP informs NR of application and their rights

If a risk is identified an assessor should not be left alone with the service user. If the police or ambulance are not at the premises to support the remaining assessor then the second assessor should arrange for a deputy. This could be the crisis team or a nurse from the admitting ward. Particular regard should be had to the risk posed to the patient and/or others and arrangements made as appropriate.

Appropriate transport arranged by AMHP (Police to be contacted if high risk). AMHP/Section 12 doctor signs an 'Authority to convey form' if another agency (e.g. police or EMAS) are conveying.

AMHP (and others dependant on risk assessment) goes with patient to hospital and personally delivers application for admission and medical recommendation to hospital ward staff. Delivery of papers can be delegated in exceptional circumstances. The reasons for this must be appropriately recorded. If the AMHP does not accompany should phone the hospital later to confirm admission.

Nurse completes **Form H3 and MHA1 Scrutiny Form and Section 132 Rights Form on SystmOne** giving patient a copy of the relevant DoH information leaflet – faxes copies of the statutory papers and the above forms to the MHA Office immediately, sending the originals in the internal post using the 'pink' envelope system.

The admitting nurse, or named nurse, continues to inform patient of their rights in accordance with section 132 of the MHA recording each attempt (where the patient hasn't understood) or reminder on SystmOne.

The patient can be detained for a maximum of 72 hours **or** until the RC assesses the patient and determines that they do not meet the criteria for further detention (whichever is sooner). The patient is not subject to Part IV consent rules and therefore any treatment provided must be in accordance with common law consent or the Mental Capacity Act.

RC sees patient as soon as possible and assesses need for further detention.

**Section 3**
RC arranges (or delegates to NIC) for s3 assessments to be undertaken (2 new medical recommendations & application required)

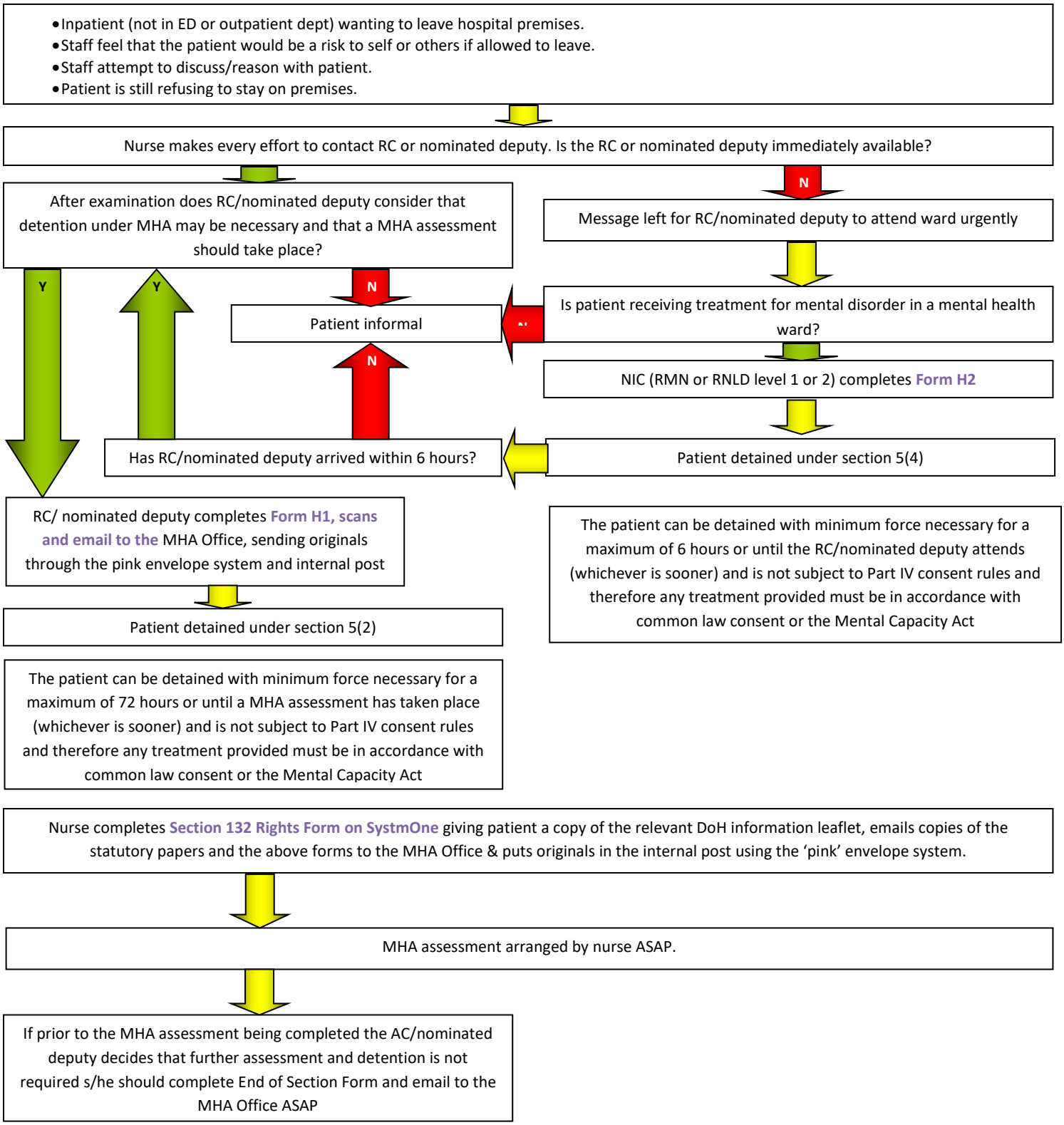
(refer to Section 3 process)

**Section 2**
RC completes **Form A4** and sends to MHA admin team ASAP.(refer to section 2 process)

**No detention required**
RC completes End of Section Form and sends to MHA Office ASAP.
RC informs patient that they are informal and what this means.

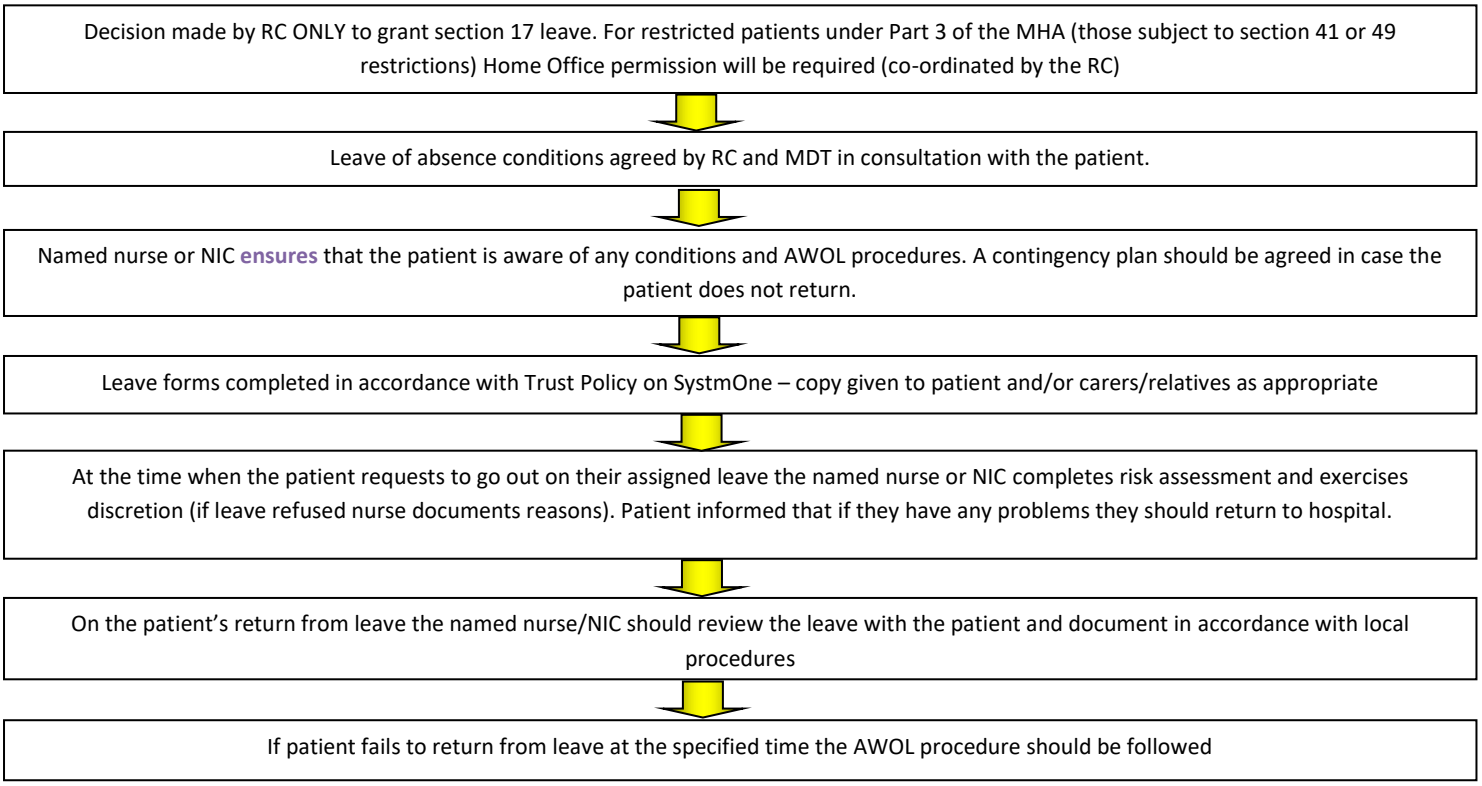
MHA Team inform patient by letter of outcome

## 7.7 – Section 5 Holding Power



## 7.8 – Section 17 Leave

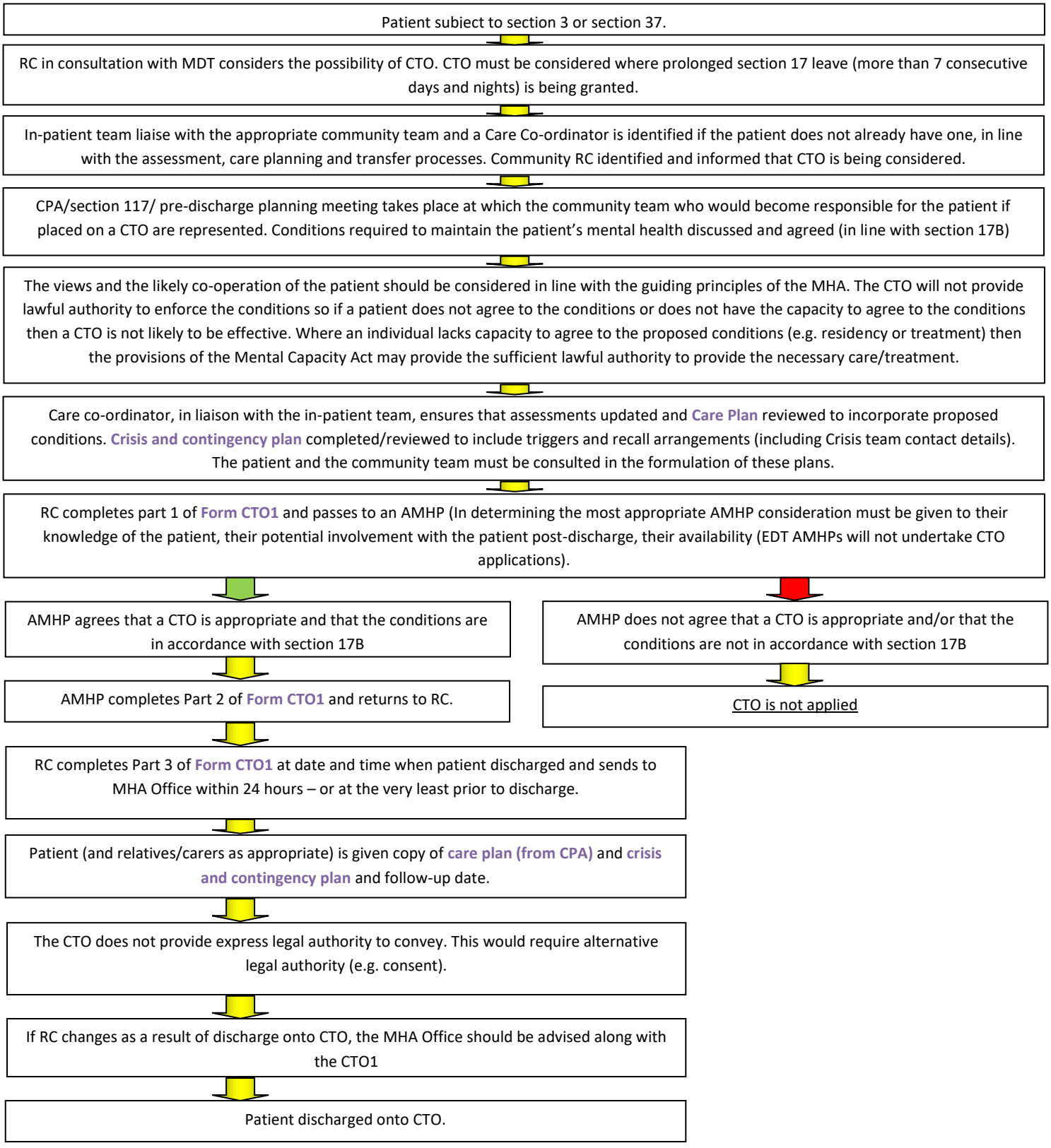
Planned Section 17 Leave




Emergency Section 17 Leave

In the case of emergency section 17 leave i.e. to an acute hospital for medical treatment, the Responsible Clinician may complete the Section 17 leave form on SystmOne retrospectively to accommodate the immediate transportation of the patient. All other principles above apply.

## 7.9 – Community Treatment Orders Assessment & Application Process



## 7.10 – Community Treatment Orders: Maintenance

The idea behind CTO is closer monitoring of those patients presenting a higher risk of deterioration and therefore regular contact should be maintained. CTO patients should be seen as soon as possible after discharge from hospital and at least within 48 hours.

All patients subject to CTO will be supported through CPA.

The conditions of a CTO are not legally enforceable and nothing can therefore be forced against the patient's will. Conditions can be amended by the RC completing **Form CTO2** to allow for changes in circumstances.

Patients should be regularly reminded of their rights (at least every 6 months) and provided with the appropriate Department of Health leaflet. This conversation should be recorded on SystmOne using the appropriate form.

Patient will initially be subject to CTO for 6 months and is subject to Part 4A consent rules

Patient should be regularly reviewed by the RC and Care co-ordinator and the necessity for the patient to remain subject to CTO should be reviewed and documented

By 4 months a decision needs to be made regarding the continuing need for CTO.

If RC believes continuation of CTO is necessary then RC completes part 1 of **Form CTO7** and sends to AMHP by the 5 month date (In determining the most appropriate AMHP consideration must be given to their knowledge of the patient, their potential involvement with the patient post-discharge, their availability (EDT AMHPs will not undertake CTO extensions). If RC does not consider continued CTO necessary, they must complete End of Section return to the MHA Office.

AMHP agrees with RC that there is a continued need for CTO?

**Y**

AMHP completes part 2 of **Form CTO7** and returns to RC at least 4 weeks before expiry

RC completes part 3 of **Form CTO7 and MHA4** and returns to MHA admin team ASAP

**N**

RC completes End of Section form and forward to the MHA Office

After 4 months MHA Admin team write to RC and care co-ordinator advising of requirement to review the patient is extension of the CTO is being considered, a **Form CTO7** for renewal including a Capacity Statement Form will be attached

If no response within 2 weeks MHA admin team write to RC and care co-ordinator again

Part 4A Consent Rules

Compulsory treatment cannot be given to a patient on a CTO under the same conditions as those subject to part 4.

## 7.11 – Community Treatment Orders: Recalling and Revoking

Where the patient is non-compliant with conditions/ mental health deteriorates or there is a change in circumstances either reported by the carers/relatives or directly by the care team to RC, where a patient is at risk of deterioration the patient should be monitored closely and pre-emptive arrangements made for re-admission to hospital, including recall. Recalls should normally be affected in normal working hours.

**In Hours**

Patient regularly seen and monitored by the Care co-ordinator and/or associated team. Concerns/risks reported to the RC.

**Out of Hours**

Crisis team may receive telephone calls in relation to crisis situations involving CTO patients OOH. It may also be discovered that a patient is on a CTO following the application of a s136. Where ward staff receive a call for the crisis team they should ascertain if the patient is on CTO and if so make immediate contact with the crisis team.

**Care Plan** and **Crisis and Contingency Plan** and CTO statutory forms should contain information about the most appropriate method of ensuring the patient receives the care they need should their mental health deteriorate and these plans should be updated following any change in circumstances.

Care Co-ordinator discusses situation with RC and they discuss next steps.

Where Crisis Team believe recall may be required they should contact the RC immediately to discuss next steps. The patient should be asked to attend the ward/unit.

Alternatives to recall may include informal admission if the patient is has the capacity to consent to this and is consenting, use of the MCA if the patient lacks capacity or application for a warrant under section 135.

Informal admission: The admission is documented in the same was as other informal admissions. The patient is free to leave at any point unless restrictions under the MCA can be applied (note s5(2) and 5(4) CANNOT be used). If the patient cannot be kept in hospital under the Mental Capacity Act then there is no lawful authority to stop them leaving the hospital unless they pose a real and immediate danger to others. The patient remains subject to Part 4A consent procedures. Where a patient is admitted informally consideration should be given to recall at the earliest opportunity.

Section 135 warrant (see 5.3.23).: Provides the possibility of forcing entry to a property and removing the individual to a place of safety while an assessment is carried out as to whether they require recall where they are refusing entry for assessment. The patient remains subject to Part 4A consent procedures (see 5.3.18). An AMHP would be required to make the application prior to recall being effective and the patient being 'AWOL'

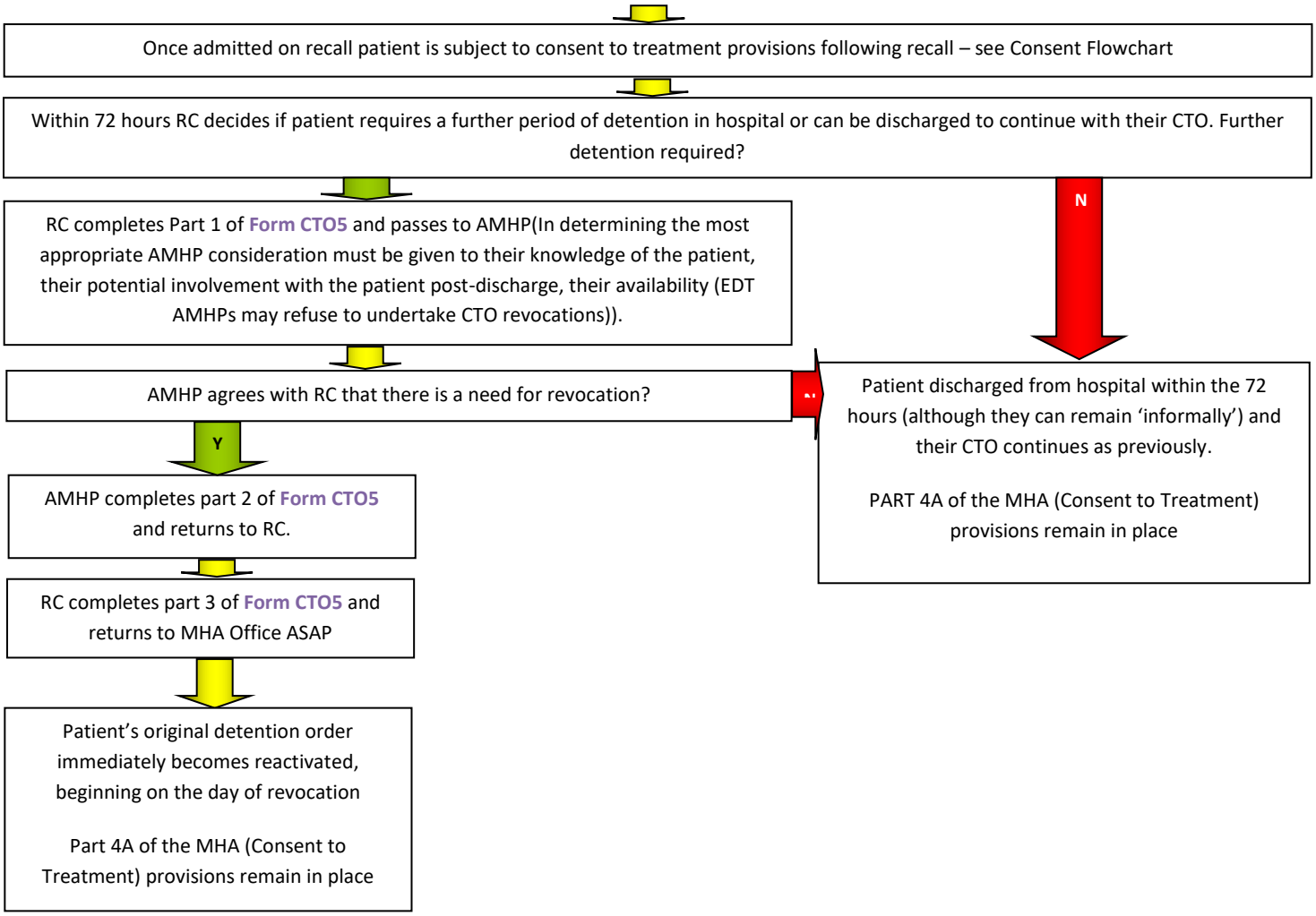
Following assessment RC decides if recall necessary and if criteria in section 17E met. The patient can be recalled to any hospital. RC should ascertain where there is a bed through hospital admission procedures. RC completes **Form CT03** (using carbonated pad if in patient's home and copier is not available). **Form CT03** copied x 2

**Form CTO3** (original) can be handed to the patient (and if accepted becomes active immediately), posted through their letterbox (active the next day – i.e. after midnight), or posted (active on 2nd working day after posting – this is not normally appropriate. OOH where the **Form CTO3** was completed at the ward/unit the Crisis Team will be expected to take the form to the patient's home (or other location).

If the patient does not return willingly to the hospital stated on **Form CT03** voluntarily after recall is active they are AWOL. A warrant can be applied for under section 135(2) by any employee of LPT if the patient is at home and refusing entry

Transport arranged by the Team. Police assistance requested where risk indicated. Reasonable force can be used to transport the patient.

Once in hospital NIC completes **Form CT03** and emails to MHA admin team ASAP (within 1 working day) along with copy of **Form CTO3.** Patient can be detained for 72 hours only and can be transferred during 72 hours. (**Form CT06** if transferred to a different Trust). Section 132 rights should be recorded on the form on SystmOne.


Once admitted on recall patient is subject to consent to treatment provisions following recall – see Consent Flowchart
Within 72 hours RC decides if patient requires a further period of detention in hospital or can be discharged to continue with their CTO. Further detention required?
N
RC completes Part 1 of Form CTO5 and passes to AMHP(In determining the most appropriate AMHP consideration must be given to their knowledge of the patient, their potential involvement with the patient post-discharge, their availability (EDT AMHPs may refuse to undertake CTO revocations)).
AMHP agrees with RC that there is a need for revocation?
N
Patient discharged from hospital within the 72 hours (although they can remain 'informally') and their CTO continues as previously.
PART 4A of the MHA (Consent to Treatment) provisions remain in place
Y
AMHP completes part 2 of Form CTO5 and returns to RC.
RC completes part 3 of Form CTO5 and returns to MHA Office ASAP
Patient's original detention order immediately becomes reactivated, beginning on the day of revocation
Part 4A of the MHA (Consent to Treatment) provisions remain in place

## 7.12 – Discharge: Mental Health Tribunal

Times when the patient and NR have the right to apply for a Tribunal:

- Within 14 days of s2 commencing (patient only)
- Once in each period of s3 detention or CTO (patient only)
- Once in each period of s37 or CTO (starting from the 2nd period) (patient and NR where applicable)
- Following displacement of NR (12 months) (NR)
- Following barring of discharge by NR (28 days) (NR)

Times when Hospital Managers automatically refer a patient to the Tribunal:

- After six months of detention if the patient has not applied (including time on section 2)
- Every 3 years if the patient has not applied (from the date of the last tribunal) (every year if <18)
- On revocation of CTO

Patient should be regularly informed of their rights and confirmation of this discussion confirmed on Rights Form on SytmOne. This discussion should include information regarding the patient's right to apply to the Mental Health Tribunal.

On receipt of application (of any route) the Tribunal will request:

1. Authority's statement *(MH Admin supply this)*
2. RC's report
3. Social circumstances report (from Care Co-ordinator if open to Community Team or Local Authority if not)
4. In-patient nursing report (as appropriate)

**The MHA Office will co-ordinate submission of documentation within statutory timescales**

MHA admin team will request reports from the relevant professionals providing a deadline for completion (3 weeks from the date of application generally or 1 day before the Tribunal for section 2 patients). All instances where reports are not available at least 1 working day prior to the Tribunal will be recorded as incidents on the electronic risk management system.

Relevant professionals should inform the MHA Office of any dates that they or the patient (or nominated representative) would be unable to attend so that they can liaise with the Tribunal Office to arrange a mutually convenient date and time.

Date offered by the Tribunal Office (within 7 days of application for section 2 patients).

All parties (including patient, representative, advocate and NR as well as health professionals) informed of date, time and venue.

MHA admin team liaise with the named nurse/ ward manager to establish if the patient has the capacity to appoint or instruct their own solicitor/representative. The patient should be provided with a list of solicitors specialising in mental health law (which should be available from each ward/unit – the Trust does not allow the display of posters advertising individual solicitors. Nor does it make recommendations.)

Where the patient lacks capacity to appoint/instruct a representative it is the responsibility of the Tribunal to appoint a representative for the patient.

CPA/section 117/Pre-discharge planning meeting held to consider plans should Tribunal discharge the patient. Assessments and Care Plans updated

Medical member of Tribunal will examine patient before the Tribunalif requested by representative

Tribunal panel sits at the hospital to review the case. The attendance of the RC, the Care co-ordinator and the named nurse (if in-patient) is expected.

After private discussion, the decision of the tribunal will be announced verbally at the end of the hearing to all present.
The written decision must be sent to all parties concerned within 7 days of the hearing.

If the patients asks to withdraw their application at any time the MHA office should be informed immediately so that they can formally withdraw the application.

## 7.14 – Discharge: Managers Panel Members' Review Meetings & Appeal Hearings

Times when the patient (or LPA) and NR have the right to apply for a Managers' Panel Members Hearing:

- At any time during detention in hospital under the MHA (patient and NR)
- At any time whilst subject to CTO (patient and NR)

Times when Hospital Managers automatically hold a renewal meeting:

- On renewal of detention under section 3 or 37 (receipt of **Form H5**)
- On extension of CTO (receipt of **Form CTO7**)
- Following the barring of discharge by NR (receipt of **Form M2**)

Patient should be regularly informed of their rights and confirmation of this discussion confirmed on SystmOne. This discussion should include information regarding the patient's right to apply to the Managers Panel Members.

Patient / NR requests an appeal hearing or H5 received

**Form CTO7** (including RC's report) received by MHA admin team together with capacity form

MHA Office request reports from the relevant professionals providing a deadline for completion:

If the patient does have capacity or does wish to attend the hearing

If patient has capacity the MHA admin team liaise with the co-ordinator to establish if the patient wishes to attend the hearing, if not then a paper hearing will be held

Attendance of RC, AMHP and named nurse (inpatients only) is expected.

Relevant professionals should inform the MHA Office of any dates that they or the patient (or nominated representative/advocate) would be unable to attend so that they can liaise with the Managers Panel Members to arrange e a mutually convenient date and time.

MHA Office arrange for a minimum of 3 Managers Panel Members to convene

All parties (including patient, representative, advocate and NR as well as RC and other health professionals) informed of date, time and venue. If reports have not been received a reminder will be sent with the date of the meeting.

CPA/section 117/Pre-discharge planning meeting held to consider plans should the HM panel discharge the patient. Assessments and Care Plans updated.

The Panel will communicate the decision verbally to the patient.

The MHA Office record the decision and send the written decision to all parties concerned within 7 days of the hearing.

Chair of Managers' Panel completes relevant decision form. Panel also complete Highlighting concerns form if any concerns or issues raised.

## 7.15 – Discharge by Nearest Relative

Nearest Relative (NR) writes letter expressing their wish to discharge the patient and sends to ward or MHA Office.

From the moment of receipt (by any staff member) there are only 72 hours for the following process to be enacted or the NR is able to discharge the patient.

**If received by Ward staff:**

- Ward staff date and time receipt of letter & sign with their designation.
- Notify MHA Office **immediately** by phone.
- Leave message on voicemail if out of hours.
- Notify RC **immediately**

**If received by MHA admin team**

- MHA Office to date & time receipt of letter and sign with their designation
- MHA Office will notify RC & ward immediately and issue RC with **Form M2** to complete **if** s/he wishes to block the discharge.

MHA Office send letter to NR acknowledging receipt of letter.

RC has 72 hours from receipt of the letter to consider whether it is possible to block the discharge. Does RC wish to block discharge?

**Y**

RC completes part 1 of **Form M2** declaring that "if discharged [the patient], would be likely to act in a manner dangerous to other persons or to himself/herself" and sends to MHA Office ASAP

MHA Office complete part 2 of **Form M2** and write to the NR informing them of the outcome.

MHA admin arrange a Hospital Managers' hearing

If the Hospital Managers uphold the barring the NR is prevented from applying for discharge again for 6 months.

**N**

RC notifies MHA Office ASAP by email and End of Section form MHA7

RC informs the patient that they are informal and what this means.

MHA Office write to the NR informing them of the outcome and to patient.

## 7.16 – Part 4 Consent to Treatment

The following procedure is applicable to patients detained under sections 2, 3, 36, 37, 38 and 45A

Is the treatment for Mental Disorder?

Y

N

The MHA does not provide sufficient lawful authority to provide the treatment. Alternative lawful authority is required (See Consent to Treatment Policy)

**What is the treatment proposed?**

**Medication (s58)**

**Psycho-surgery (s57)**
Patient must have capacity and must consent. SOAD must be requested. SOAD completes **Form T1**

**ECT (s58A)**
18+ with capacity- **Form T4**
<18 with capacity- **Form T5** (SOAD)
Lacks capacity – **Form T6** (SOAD) (can't conflict with LPA or ADRT)

**Other Treatment**
Can be given without consent under section 63.

RC informs MHA Office when first treatment given under detention.

After 2 months following first administration under detention (including whilst on section 2) MHA Office write to RC requesting **Form T2** **or** **Form T3** is completed.

If within 2 weeks a **Form T2** or a **Form T3** has not been sent to the MHA admin team they will send a reminder to the RC

Does the patient have capacity to consent to the treatment? Document on designated form on RiO

Y

N

Does the patient consent to all the treatment or the plan of treatment proposed (discussion and outcome documented in Healthcare record)

N

RC completes SOAD Request and sends to CQC.

Y

RC and patient complete **Form T2** including BNF category, route and dosage.

SOAD attends the ward. They will discuss the proposed treatment with the RC, one nurse and one other professional (non nurse/non-medic) involved in the patient's care.

If SOAD believes treatment is appropriate (and where against patient's wishes is medically necessary) they will complete **Form T3**.

Copies of **Form T2** and/or **Form T3** to be sent to the MHA Office. A copy must also be attached to the prescription card.

It is the responsibility of anyone who prescribes, dispenses or administers medication to a detained patient after 3 months of being treated under detention to ensure that all medication is legally authorised by a **Form T2** or a **Form T3**.

The **Form T2** or a **Form T3** should be reviewed by the RC at regular intervals and at each renewal of section or change in section status. Where the patient's capacity changes or they change their mind regarding the provision of consent a new **Form T2** or **Form T3** should be completed as appropriate and the old one superseded (marking as such)

Treatment in an emergency must follow the provisions of section 62. If medication is to be provided in an emergency **Form T3a** must be completed. If ECT is to be provided in an emergency **Form C6** must be completed.

## 7.17 – Part 4A Consent to Treatment (CTO patients)

The following procedure is applicable to patients who are subject to CTO whilst they are in the community or are voluntarily in hospital as informal patients.

Is the treatment for Mental Disorder?

Y

The MHA does not provide sufficient lawful authority to provide the treatment. Alternative lawful authority is required (See Consent to Treatment in Clinical Care Policy).

What is the treatment proposed?

**Medication (s58)**

**ECT (s58A)**

SOAD must be requested and **Form CTO11** completed before treatment can be given

**Other Treatment**

Can be given only if the patient or LPA (or court-appointed deputy) consents or if patient lacks capacity if it is in their best interests and not against LPA/ADRT.

Does the patient have capacity to consent to the treatment? (Undertake capacity assessment if any doubt and outcome documented)

Does the patient consent to all the treatment or the plan of treatment proposed

For first month of CTO treatment can be given. After one month **Form CTO11**

Treatment cannot be given. Consider recalling the patient to hospital (if criteria met).

Consent can be given by LPA/Deputy.
**OR**
Treatment may be given in the best interests of the patient as long as:

- It does not conflict with an ADRT
- It does not conflict with an LPA/Deputy
- It is in the patient's best interest
- No reason to believe patient objects or force is not required

**Form CTO11** required after 1 month.

A request for a SOAD to complete **Form CTO11** will have been made by the RC on application of the CTO

SOAD visit arranged (irrespective of capacity) with Care co-ordinator.

If the patient does not attend the SOAD appointment the SOAD will require evidence from the care co-ordinator/MHA admin team that all efforts have been made and the patient has been informed of the consequences of not attending. If the SOAD is not satisfied that appropriate arrangements were made s/he will ask for new SOAD referral to be made.

The SOAD will discuss the proposed treatment with the RC, one nurse and one other professional (non nurse/non-medic) involved in the patient's care. If SOAD believes treatment is appropriate, they will complete **Form CTO11**. They will also include on the form treatment that may be provided should the patient be recalled to hospital.

The Care co-ordinator should arrange for a copy of **Form CTO11** to be given to the patient, a copy to be sent to the GP, a copy attached to any relevant prescription charts and a copy placed in the healthcare record. The original must then be sent to the MHA admin team.

It is the responsibility of anyone who prescribes, dispenses or administers medication to a CTO patient after 1 month of being treated whilst on CTO to ensure that all medication is legally authorised by a **Form CTO11**.

Treatment in an emergency must follow the provisions of section 64B (with capacity) or section 64G (lacking capacity). If medication is to be provided in an emergency **Form C6** must be completed. If ECT is to be provided in an emergency **Form C6** must be completed.

**Once recalled to Hospital/CTO revoked -** The patient becomes subject to Part 4 consent to treatment provisions as though they had never been discharged onto CTO (see 7.3.17). Therefore a certificate (**Form T2, T3, T4, T5, T6**) is required to authorise treatment with only 3 exceptions:

If it has been less than 1 month since patient discharged onto CTO (i.e., does not have **Form CTO11**)

If the treatment is explicitly written on **Form CTO11** as being authorised following recall.

If the treatment was being given on CTO and the RC believes discontinuing would cause the patient suffering.

The **Form T2, T3 etc** should be reviewed and arrangements made for a new certificate where necessary as the above exceptions will only apply whilst a new certificate is obtained.

Treatment in an emergency must follow the provisions of section 62. If medication is to be provided in an emergency C6 must be completed. If ECT is to be provided in an emergency **C6** must be completed.

## 7.18 – Death of a Detained/ CTO Patient

Patient is declared deceased whilst subject to the provisions of the MHA **(including CTO)**

Inform the MHA Office ASAP.

Death of patient procedures followed.

Responsible Clinician liaises with the Compliance Team for the completion and timely submission of the **CQC Notification of Death Form** (in-patient/CTO.

The MoJ requires immediate notification of the death of a restricted patient, this remains the responsibility of the RC in conjunction with the Compliance Team. For restricted patients NIC informs MOJ immediately.

## 7.19 – Section 19 Transfer

Patient subject to MHA requires transfer – RC to discuss with patient and care team and document reasons.

**INTERNAL TRANSFER**
The patient remains under the authority of LPT.

From one Trust ward/unit to another Trust ward/unit.

RC is responsible for patient until transfer is complete and agrees transfer of care with accepting RC.

Ward Manager/ NIC informs MHA Office immediately.

**EXTERNAL TRANSFER**
The patient transfers to the authority of another provider

From a Trust ward/unit to a hospital managed by a different Trust

RC remains responsible for patient until transfer is complete and agrees transfer of care with accepting RC.

RC informs Ward Matron (inpatients) or Care Co-ordinator (CTO patients- see notes below) who completes form H4 can be delegated in accordance with Delegation Document

MHA Office should be informed at the EARLIEST opportunity and will provide original detention papers to Ward Matron

Original section papers and **Form H4** must accompany the patient for transfer.

Receiving hospital sign and date **Form H4**

Staff member accompanying patient requests a photocopy of **Form H4**

Copy sent to MHA Office

This process will be reversed for transfers into LPT from another provider.

The responsibility for CTO patients can be transferred to another Trust/Independent Hospital by completion of **Form CTO10** whilst the patient remains in the community or by completion of **Form CTO6** during the 72 hours of recall.

Where patient is transferred to the Trust from another Trust/Local Authority the individual accepting the transfer must ensure that the original section papers are received (including **Form H3**) and checked as well as the relevant transfer documentation (see above) before accepting responsibility or signing transfer documentation. In exceptional circumstances photocopies may be accepted by the admitting nurse. For transfer into the Trust of section 2 or section 3 patients the admitting nurse should follow the procedure described in 7.3.3 or7.3.5 respectively. All paperwork should be sent to the MHA admin team ASAP (within 1 working day).

## 7.20 – Section 132 Duty to Provide Information

Maintaining accurate records of section 132 in accordance with the legislative and Code of Practice requirements is essential in ensuring compliance and best practice.

The Trust provides for the electronic recording of section 132. It is the responsibility of the nursing staff (with responsibility for patients subject to the Act) to ensure accurate and up to date records are maintained.

Electronic recording - There are several electronic forms each with a specific purpose that follow the patient's detention pathway. These forms should be completed at relevant points in that pathway.

- *The six forms are:*

  *S132 – at the point of detention*
  *S132 – Review (revisit)- at least monthly for inpatients*
  *S132 – Regrade of detention order*
  *S132 – Renewal or Extension (CTO)(this will provide for the revisit of rights for CTO patients)*
  *S132 – Discharge from detention*
  *S132 – Going onto a CTO*

It is the responsibility of qualified nursing staff to familiarise themselves with the process and the relevant forms.

## 8. References & Bibliography

Mental Health Act 1983 (legislation.gov.uk)

Code of practice: Mental Health Act 1983 - GOV.UK (www.gov.uk)

Mental Health Act 1983: reference guide - GOV.UK (www.gov.uk)

## Appendix 1 Training Requirements

Training Needs Analysis

| | |
|---|---|
| **Training topic:** | Mental Health Act 1983 |
| Type of training:<br>(see study leave policy) | ☐ Mandatory (must be on mandatory training register)<br>X Role specific<br>☐ Personal development |
| Directorate to which the training is applicable: | X Adult Mental Health<br>X Community Health Services<br>☐ Enabling Services<br>X Families Young People Children / Learning Disability/ Autism Services<br>☐ Hosted Services |
| Staff groups who require the training: | *Band 5 nurses and above* |
| Regularity of Update requirement: | Three-yearly |
| Who is responsible for delivery of this training? | Senior MHA Administrator<br>Deputy to the Senior MHA Administrator |
| Have resources been identified? | Yes |
| Has a training plan been agreed? | Yes |
| Where will completion of this training be recorded? | X ULearn<br>☐ Other (please specify) |
| How is this training going to be monitored? | Through reporting to the MHA GDG |

## Appendix 2 The NHS Constitution

- The NHS will provide a universal service for all based on clinical need, not ability to pay.
- The NHS will provide a comprehensive range of services.

| | |
|---|---|
| Shape its services around the needs and preferences of individual patients, their families and their carers | Y |
| Respond to different needs of different sectors of the population | Y |
| Work continuously to improve quality services and to minimise errors | Y |
| Support and value its staff | *Y* |
| Work together with others to ensure a seamless service for patients | Y |
| Help keep people healthy and work to reduce health inequalities | Y |
| Respect the confidentiality of individual patients and provide open access to information about services, treatment and performance | Y |

## Appendix 3 Due Regard Screening Template

| Section 1 | |
|---|---|
| Name of activity/proposal | Mental Health Act Procedural Document |
| Date Screening commenced | January 2024 |
| Directorate / Service carrying out the assessment | Enabling Directorate |
| Name and role of person undertaking this Due Regard (Equality Analysis) | Alison Wheelton<br>Senior MHA Administrator |
| Give an overview of the aims, objectives and purpose of the proposal: | |
| AIMS: This procedure aims to provide staff with delegated responsibility under the Mental Health Act and in accordance with the Trust Delegation Document, with the knowledge to undertake those responsibilities. | |
| OBJECTIVES: To ensure staff have the necessary knowledge and tools to ensure the authorisation, implementation and recording and monitoring of the Mental Health Act is done so in accordance with legislative and good practice requirements. | |

| Section 2 | |
|---|---|
| Protected Characteristic | If the proposal/s have a positive or negative impact please give brief details |
| Age | Positive impact as this procedure is supportive to staff who fall within the remit of the Equality Act 2010, ensuring consistency in approach for all staff irrespective of who they are. |
| Disability | As above |
| Gender reassignment | As above |
| Marriage & Civil Partnership | As above |
| Pregnancy & Maternity | As above |
| Race | As above |
| Religion and Belief | As above |
| Sex | As above |
| Sexual Orientation | As above |
| Other equality groups? | As above |

| Section 3 | |
|---|---|
| Does this activity propose major changes in terms of scale or significance for LPT? For example, is there a clear indication that, although the proposal is minor it is likely to have a major affect for people from an equality group/s? Please tick appropriate box below. | |
| | No |
| High risk: Complete a full EIA starting click here to proceed to Part B | Low risk: Go to Section 4. |

| Section 4 | | | |
|---|---|---|---|
| If this proposal is low risk please give evidence or justification for how you reached this decision: | | | |
| This procedure outlines staff responsibilities and is in accordance with legislative and statutory requirements | | | |
| Signed by reviewer/assessor | *Alison Wheelton* | Date | 16/01/24 |
| *Sign off that this proposal is low risk and does not require a full Equality Analysis* | | | |
| Head of Service Signed | Deeanne Rennie | Date | 16/01/24 |

## Appendix 4 Data Privacy Impact Assessment Screening

Data Privacy impact assessment (DPIAs) are a tool which can help organisations identify the most effective way to comply with their data protection obligations and meet Individual's expectations of privacy.
The following screening questions will help the Trust determine if there are any privacy issues associated with the implementation of the Policy. Answering 'yes' to any of these questions is an indication that a DPIA may be a useful exercise. An explanation for the answers will assist with the determination as to whether a full DPIA is required which will require senior management support, at this stage the Head of Data Privacy must be involved.

| | | |
|---|---|---|
| **Name of Document:** | **Mental Health Act 1983 Procedural Document** | |
| **Completed by:** | **Alison Wheelton** | |
| **Job title** | **Senior MHA Administrator** | **Date January 2024** |

| **Screening Questions** | **Yes / No** | **Explanatory Note** |
|---|---|---|
| **1.** Will the process described in the document involve the collection of new information about individuals? This is information in excess of what is required to carry out the process described within the document. | No | |
| **2.** Will the process described in the document compel individuals to provide information about them? This is information in excess of what is required to carry out the process described within the document. | No | |
| **3.** Will information about individuals be disclosed to organisations or people who have not previously had routine access to the information as part of the process described in this document? | No | |
| **4.** Are you using information about individuals for a purpose it is not currently used for, or in a way it is not currently used? | **No** | |
| **5.** Does the process outlined in this document involve the use of new technology which might be perceived as being privacy intrusive? For example, the use of biometrics. | No | |
| **6.** Will the process outlined in this document result in decisions being made or action taken against individuals in ways which can have a significant impact on them? | No | |
| **7.** As part of the process outlined in this document, is the information about individuals of a kind particularly likely to raise privacy concerns or expectations? For examples, health records, criminal records or other information that people would consider to be particularly private. | No | |
| **8.** Will the process require you to contact individuals in ways which they may find intrusive? | **No** | |

**If the answer to any of these questions is 'Yes' please contact the Data Privacy Team via Lpt-dataprivacy@leicspart.secure.nhs.uk**
**In this case, ratification of a procedural document will not take place until review by the Head of Data Privacy.**

| | |
|---|---|
| **Data Privacy approval name:** | **N/A** |
| **Date of approval** | |

Acknowledgement: This is based on the work of Princess Alexandra Hospital NHS Trust