Gateshead Health
NHS Foundation Trust

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This policy supersedes all previous issues

Version Control

Version	Release	Author/Reviewer	Ratified by/Authorised by	Date	Changes (Please identify page no.)
1.0	08/08/2012	Claire Downes	Mental Health Act Committee	27/07/2012	
2.0	25/08/2015	Simon Rowland	Mental Health Committee	24/07/2015	Page 7. Change in Guiding principles Page 25. Appendix 4 added to reflect changes in Code of Practice
3.0	18/10/2018	Simon Rowland	Mental Health Act Compliance Group	18/09/2018	Appendix 4 expanded to clarify use of MHA or MCA. Appendix 5: Addition of Reading Rights guidance. Appendix 6: Addition of MHA Forms. Joint Memorandum of Understanding removed as Trust preparing own Section 136 Policy.
3.1	12/02/2019	Simon Rowland	Nichola Kenny, Associate Director Medicine	09/01/2019	

CONTENTS

APPENDICES

Mental Health Act 1983 Policy

1. Introduction

The Mental Health Act 1983 (MHA) provides a framework for the compulsory admission to hospital and subsequent treatment of patients with a mental disorder.

All health professionals who are considering a course of action under the MHA must ensure they proceed in accordance with the guiding principles set out in the Code of Practice.

This Policy and Procedure Guidance outlines the management of the MHA across Gateshead Health NHS Foundation Trust and aims to highlight the key principles within the Code of Practice and provide guidance on those cases where it might be more appropriate to use the Mental Capacity Act 2005 (MCA) as alternative legislation.

2. Policy scope

There is no minimum age limit for detention in hospital under the Act therefore this policy applies to all frontline staff, locums, bank staff and voluntary workers involved in delivery of care of patients who are detained, or liable to be detained, under the MHA.

3. Aim of policy

The aim of this policy is to protect users and the public, provide staff with guidance to ensure compliance with the provisions of the MHA.

The policy includes procedural guidelines (as appendices) which must be adhered to. These are based on the MHA (as amended by the 2007 Act), the Code of Practice, the MHA Regulations, DOH circulars and established best practice. However, these are a simplified guideline only and do not constitute a guide to the law.

4. Duties – Roles and responsibilities

Trust Board

The Trust Board is responsible for implementing a robust system of corporate governance within the organisation. This includes having a systematic process for the development, management and authorisation of policies.

Chief Executive

The Chief Executive is ultimately responsible for ensuring effective corporate governance within the organisation and therefore supports the Trust-wide implementation of this policy.

Hospital Managers

Hospital Managers have a statutory role under the Mental Health Act 1983. The term is used to refer to the corporate body of the detaining authority, e.g. the NHS Trust, which has various statutory functions normally delegated to members of staff. They have the primary responsibility for seeing that the requirements of the Act are followed. In particular, they must ensure that patients are detained only as the Act allows, that their treatment and care accord fully with its provisions, and that they are fully informed of, and are supported in exercising, their statutory rights.

It is also used to refer to lay members of the Trust appointed solely to hear appeals and other review hearings under the Act. This is also a statutory function and the Associate Hospital Managers have a power to discharge embodied in Section 23 of the Act.

Mental Health Act Compliance Group
The Mental Health Act Compliance Group monitor the responsibilities of hospital managers under the MHA, ratify policy and review Trust compliance within the legal framework of the MHA.

Mental Health Act Administration Team
The MHA Admin Team are responsible for the scrutiny of legal paperwork on behalf of the Hospital Managers and ensure rectification of errors. The team will provide written information to patients and their nearest relative. The Team has delegated responsibility to co-ordinate Hospital Managers Hearings and Mental Health Review Tribunals. Capture and present Mental Health Act data, audit compliance with the legislation, inform CQC of the death of a detained patient, a detained patient who is Absent Without Leave (AWOL) and any other functions delegated to them by the Hospital Managers.

Trust Managers
The Trust Managers are responsible for ensuring staff are aware of and adhere to this policy and that their actions comply with the MHA.

Approved Clinicians (AC)
AC's are personally accountable for discharging their duties under the MHA and must abide by any applicable professional code of conduct.

Responsible Clinicians (RC)
RC's are personally accountable for discharging their duties under the MHA and must abide by any applicable professional code of conduct
Ensure all staff are aware who the nominated deputy is and how to contact them for times when they are unavailable. Responsible for the maintenance of the section including renewal, discharge and granting leave.

2nd Professionals
Staff taking on 2nd professional responsibility are responsible for providing a second opinion at renewal of section.

Admitting Nurse
The admitting Nurse is responsible to accepting the detained patient on behalf of the Hospital Managers. The admitting nurse is responsible for completing Forms H3, H3A and H3B, the initial checking of all detention paperwork and ensure paperwork is delivered to the MHA Admin Team promptly.

Named Nurse
The named nurse will continue to inform the patient of their rights and document on Form H3B. Where appropriate ensure referral to Independent Mental Health Advocate (IMHA).

All Clinical Staff
All clinical staff will adhere to this policy when assessing or providing care and treatment (directly or indirectly) to individuals suffering from a mental illness.

5. Definition of Terms of the Act

Terms used under the MHA are described in Appendix 1

6. The Mental Health Act and its usage

The Act comprises of 10 parts as described below;

Part	Sections	Heading	Deals with
1	1	Application of the Act	Definition of mental disorder
2	2 - 34	Compulsory admission to Hospital & Guardianship	Detention in Hospital Community Treatment Orders (CTO) Guardianship (including procedures for admission, renewal, transfer and discharge for each of the above) Nearest relative – definition and displacement
3	35 - 55	Patients Concerned in Criminal Proceedings or Under Sentence	Powers of the courts to remand defendants to hospital while awaiting trial or sentence Powers of the courts to detain convicted offenders in hospital or make them subject to guardianship Transfer of patients from prison to hospital (and their return) Special restrictions on certain patients ("restricted patients") Conditional discharge of restricted patients by the Secretary of State
4	56 - 64	Consent to Treatment	Treatment for mental disorder without consent of patients detained in (or recalled to) hospital Safeguards for detained (and other) patients in respect of particular forms of treatment (e.g. medication, electro-convulsive therapy)
4A	64A - 64K	Treatment of Community Patients Not Recalled to Hospital	Safeguards for Community Treatment Orders (CTO) patients in relation to treatment for mental disorder while not recalled to hospital
5	65 - 79	Mental Health Review Tribunals	The establishment of Mental Health Review Tribunals Right for patients (and nearest relatives) to apply to the Tribunal for discharge Powers and duties of other people to refer cases to Tribunals Powers of Tribunals

Part	Sections	Heading	Deals with
6	80 - 92	Removal and Return of Patients Within the United Kingdom	Transfer of patients between England and Wales and Scotland, Northern Ireland, the isle of Man and the Channel Islands. Removal of patients to places outside the UK, the Isle of Man and the Channel Islands Patients who go absent across borders
8	114 – 123	Miscellaneous Functions of Local Authorities and the Secretary of State	Approval of approved mental health professionals (AMHPs) Duty to provide after-care services Code of Practice Mental Health Act Commission
9	126 – 130	Offences	Specific offences under the Act, including ill-treatment or neglect of patients
10	130A - 149	Miscellaneous and Supplementary	Independent mental health advocacy Informal admission of patients to hospital Children and young people admitted to hospital Duties of hospital managers to give information to patients and nearest relatives Patients correspondence Warrants to enter premises Detention in places of safety by the police Legal custody, conveyance and absconding Interpretation

6.1 Guiding Principals

The MHA Code of Practice sets out five guiding principles which should be considered when making decisions about a course of action under the Act.

- **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.
- **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.

- **Respect and dignity**. Patients, their families and carers should be treated with respect and dignity and listened to by professionals.
- **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.
- **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.

6.2 Using the principles

All five sets of principles are of equal importance, and should inform any decision made under the Act. The weight given to each principle in reaching a particular decision will need to be balanced in different ways according to the circumstances and nature of each particular decision. The guidance in the Code is based on these principles and reference is made to them throughout the Code.

Professionals providing care under the Act should document, and justify, any decision to depart from the Code or a particular guiding principle. The Care Quality Commission will look for evidence of this during their inspections and commissioners can use it as part of their contract monitoring

6.3 Applications for Detention

Applications for detention require certain criteria to be met:

The person must be suffering from a mental disorder of a nature or degree which warrants their detention in hospital for assessment and/or treatment and detention and/or treatment is in the interests of the patient's own health, safety and protection of others.

In all cases, consideration must be given to:

- The patient's wishes and views of their own needs
- The patient's age and physical health
- Any past wishes or feelings expressed by the patient
- The patient's cultural background
- The patient's social and family circumstances
- The impact that any future deterioration or lack of improvement in the patient's condition would have on their children, other relatives or carers, especially those living with the patient, including an assessment of their ability and willingness to cope
- The effect of the patient and those close to the patient of a decision to admit or not to admit under the Act

6.4 Appropriate Medical Treatment

The Mental Health Act 2007 introduced new criteria for detention and community treatment orders known as the appropriate treatment test. For purposes of the Act, medical treatment includes:

- Nursing
- Psychological intervention

- Specialist mental health habilitation
- Rehabilitation
- Care

Medical treatment need only have the intended purpose of alleviating or preventing a worsening of a mental disorder or one or more of its symptoms or manifestations. Even if particular mental disorders are likely to persist or get worse, despite treatment, there may be a range of interventions which would represent appropriate medical treatment and it should never be assumed that any disorders are inherently or inevitably untreatable or that such treatment is therefore inappropriate or unnecessary.
Appropriate medical treatment does not have to involve medication or psychological therapy. There may be patients whose circumstances mean that treatment may be appropriate even though it consists of nursing care or day care under the clinical supervision of an approved clinician.

6.5 The use of the Act in General Hospitals

It may be necessary to use the MHA to admit a patient to a general hospital where, for example, they have been assessed as requiring detention under the Act but also need treatment for their physical health that cannot be provided by mental health services. Patients detained in general hospitals should be transferred to a mental health unit as soon as their physical health permits.

- From time to time, in-patients of general hospitals are thought to require detention under the MHA. If so, they are assessed as shown in Appendix 2. In an emergency, where a patient who needs to be detained is already in hospital, the doctor in charge of their treatment may or any approved clinician (defined at s145 (1) of the MHA) can initiate a 72-hour 'holding' power, which will prevent the patient leaving hospital and allow time for consideration to be given as to whether an application should be made under the MHA. This power is granted under Section 5(2) of the MHA.

- General hospitals that admit a patient under the MHA should retain a copy of the legal paperwork and follow the Procedure for Receipt and Scrutiny of MHA Documentation as shown in Appendix 3.

6.6 Alternatives to Use of the Mental Health Act

The Codes of Practice to both the Mental Health Act and the Mental Capacity Act (MCA) contain guidance on the circumstances when one of the Acts mat be used as an alternative to the other. At present, the use of the Mental Capacity Act as an alternative to the Mental Health Act is limited to those cases where:

- The patient is found to lack the capacity to consent to admission and treatment in hospital **and**
- Is not objecting or considered to be objecting to admission and treatment **and**
- The use of force or restraint is not required **and**
- Admission and Treatment would not amount to a Deprivation of Liberty

The MHA Code of Practice provides an options grid summarising the availability of the Mental Health Act and Mental Capacity Act Deprivation of Liberty Safeguards (appendix 4).

7 Training

Staff working within Mental Health Wards/Departments	Update training every three years provided in-house.

8 Diversity and Inclusion

The Trust is committed to ensuring that, as far as is reasonably practicable, the way we treat members of staff and patients reflects their individual needs and does not discriminate against individuals or groups on the grounds of any protected characteristic (Equality Act 2010). An equality analysis has been undertaken for this policy.

9 Monitoring compliance/effectiveness of the policy

Monitoring compliance with this policy will be the responsibility of the Mental Health Act Compliance Group

Standard / process / issue	Monitoring and audit			
	Method	**By**	**Committee**	**Frequency**
The principles of best practice as set out in the Mental Health Act 1983 will be embedded into the practice of employees within the organisation who provide care and treatment for those who are detained or liable to be detained under the Act.	Regular monitoring of all Section paperwork will be routinely carried out.	Mental Health Act Administration Team	Mental Health Act Compliance Group	Each time a section is applied.
	Audit will be carried out.	Mental Health Act Administration Team	Mental Health Act Compliance Group	Yearly

10 Consultation & Review

This policy has been reviewed against the Mental Health Act 1983, The Code of Practice 2015 and the Reference Guide to the Mental Health Act 1983 2015 and in discussion with the Mental Health Act Compliance Group.

11 Implementation of policy

This policy will be implemented in accordance with policy OP27 “Policy for the development, management and authorisation of policies” and policy training will be included in the programme of training as detailed in section 7.

12 References

The Mental Health Act 1983 (as amended by the 2007 Act)
Department of Health (2015) Mental Health Act 1983 Code of Practice
Department of Health (2015) Reference Guide to the Mental Health Act 1983
Mental Capacity Act 2005 & Deprivation of Liberty Safeguards

13 Associated Documents

Mental Capacity Act Policy RM74

Appendix 1

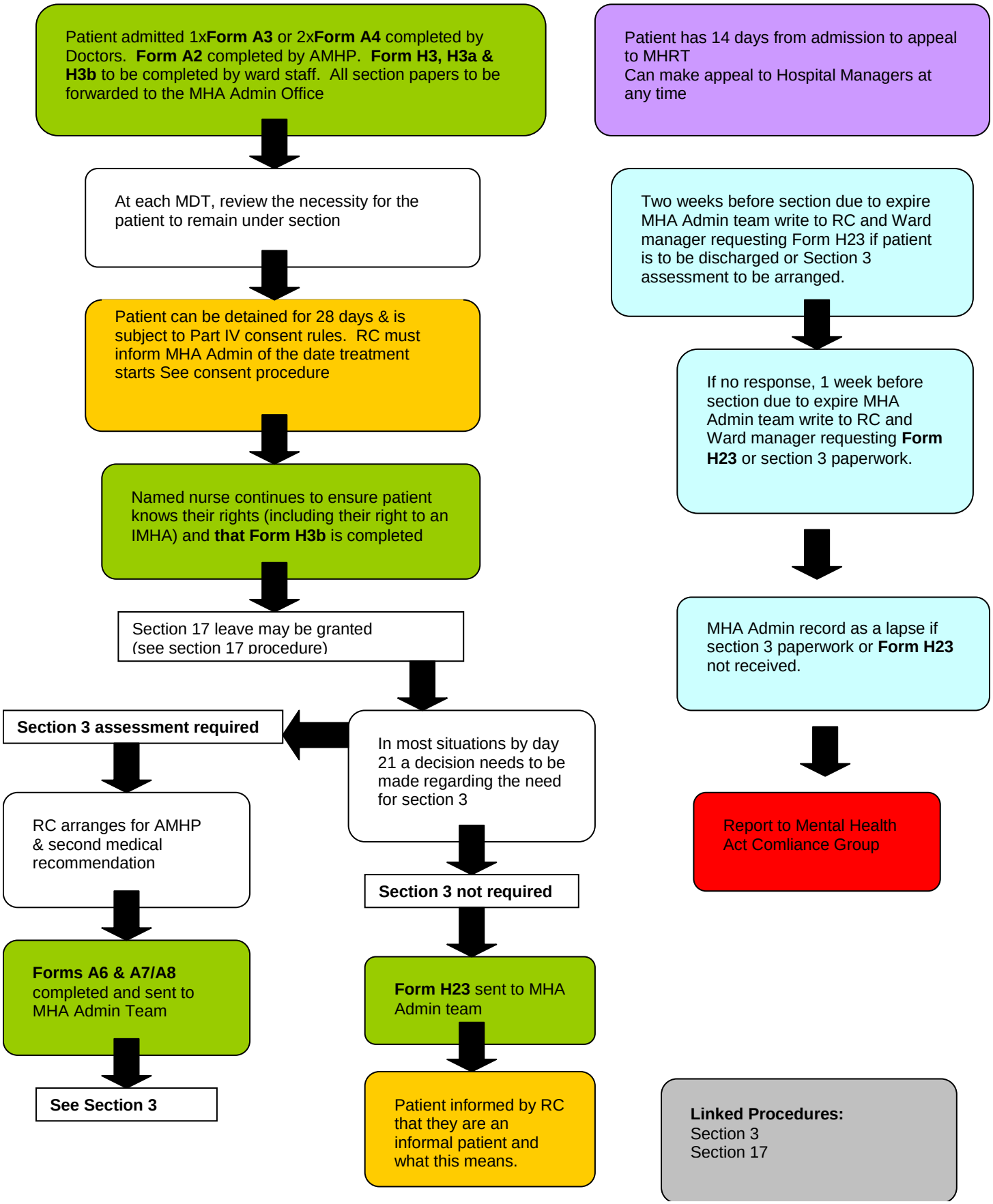
Definition of terms

Absent without leave (AWOL)	A patient being absent, without permission, from the place they ought to be under the Act
The Act	The Mental Health Act 1983, as amended over time
Application for admission	An application to the managers of a hospital for a patient to be detained there under Part 2 of the Act. As well as being a request for detention, the application becomes the legal authority on the basis of which the patient is detained.
Application for assessment	An application for admission under Section 2 of the Act for the patient to be detained in hospital for up to 28 days to be assessed. An emergency application under Section 4 is also a form of application for admission for assessment.
Application for admission for treatment	An application for admission under Section 3 of the Act for a patient to be detained in hospital for medical treatment.
Approved Clinician	A mental health practitioner approved for the purpose of the Act, or on behalf of, the Secretary of State in England. Certain decisions under the Act can be made only by approved clinicians. In particular, medical treatment cannot be given without a patient's consent unless an approved clinician is in charge of it. Only approved clinicians can be responsible clinicians.
Approved Mental Health Professional (AMHP)	A social worker or other professional approved by a local social services authority (LSSA) to perform a variety of functions under the Act. Those functions include making applications for admission to hospital and guardianship applications, and agreeing that patients should become CTO patients.
Code of Practice	Under Section 118 of the Act, the Secretary of State must publish a Code of Practice for the guidance of certain people who make decisions under the Act.
Detained patient	A patient who is detained (or liable to be detained) in hospital against their wishes.
Discharge	Under the Act this usually means discharge from being liable to be detained under the Act.
Escorted Leave	Leave to be absent from hospital on condition that the patient remains in the custody of a named person whilst away from the hospital.
Emergency application	An application for admission for assessment made under Section 4 of the Act where obtaining a second medical recommendation would cause undesirable delay where it is urgently necessary to admit the patient.
First-tier Tribunal	An independent judicial body with the power to discharge detained patients, CTO patients and guardianship patients.
Guardianship	The regime established by the Act under which patients mat become and remain subject to the guardianship of an individual or body that has certain powers, including the power to decide where the patient should live.
Holding Powers	Under Section 5(2) a doctor or AC in charge of a patient's treatment may detain them for up to 72 hours. Under

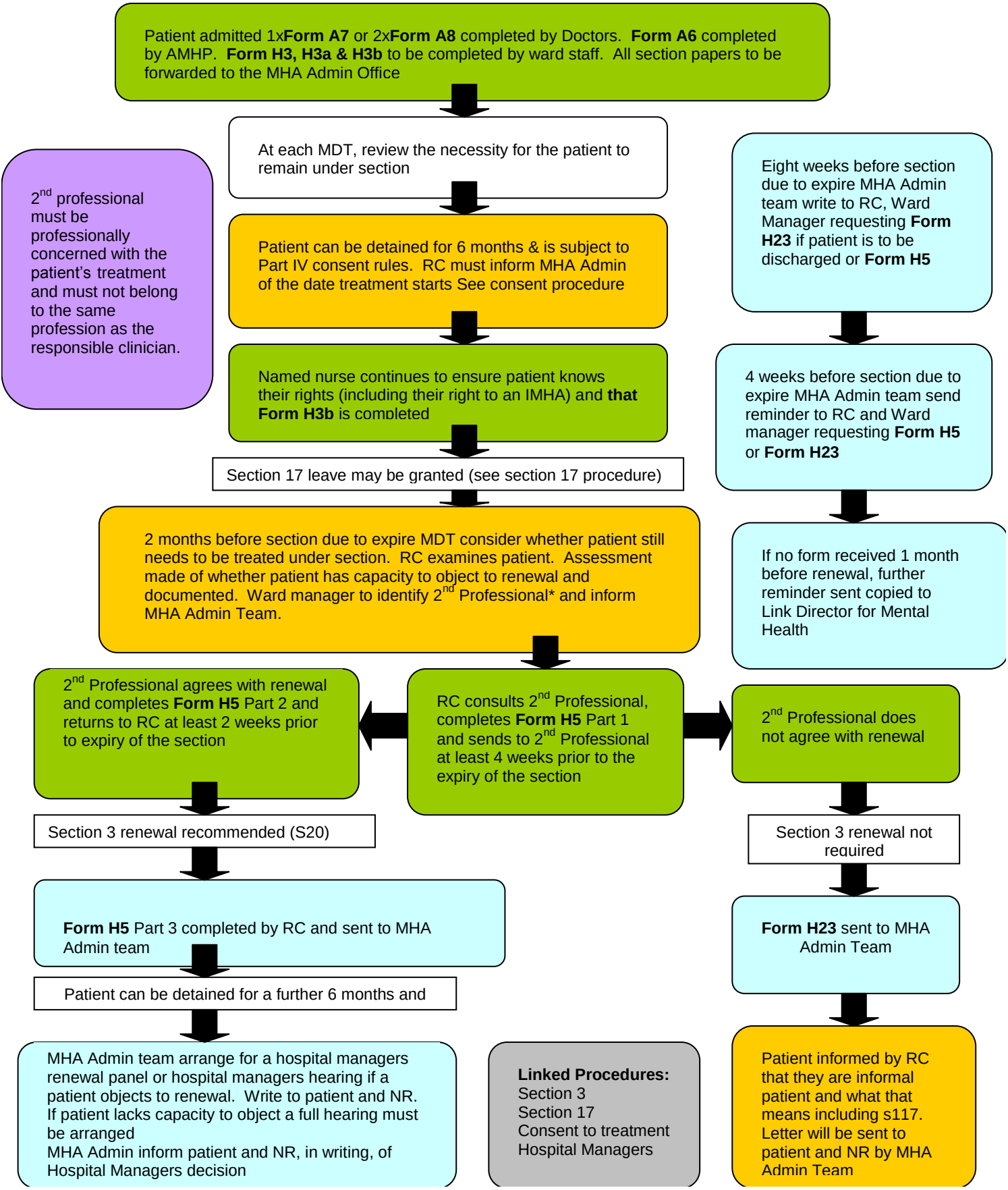
	Section 5(4) certain nurses may detain existing mental health patients for up to six hours pending the arrival of the doctor or AC who could then use Section 5(2).
Hospital Managers	The individual or body responsible for a particular hospital. It generally refers to the managers of the hospital in which a patient is (or is liable to be) detained.
Independent Mental Health Advocate (IMHA)	Means the advocacy services for detained patients and is provided under Sections 130A to 130D of the Act.
Leave of absence	Leave to be absent from hospital whilst under detention to a named place for designated periods.
Mental Capacity Act (MCA)	Provides a legal framework for decision-making in relation to people who lack capacity to make particular decisions for themselves. The MCA does not apply to anyone under the age of 16.
Mental Disorder	The Act defines mental disorder as any disorder or disability of the mind (apart from dependence on alcohol or drugs).
Nearest Relative (NR)	The NR is defined in Section 26 of the Act. If often does not mean the same thing as 'next of kin'. Under the Act nearest relatives have various rights.
Recall	An enforceable order requiring a patient who was previously detained to come back to hospital.
Renewal (of detention)	Authorises the continuation of the authority to detain a patient, or to keep someone subject to guardianship.
Responsible Clinician (RC)	The RC is the AC in overall charge of the patient's care.
CTO patient	A patient who has been discharged from detention by means of a community treatment order (CTO)
Section 12 approved doctor	A doctor approved by a strategic health authority on behalf of the Secretary of State for Health to carry out certain functions under the Act.
Section 57 treatment	Treatment for mental disorder which may not be given to ant patient except in accordance with section 57 (neurosurgery).
Section 58 treatment	Treatment for mental disorder which may not be given to a detained patient except in accordance with Section 58. This applies to medication given after an initial 3 month period.
SOAD Certificate	A certificate given by a second opinion appointed doctor approving the administration of specified treatments. A SOAD certificate will always be needed for section 57 treatments and for section 58 treatments where patients cannot or do not consent to treatment.
CTO	The scheme in the Act by which certain patients may be discharged from detention in hospital by their RC, subject to the possibility of recall to hospital for further medical treatment if necessary.

SECTION 2

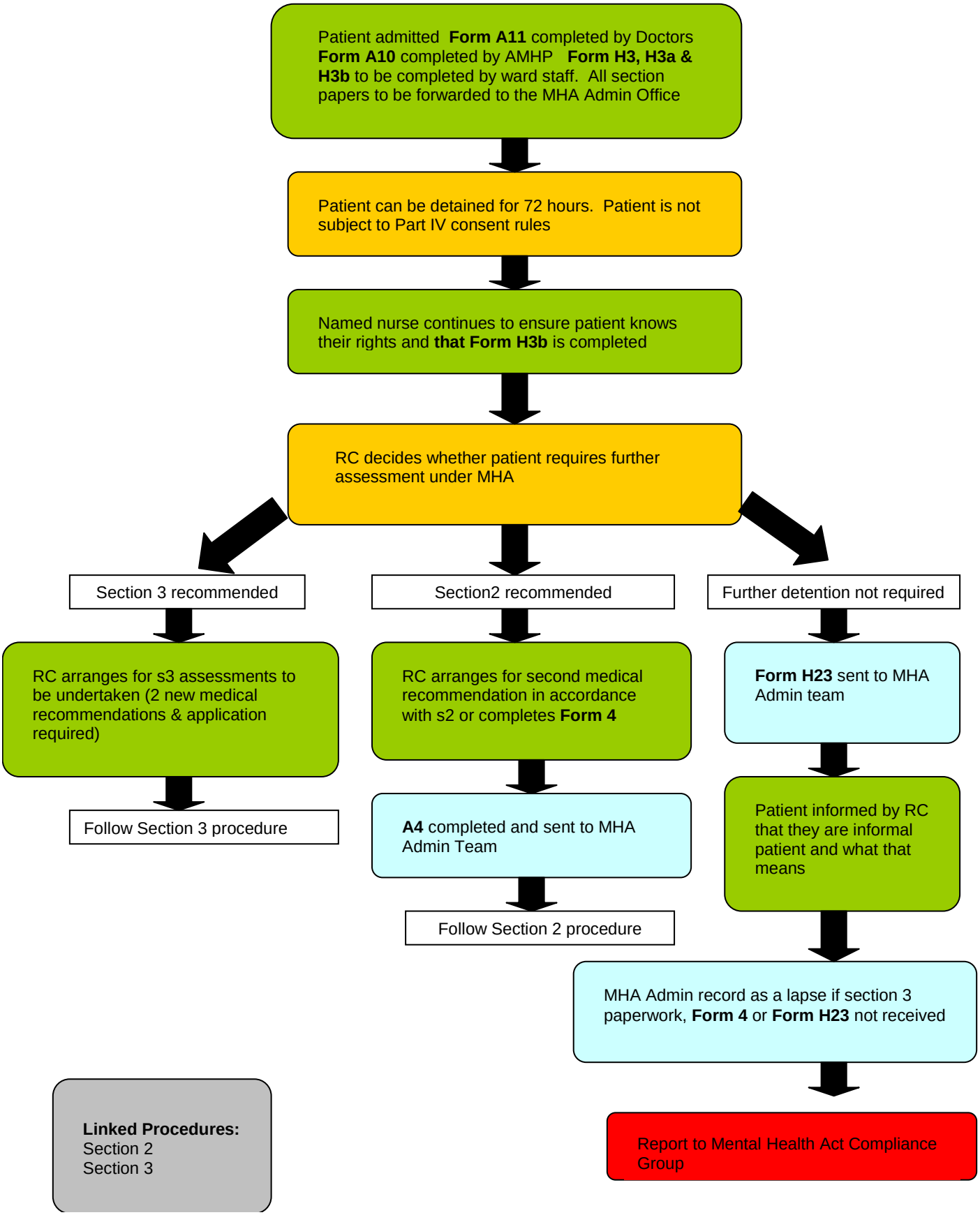
Appendix 2



SECTION 3


Patient admitted 1xForm A7 or 2xForm A8 completed by Doctors. Form A6 completed by AMHP. Form H3, H3a & H3b to be completed by ward staff. All section papers to be forwarded to the MHA Admin Office
At each MDT, review the necessity for the patient to remain under section
2nd professional must be professionally concerned with the patient's treatment and must not belong to the same profession as the responsible clinician.
Patient can be detained for 6 months & is subject to Part IV consent rules. RC must inform MHA Admin of the date treatment starts See consent procedure
Named nurse continues to ensure patient knows their rights (including their right to an IMHA) and that Form H3b is completed
Section 17 leave may be granted (see section 17 procedure)
2 months before section due to expire MDT consider whether patient still needs to be treated under section. RC examines patient. Assessment made of whether patient has capacity to object to renewal and documented. Ward manager to identify 2nd Professional* and inform MHA Admin Team.
2nd Professional agrees with renewal and completes Form H5 Part 2 and returns to RC at least 2 weeks prior to expiry of the section
RC consults 2nd Professional, completes Form H5 Part 1 and sends to 2nd Professional at least 4 weeks prior to the expiry of the section
2nd Professional does not agree with renewal
Section 3 renewal recommended (S20)
Form H5 Part 3 completed by RC and sent to MHA Admin team
Patient can be detained for a further 6 months and
MHA Admin team arrange for a hospital managers renewal panel or hospital managers hearing if a patient objects to renewal. Write to patient and NR. If patient lacks capacity to object a full hearing must be arranged
MHA Admin inform patient and NR, in writing, of Hospital Managers decision
Linked Procedures:
Section 3
Section 17
Consent to treatment
Hospital Managers
Section 3 renewal not required
Form H23 sent to MHA Admin Team
Patient informed by RC that they are informal patient and what that means including s117. Letter will be sent to patient and NR by MHA Admin Team
Eight weeks before section due to expire MHA Admin team write to RC, Ward Manager requesting Form H23 if patient is to be discharged or Form H5
4 weeks before section due to expire MHA Admin team send reminder to RC and Ward manager requesting Form H5 or Form H23
If no form received 1 month before renewal, further reminder sent copied to Link Director for Mental Health

SECTION 4


Patient admitted **Form A11** completed by Doctors **Form A10** completed by AMHP **Form H3, H3a & H3b** to be completed by ward staff. All section papers to be forwarded to the MHA Admin Office
Patient can be detained for 72 hours. Patient is not subject to Part IV consent rules
Named nurse continues to ensure patient knows their rights and **that Form H3b** is completed
RC decides whether patient requires further assessment under MHA
Section 3 recommended
Section2 recommended
Further detention not required
RC arranges for s3 assessments to be undertaken (2 new medical recommendations & application required)
RC arranges for second medical recommendation in accordance with s2 or completes **Form 4**
Form H23 sent to MHA Admin team
Follow Section 3 procedure
A4 completed and sent to MHA Admin Team
Patient informed by RC that they are informal patient and what that means
Follow Section 2 procedure
MHA Admin record as a lapse if section 3 paperwork, **Form 4** or **Form H23** not received
Report to Mental Health Act Compliance Group
Linked Procedures:
Section 2
Section 3

SECTION 5

- Inpatient wanting to leave hospital premises
- If staff feel that the patient would be at risk to self or others if allowed to leave
- Staff attempt to discuss/reason with patient
- Patient is still refusing to stay on premises

Contact AC or nominated deputy (ensure every effort made to contact them) Are either immediately available?

Yes

After examination does AC/Nominated Deputy consider detention necessary?

No

Patient remains informal

Yes

AC or deputy (not F1's) completes **Form H1. Hand to registered Nurse for acceptance.** Contact AMHP service. Send MHA Office

Patient admitted under section 5(2). Patients' rights explained to them. **Form H3a** completed and enter reason for use in notes. Section papers sent to MHA Admin team

Patient can be held for 72 hours with minimum force necessary

Named nurse continues to ensure patient knows their rights and that **Form H3b** is completed

Decision made as to whether patient requires assessment for s2 or s3

No further section

Further section
AC completes Medical recommendation and arranges for other assessments urgently.

Patient is not subject to Part IV consent rules

No

Message left for AC/Nominated Deputy to attend ward as a matter of urgency

Is patient receiving treatment for mental disorder

If yes RMN fills in **Form H2**

Patient admitted under section 5(4). Patients' rights explained to them. **Form H3a** completed. Section papers sent to MHA Admin team

Patient can be held for 6 hours with minimum force necessary

Attempt to make contact with AC/Nominated Deputy

Has AC/Nominated Deputy arrived within 6 hours

Yes

If Yes, AC/Nominated Deputy completes **Form H1**. The time held by the nurse counts towards the 72hr maximum. Send to MHA Admin Team.

No

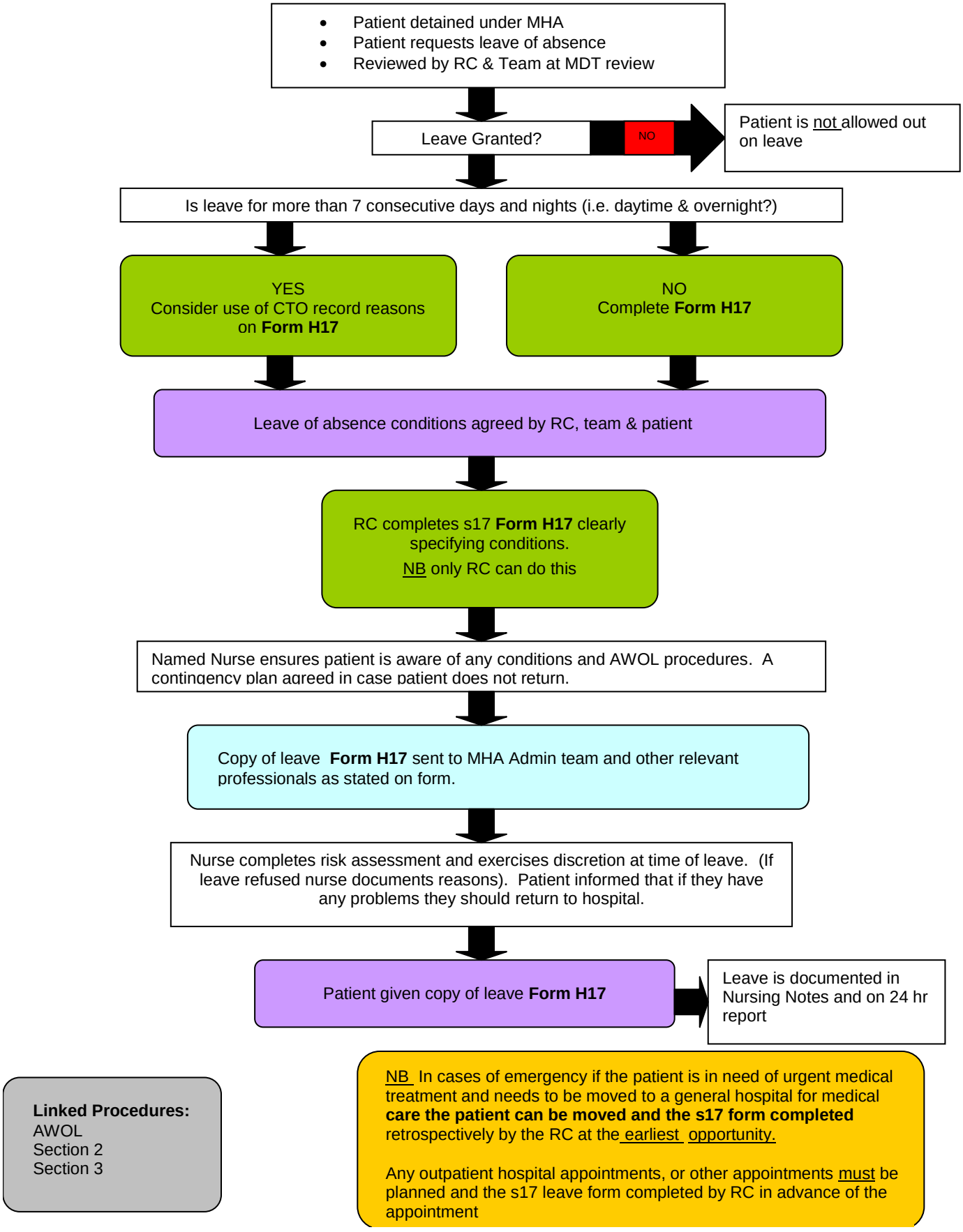
AC/Nominated Deputy decides whether to further detain the patient. If no, Patient informed they are informal and completed **Form H2** sent to MHA Admin team

Nurse completes **Form H2** & **monitoring form** sends to Admin & patient becomes informal

Linked Procedures:
Section 2
Section 3

Authority to detain is not renewable

SECTION 17 Leave



Linked Procedures:
AWOL
Section 2
Section 3

NB In cases of emergency if the patient is in need of urgent medical treatment and needs to be moved to a general hospital for medical **care the patient can be moved and the s17 form completed** retrospectively by the RC at the earliest opportunity.

Any outpatient hospital appointments, or other appointments must be planned and the s17 leave form completed by RC in advance of the appointment

Absent Without Leave (AWOL)

To be read in conjunction with Trust Policy OP44 Missing Patient policy

Patient is considered to be missing (AWOL)

- Absent from ward without authorised S.17 leave or
- Failed to return following authorised leave or
- Failed to return following recall to hospital for CTO patient or
- Are absent without permission from a place where they are required to reside as a condition of leave under Section 17

Inform Nurse in Charge of the ward and the patients RC
Inform Care-co-ordinator/ Community Nurse if involved and MHA Admin Team.

Follow Trust Policy OP44 Missing Patient Policy

CQC AWOL NOTIFICATION FORM (part 1) TO BE COMPLETED BY WARD MANAGER AND FAXED WITHIN ONE WORKING DAY OF THE INCIDENT

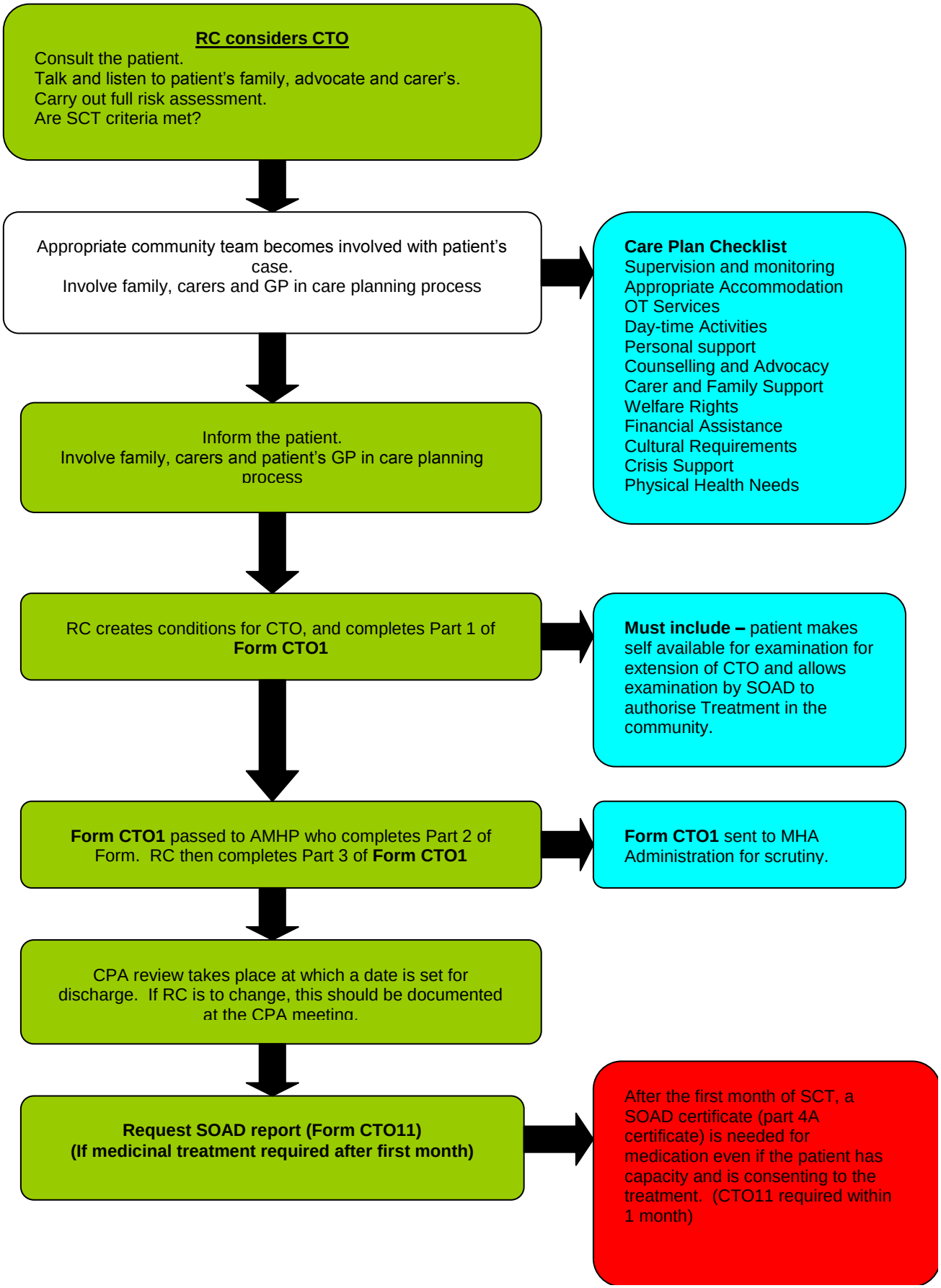
The patient can be brought back to the hospital by:

- An AMHP
- Any member of staff from the ward/unit
- Any police officer
- Any person authorised by the Hospital Managers
- If the patient is on leave at another hospital, any member of that hospital's staff or authorised person

It is the responsibility of the detaining authority to arrange for the patient to be conveyed back to the place where they are liable to be detained.

ON PATEINTS RETURN ALL RELEVANT INDIVIDUALS TO BE INFORMED AND CQC AWOL NOTIFICATION FORM (part 2) TO BE COMPLETED BY WARD MANAGER AND FAXED WITHIN ONE WORKING DAY

Community Treatment Order



Appendix 3

Procedure for receipt and scrutiny of Documentation relating to the Mental Health Act 1983

1. Introduction

Patients can only be detained lawfully under the MHA if the correct documentation has been accurately completed within the timescales permitted and in accordance with all other legal requirements. Where there are failures the lawfulness of the patient's detention becomes questionable. For this reason it is important that the procedure for the receipt and scrutiny of statutory paperwork is adhered to.

2. Purpose

This procedure will ensure the lawfulness of section applications. It does not apply where a patient feels that they do not meet the criteria for detention under the Act: in that case they should exercise their right of appeal to the Hospital Managers or First-tier Tribunal. However, if the issue is about whether the procedure used to detain a patient is lawful, reference should be made to this procedure.

3. Duties & Responsibilities

Ward Staff – The receiving Nurse in Charge of a Ward admitting a detained patient is responsible for;

- Receiving the statutory paperwork
- Carrying out initial check that all paperwork is there and appears to be in order
- Completing Form H3,H3A & H3B to signal that the patient and paperwork have been received

Approved Mental Health Professionals (AMHP) – are responsible for completing their own application correctly.

Consultant Psychiatrists – Consultants must nominate a suitable doctor or rota of doctors to be responsible for the scrutiny of medical recommendations.

MHA Administration team – have the primary responsibility for scrutinising section documentation. This includes responsibility for ensuring that mistakes are corrected where possible within the legally permitted timescales.

General Procedure

3.1. The authority to receive the statutory paperwork by signing Form H3, is delegated to the nurse in charge. A failure to complete this form at the time of receipt would not in itself invalidate the authority to detain, it is good practice and the expectation of the Trust is that it is completed at the time the patient and detention papers are received.

3.2. When checking papers for errors, the receiving nurse in charge should accept in good faith and at face value the information in them. Minor errors that can be rectified should not prevent the section being accepted.

Wherever possible the Doctors making the medical recommendations should remain on the ward until the papers have been checked to avoid having to return to rectify errors.

If the receiving nurse in charge believes there are major or fundamental errors, which cannot be rectified, the section cannot be accepted. They should consider holding the patient under Section 5 powers until a new assessment under the Act can be arranged. In the first instance, where possible, staff should contact the MHA Admin team for advice before any decisions are reached on Ext. 5714.

3.3. All papers must undergo administrative and medical scrutiny to ensure that they are technically correct and that the clinical reasons given are sufficient for detaining the patient under the Act. On completion of all papers, the nurse in charge will arrange for the papers to be collected/taken to the Mental Health Act Administration Office for scrutiny.

The MHA Admin team will carry out the administrative scrutiny and a consultant psychiatrist who is not involved with the patient concerned will undertake the medical scrutiny.

Once scrutinised and any errors corrected the original papers will be stamped as such by the MHA Admin team and kept in the MHA Admin Office, QEH. A duplicate will be sent to the ward to be kept in the medical notes. Any earlier copies (which may still show uncorrected errors) should be destroyed.

3.4. Any detained patient who is receiving care from Gateshead Health NHS Foundation Trust, and requires transfer to another ward for medical treatment will transfer under Section 17 of the Mental Health Act 1983 (Authority for Leave of Absence). If the patient is transferred from one ward to another within the same hospital then they will transfer under Section 19 of the Mental Health Act 1983.

The receiving ward must ensure that they receive a copy of Local Form H17, or a Local Form H4B from the ward of origin, which will state where the patient is to be treated. Wards must complete a new H4B form for each move.

In all situations contact the Mental Health Administration Office to notify staff that a detained patient has been transferred. Give details of the originating ward and if a copy Local Form H17/Local Form H4B has been received or requested.

3.5. If the patient is not receiving psychiatric care from Gateshead Health NHS Foundation Trust and is transferred to QEH using Section 17 leave for medical treatment of a physical illness/condition. In this instance notify the MHA Admin team at QEH that a detained patient is currently being cared for on the ward and send them a copy of the H17 leave form.

3.6. All deaths of detained patients require notification to the Mental Health Act Administration Office immediately, within office hours, of a death of a detained patient. The Administration Office will subsequently inform the Care Quality Commission.

4. Faults which <u>can</u> be rectified

When detention papers are incorrectly completed, most errors can be corrected under Section 15 of the Act within 14 days of formal admission and the patient can continue to be legally detained for this period. The following errors may be rectified **within 14 days** – unless the documents have been issued by a court.

- The leaving of blank spaces on the form other than the signature
- Failure to delete one or more alternatives
- A patient's forename, surname or address not being fully completed or being inaccurately stated or not being identical on all forms
- Spelling mistakes
- Genuine errors in entering dates
- A medical recommendation for Section 3 which contains insufficient clinical description of grounds for detention may have further clinical descriptions added by the same doctor or it may be disregarded and replaced by a fresh recommendation within the 14 day specified period.

The person who signed the form must rectify any errors and initial and date the correction, within the specified timescale.

5. Faults which cannot be rectified

- The application is not accompanied by the correct number of medical recommendations or
- The application or recommendation is not signed at all, or is signed by someone not qualified to do so or
- The application does not specify the correct hospital or
- If the time limits of each section are not complied with (i.e. medical recommendations must not be more than 5 clear days apart, AMHP application is completed within 14 days of seeing patient and after both medical recommendations have been completed and admission to hospital is no later than 14 days after completion of the later of the medical recommendations)

If any of the above errors are identified and the patient has been admitted to Hospital it may be possible to detain them under Section 5(2) or Section 5(4).

6. Applications for Community Treatment Orders (CTO)
Applications for placing a patient on a CTO should also be sent directly to the Mental Health Legislation Lead Nurse for scrutiny.

7. Hospital Orders
Section 15 (allowing the correction of errors in statutory documentation) does not apply to Hospital Orders or other documents issued by the Court. Unlike civil sections, Hospital Orders are not 'accepted' by the Hospital Managers and paperwork is not corrected. Any serious errors should be raised by the Mental Health Legislation Lead Nurse with the Clerk of the Court, but should not be thought to invalidate a section unless there is direction to this effect from the Court.

8. Consent to Treatment Documentation
Sections 57, 58 and 58A of the Act set out types of medical treatment for mental disorder to which special rules and procedures apply, including the need for a certificate from a second opinion appointed doctor (SOAD) approving the treatment. Section 57 covers Neurosurgery for mental disorder and surgical implantation of hormones to reduce male sex drive. Section 58 covers medication (after an initial three-month period) – except medication administered as part of electro-convulsive therapy (ECT). Section 58A covers ECT and medication administered as part of ECT. The Act uses statutory forms to authorise treatment.

- Section 57 is covered by Form T1
- Section 58 is covered by Form T2 and Form T3
- Section 58A is covered by Form T4, Form T5 and Form T6

After the first month of a Community Treatment Order, a SOAD certificate (part 4A certificate) is needed for medication even if the patient has capacity and is consenting to the treatment (Form CTO11).

8.1 Medication or ECT which is not covered by a correct statutory form may not be lawfully administered.

8.2 It is the responsibility of the RC to ensure the correct forms are completed and that a Second Opinion is sought where applicable.

8.3 It is the responsibility of the nurse administering medication or arranging for ECT to ensure they are covered by the appropriate statutory Form.

8.4 The MHA Admin team will notify the appropriate RC when consent to treatment is due.

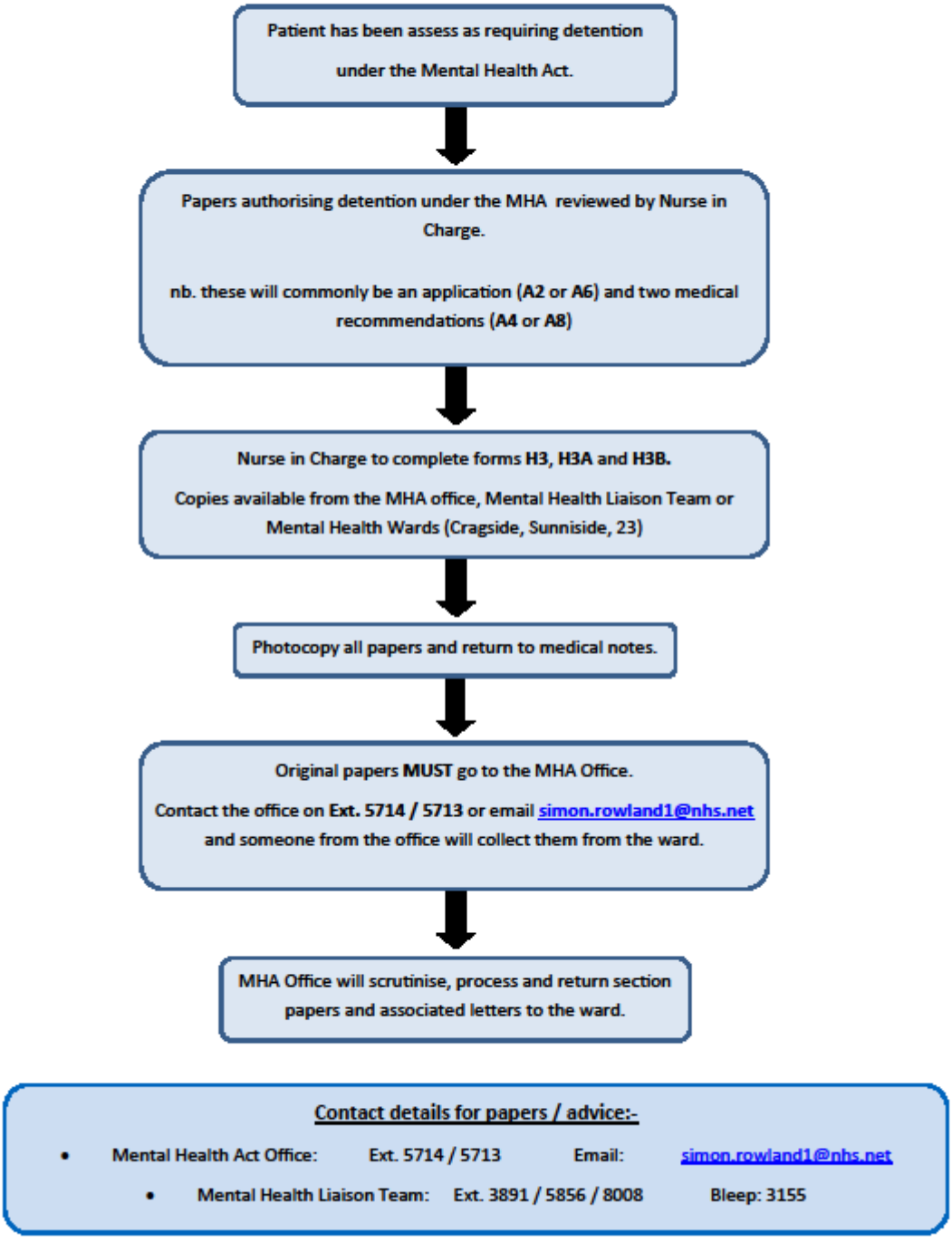
8.5 The RC will notify the MHA administration office when a Second Opinion request has been made.

Receipt of

Mental Health Act (MHA) Papers

Process Flow Chart

NHS
Gateshead Health
NHS Foundation Trust



Contact details for papers / advice:-

- Mental Health Act Office: Ext. 5714 / 5713 Email: simon.rowland1@nhs.net
- Mental Health Liaison Team: Ext. 3891 / 5856 / 8008 Bleep: 3155

Appendix 4

Interface between the Mental Capacity Act 2005 and the Mental Health Act 1983

A sound understanding and application of the principles and provisions of the Mental Capacity Act (MCA) and of the common law relating to consent, is essential to enable decision makers to fulfil their legal responsibilities and to safeguard their patients' rights under the European Convention on Human Rights (ECHR).

Practitioners should be able to identify the legal framework that governs a patient's assessment and treatment and authorise any appropriate deprivation of a patient's liberty whether by using the MCA or Metal Health Act (MHA). The legal framework is not static and may change as the patient's circumstances and needs change.

The MHA is used to ensure that people who need treatment for serious mental disorder receive this treatment, even against their wishes, if there are sufficient risks to their own health or safety, or risks to the safety of other people.

There are situations where MHA is the most appropriate piece of legislation, situations where MCA is most suitable and situations where both are needed. It can be difficult to determine which law applies; and in addition the MHA and MCA Codes of Practice are further developed by case law.

The MHA may be the suitable piece of legislation to use if:

- the person needs to be deprived of their liberty to receive treatment for a mental disorder in a psychiatric unit
- they need treatment for their mental disorder but do not lack capacity
- they need treatment that can't be provided under MCA – for example because of an Advance Decision
- the risks are to other people and not to the person themselves. Principle 4 of MCA is clear that best interests decisions can only be made to address risks faced by the person who lacks capacity. MHA, in contrast, can be used to address risks to the person's health or safety or the safety of other people.

The Mental Health Act:

- does not differentiate between people who have capacity and those who don't – decisions are made about the nature or degree of someone's mental disorder.
- has no age limits
- allows for people to be deprived of their liberty
- overrules any Advance Decisions – however, if someone makes an Advance Decision refusing ECT (electro-convulsive therapy) this cannot be overruled. ECT can then only be given in an emergency to save someone's life
- has a process to identify the person's nearest relative who must be informed or consulted about many decisions and can veto some decisions
- has clear criteria for all decisions taken under MHA; there are set assessment procedures, prescribed professional roles and set methods of recording decisions. There are rigorous review and appeal processes.

MCA covers decisions about all aspects of someone's life while MHA only applies to assessment and treatment for mental disorder. This means that someone who is detained in hospital under MHA for treatment of their mental disorder will also need to be assessed under MCA to see if they have capacity to make decisions about treatment for physical illness.

The MCA applies to anyone who may have 'an impairment of or disturbance in the functioning of the mind or brain.' The MHA applies to 'any disorder or disability of the mind.' By excluding 'the brain' the MHA's application is limited.

If someone needs serious medical treatment for a physical illness their capacity to make this decision should be assessed. The process of assessment must include consultation with others. If there is no family or friends who can be consulted the person must be referred for Independent Mental Capacity Advocate support.

Summary of key differences between common law, the Mental Capacity Act (MCA), Mental Health Act (MHA)

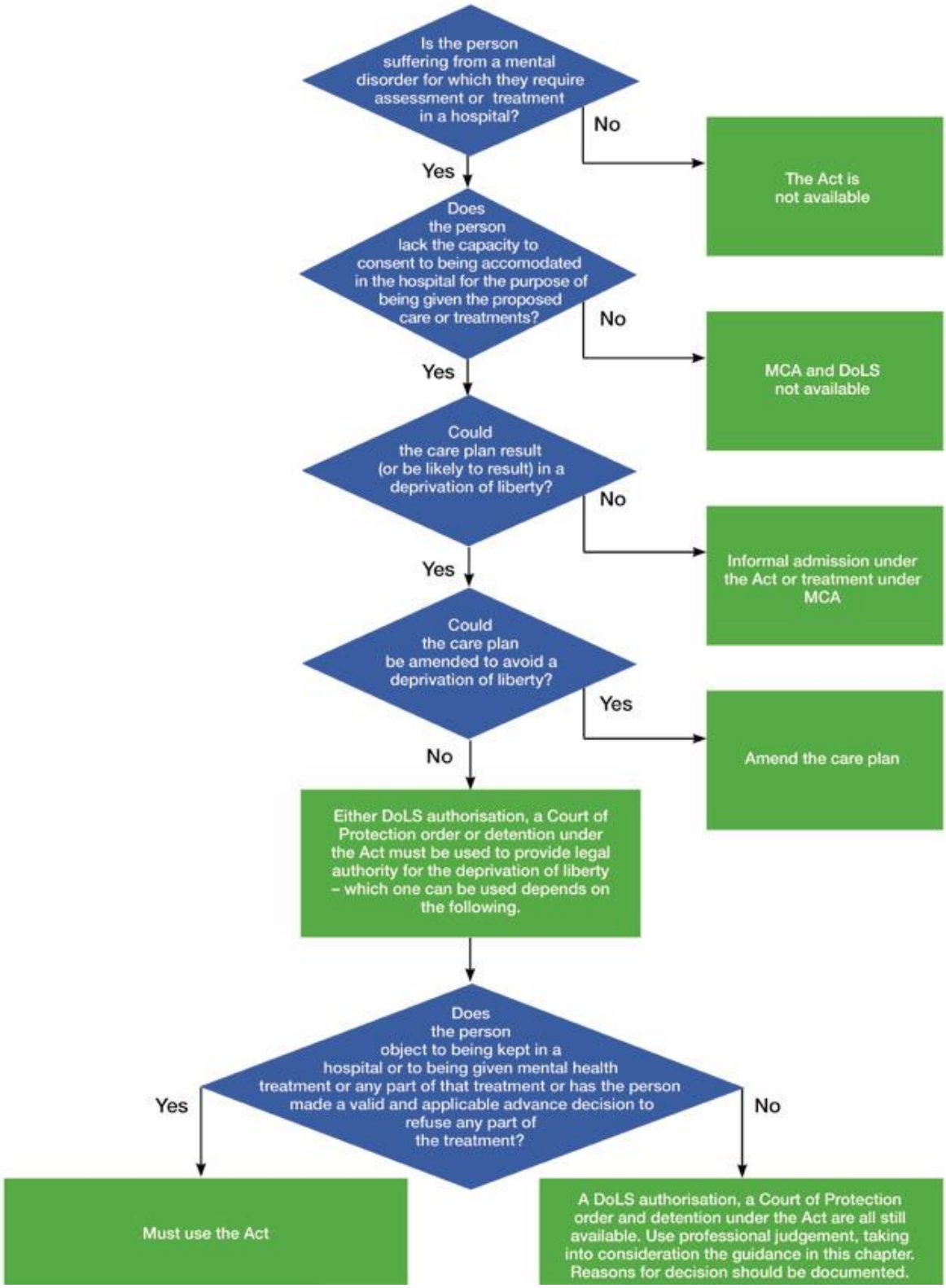
Aspect	Common Law	MCA	MHA
Disorders covered	Any disorder (physical or mental)	Disturbance in functioning of brain or mind	Any disorder or disability of the mind
Criteria	Action is needed to prevent harm; in emergencies only until there is time to assess capacity or undertake an MHA assessment	The patient lacks capacity for a specific treatment decision(s); applies only to patients aged 16 years and over	The patient's mental disorder is of a nature (type) or degree (severity) that requires compulsory assessment or treatment in hospital
Who it protects	Patient or others	Patient only	Patient or others
Disorders that can be treated	Mental and physical health treatment	Mental and physical treatment in patient's best interests	Treatment of mental disorder only
Limits of restraint	Emergencies only	Deemed a necessary and proportionate response to prevent harm to the patient	Involuntary detention in hospital
Important exclusions of application	Non-immediately life-threatening situations where there is time to assess capacity	Cannot be used to treat patients under the age of 16 years	Cannot be used to treat physical disorders unless it is causing the mental illness or is a direct consequence of it

Deciding whether the Act and/or MCA will be available to be used

The following grid provided within the MHA Code of Practice assists staff in deciding which legislative route to use:-

	Individual **objects** to the proposed accommodation in a hospital for care and/ or treatment; or to any of the treatment they will receive there for mental disorder	Individual **does not object** to the proposed accommodation in a hospital for care and/or treatment; or to any of the treatment they will receive there for mental disorder
Individual has the capacity to consent to being accommodated in a hospital for care and/or treatment	Only the Act is available	The Act is available. Informal admission might also be appropriate. Neither DoLS authorisation nor Court of Protection order available
Individual lacks the capacity to consent to being accommodated in a hospital for care and/or treatment	Only the Act is available	The Act is available. DoLS authorisation is available, or potentially a Court of Protection order

The flowchart below describes the key decision-making steps when determining whether the Act and/or the MCA including the DoLS will be available to be used. The flowchart does not replace careful consideration by decision-makers of all relevant circumstances in individual cases. Decision-makers should use their professional judgment within the framework of the legislation.



For further guidance if required contact the mental Health Act office on ext. 5714

Appendix 5

Mental Health Act Policy Practice Guidance Note

Duty of Hospital Managers to give Information to Detained and Community Patients - Section 132 and 132A Mental Health Act 1983

1. Introduction

1.1 This guidance note sets out what information must be given to detained and community patients and their nearest relatives and when and how that information must be given and recorded.

1.2 The Mental Health Act 1983 (MHA) as amended by the MHA 2007, provides the legislative framework within which practitioners are expected to operate in order to ensure that any actions they take fulfil legal requirements.

2. Objectives and Scope

2.1 The objectives and scope is to ensure the consistent fulfilment of the Hospital Managers duty under Sections 132 and 132A of the MHA to ensure that all patients subject to the MHA are given and understand:

- Specific information as soon as is practicable after being made subject to the Mental Health Act
- Particular information in so far as it is relevant to the patient

2.2 The Hospital Managers are required to ensure that the above information is given to the patient both orally and in writing and must also be given in writing to the patient's nearest relative, except where the patient requests otherwise. Where the patient lacks capacity, information will always be given to the nearest relative under best interests, unless there is reason not to. Reasons for which should be clearly recorded.

3. Definitions/Glossary

3.1 Hospital Managers - have a central role in operating the provisions of the Mental Health Act. In NHS Foundation Trusts, the Trust itself is defined as the 'Managers' though most of the Hospital Managers' responsibilities are delegated to officers of the Trust, for example Mental Health Act officers or members of ward staff.

4. Process/Procedure

4.1 As soon as practicable after the MHA is implemented, the nurse in charge of the ward will ensure that the patient is informed about their rights under the MHA 1983. This includes the shorter Sections of the MHA such as Section 136.

4.2 Where a patient is a community patient subject to a Community Treatment Order (CTO)) the responsible clinician (RC) will ensure that the patient is informed about their rights under the MHA at the time the Community Treatment Order is made.

4.3 This information may be reinforced by MHA Administration staff or Independent Mental Health Advocate.

4.4 The information given must be:

- Correct
- Given in a suitable manner and at a suitable time and in accordance with the requirement of the law
- In a language that can be understood by the patient, taking into consideration ethnicity, sensory impairments, or any disabilities that the patient may have
- Given by a member of staff who has relevant knowledge and skills
- Recorded accurately, including how, when, where and by whom it was given
- Regularly checked to ensure that the information has been given to each patient subject to the MHA and that they have understood it

4.5 The patient must be provided with both verbal and written information on:

- Detention, renewal and discharge
- Consent to treatment
- Applications to Mental Health Tribunals
- Hospital Managers Panels
- Independent Mental Health Advocacy (IMHA)
- Information about the Care Quality Commission (CQC)
- Complaints
- Legal advice

4.6 Written information can be found in leaflets

- These are specifically produced for this purpose, and are available from the MHA Administration office.
- Interpretation Services should be accessed for patients whose first language is not English or who require interpretation due to sensory deficits.

4.7 **Detention, Renewal and Discharge** - The patient must be informed:

- Of the provisions of the Act under which they are detained or on CTO, the effect of those provisions including (for CTO patients) the conditions they are required to keep and the circumstances in which their responsible clinician may recall them to hospital
- Of the reasons for detention or CTO
- Of the maximum length of the current period of detention or CTO
- Of the right (if any) of the nearest relative to discharge them and what can happen if the responsible clinician disagrees with that decision
- That their detention or CTO may be ended at any time if it is no longer required or the criteria for it are no longer met

- That they will not automatically be discharged when the current period of detention/CTO ends
- That their detention/CTO will not automatically be renewed or extended when the current period of detention/CTO ends
- Of their right to have their views about their continued detention/CTO or

discharge considered before any decision is made

- Detained patients must be told that their letters for posting may be withheld if the person to whom it is addressed asks the hospital managers to do so

4.8 **Consent to Treatment** – This section should also be reinforced by the patient's RC. The patient must be informed:

- Of the nature, purpose and likely effects of the treatment which is planned
- Of their rights to withdraw their consent to treatment at any time and of the need for consent to be given to any further treatment
- How and when treatment can be given without their consent, including by the second opinion process and the likely effects of their stopping treatment against medical advice
- Where relevant, the rules on ECT

4.9 **Applications to Mental Health** Tribunals - Patients must be informed by Nursing Staff or RC.

- Their right to apply to the Mental Health Tribunal
- About the role of the Tribunal
- How to apply to a Tribunal
- How to contact a suitably qualified solicitor
- That free Legal Aid may be available
- How to contact any other organisation, which may be able to help them make an application to a Tribunal

4.10 **Hospital Managers** - The patient must be informed by nursing staff, RC:

- Of their right to seek discharge by the Hospital Managers
- Of the distinction between this and their right to a Mental Health Tribunal

4.11 Independent Mental Health Advocacy (IMHA) - The patient must be informed by nursing staff, or RC, of their right to have access to statutory independent mental health advocacy and how they can obtain that help. Information relating to IMHA services will be given to all eligible patients and a specific leaflet is available for the purpose of providing information in writing.

4.12 **Care Quality Commission** - Patient must be informed:

- About the role of the Care Quality Commission
- When the Commission is to visit a hospital or unit – where advance notice is given
- Of their right to meet with the Commissioners in private
- Of their right to complain to the Commission

5. When to give information to Detained/Community Patients and Record Keeping

5.1 The above procedure will be recorded using the Form H3B. This will be completed as soon as practicable after admission/CTO.

5.2 The patient's rights will be revisited at regular intervals determined by their level of understanding and comprehension and recorded using Form H3B:

5.3 The patient's rights will be revisited at regular intervals. This should be sooner if there is a significant change in the patient's mental health and/or their level of understanding means they are unable to understand the information relevant to Section 132/132A; and always;

- Following renewal
- When the patient is considering applying to the Tribunal, or when the patient becomes eligible again to apply to the Tribunal
- When the patient requests the hospital managers to discharge them, or such a

request is refused

- Following an unsuccessful appeal to MHT or Hospital Managers
- When the rules in the Act about their treatment change (e.g. because three months have passed since they were first given medication, or
- Because they have regained capacity to consent to treatment.
- When any significant change in their treatment is being considered
- When there is to be a care programme approach review (or its equivalent)
- If renewal of their detention, or extension of their CTO is being considered
- If a decision is taken to renew their detention or to extend their CTO
- Following transfer
- When the patient is discharged from detention or CTO, or the authority for their detention expires. This fact and what happens next should be made clear to them
- When a decision is taken to recall a community patient or revoke a CTO, or a decision is taken to recall a conditionally discharged patient to hospital

6. Training / Advice / Monitoring

6.1 Training of the contents and implications of this guidance will be incorporated in the existing MHA training programme. This can also be delivered on an individual basis to teams and departments on request to the MHA office and in response to incidents and inspections.

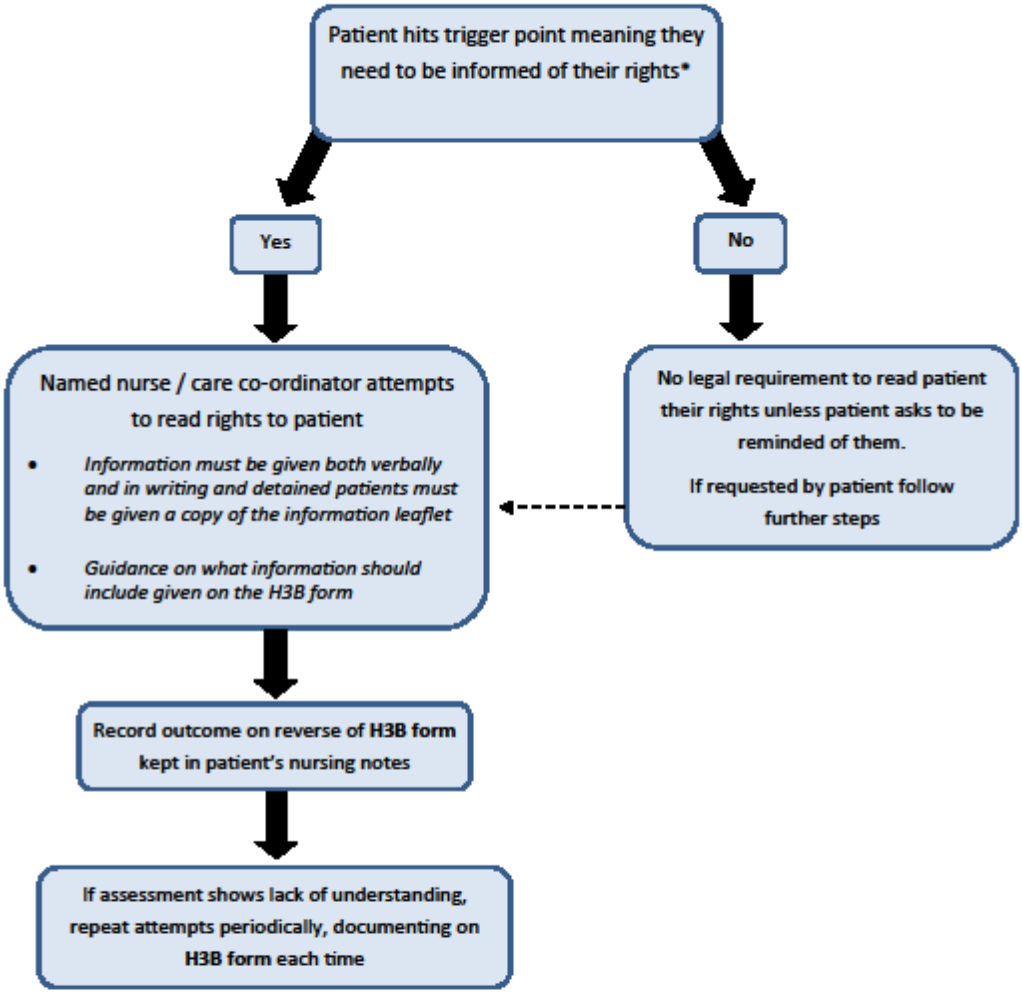
6.2 Staff requiring further advice on issues relating to the operation of this guidance, or the interpretation of legal points should use their usual reporting and consultative arrangements in the first instance. Local Mental Health Act offices can also offer advice.

6.3 It is a legislative requirement that every time the MHA is implemented to detain a person, the documentation and the process is scrutinised, both administratively and medically.

Informing patients of their rights

Section 132, Mental Health Act

NHS
Gateshead Health
NHS Foundation Trust



***Trigger points for the patient to be informed of their rights:**

- As soon as practicable after detention/CTO
- At regular intervals during the period of detention
- When a section is regraded
- When a section is regraded to a CTO
- When a section is renewed or CTO extended
- The patient is transferred
- There has been an unsuccessful appeal to the Mental Health Tribunal or Hospital Managers
- A CTO has been revoked
- The patient becomes informal

Further advice and information is available from the Mental Health Act Office on ext. 5714 / 5713

Appendix 6

Mental Health Act 1983 Forms

Appendix two describes the use of both Statutory and Local Forms

The Statutory Forms can be located and downloaded at:-

http://www.mentalhealthlaw.co.uk/Mental_Health_Act_1983_Statutory_Forms

This link enables access to the following forms:-

Admission Forms
•Form A1 section 2 - application by nearest relative for admission for assessment
•Form A2 section 2 - application by an approved mental health professional for admission for assessment: PDF | RTF (editable)
•Form A3 section 2 - joint medical recommendation for admission for assessment: PDF | RTF (editable)
•Form A4 section 2 - medical recommendation for admission for assessment: PDF | RTF (editable)
•Form A5 section 3 - application by nearest relative for admission for treatment
•Form A6 section 3 - application by an approved mental health professional for admission for treatment
•Form A7 section 3 - joint medical recommendation for admission for treatment
•Form A8 section 3 - medical recommendation for admission for treatment
•Form A9 section 4 - emergency application by nearest relative for admission for assessment
•Form A10 section 4 - emergency application by an approved mental health professional for admission for assessment
•Form A11 section 4 - medical recommendation for emergency admission for assessment

Hospital forms
•Form H1 section 5(2) - report on hospital in-patient
•Form H2 section 5(4) - record of hospital in-patient
•Form H3 sections 2, 3 and 4 - record of detention in hospital
•Form H4 section 19 - authority for transfer from one hospital to another under different managers
•Form H5 section 20 - renewal of authority for detention
•Form H6 section 21B - authority for detention after absence without leave for more than 28 days

Miscellaneous forms
•Form M1 Part 6 - date of reception of a patient in England
•Form M2 section 25 - report barring discharge by nearest relative

Treatment forms
•Form T1 section 57 - certificate of consent to treatment and second opinion: PDF | Word
•Form T2 section 58(3)(a) - certificate of consent to treatment: PDF | Word
•Form T3 section 58(3)(b) - certificate of second opinion: PDF | Word
•Form T4 section 58A(3) - certificate of consent to treatment (patients at least 18 years old): PDF | Word
•Form T5 section 58A(4) - certificate of consent to treatment and second opinion (patients under 18): PDF | Word
•Form T6 section 58A(5) - certificate of second opinion (patients who are not capable of understanding the nature, purpose and likely effects of the treatment): PDF | Word

CTO forms
•Form CTO1 section 17A - community treatment order
•Form CTO2 section 17B - variation of conditions of a community treatment order: PDF | RTF (editable)
•Form CTO3 section 17E - community treatment order - notice of recall to hospital: PDF | RTF (editable)
•Form CTO4 section 17E - community treatment order - record of patient's detention in hospital after recall

•Form CTO5 section 17F(4) - revocation of community treatment order
•Form CTO6 section 17F(2) - authority for transfer of recalled community patient to a hospital under different managers
•Form CTO7 section 20A - community treatment order - report extending the community treatment period: PDF | RTF (editable)
•Form CTO8 section 21B - authority for extension of community treatment period after absence without leave for more than 28 days
•Form CTO9 Part 6 - community patients transferred to England
•Form CTO10 section 19A - authority for assignment of responsibility for community patient to hospital under different managers
•Form CTO11 section 64C(4) - certificate of appropriateness of treatment to be given to community patient (Part 4A certificate)
•Form CTO12 section 64C(4A) - certificate that community patient has capacity to consent (or if under 16 is competent to consent) to treatment and has done so (Part 4A consent certificate)

In addition to the Statutory Forms there are a number of local Forms

Form H3A (local)
(To be attached to all papers relating to detention in hospital under the MHA1983)
Notification of Detained Patient

Mental Health Act 1983

Part A – all cases

Name of Patient:	Responsible Clinician:
Address:	Ward:
	Date of Admission:
	Date of Section:
Post Code:	Named Nurse:
Hospital No:	Care Co-ordinator:
DOB:	Social Worker:
GP:	Address:
Address:	

Ethnic origin that is indicated by the patient (please tick appropriate box)

White:		**Black/Black British:**		**Asian/Asian British:**		**Mixed:**	
British	☐	Caribbean	☐	Indian	☐	White/Black Caribbean	☐
Irish	☐	African	☐	Pakistani	☐	White/Black African	☐
Other	☐	Other	☐	Bangladeshi	☐	White/Asian	☐
				Other	☐	White/Other	☐

Other Ethnic Groups:	**Any Other Ethnic Group:**
Chinese ☐	☐

Spoken Language	

Nearest relative under the MHA (see note 1 overleaf)

Name…… Relationship……

Address……

Patient has consented to Nearest Relative being informed of detention Yes ☐ No ☐

I confirm the patient has been given the relevant section leaflet shown below which explains their rights and an IMHA leaflet.

(Please circle appropriate numbers)

Leaflets	S5(4)	S5(2)	S4	S2	S3	S135	S136	S35	S36	S37	S38	S37/41	S45A	S47
	S47/49	S48	S17A (CTO)	IMHA										

NB – IMHA does not apply to sections 4, 5(2), 5(4), 4, 135 or 136

Patient wishes to contact IMHA…Yes/No (If patient lacks capacity consider IMHA referral in best interests)

Date IMHA referral sent:……..

Signed…….. Designation……

Name (print)…… Date……

Complete Part B where a patient with a learning disability is admitted

NB. It does not apply to patients detained under Section 2.

Part B
If the patient has a learning disability as defined under The Act and has been detained under any of the following sections 3, 35 to 38, 45A, 47, 48, 51 or made subject to Part 2 or Part 3 Supervised Community Treatment, the following section must be completed.

***PLEASE DELETE AS APPLICABLE**

- *the patient was admitted on the basis of a learning disability which is associated with abnormally aggressive or seriously irresponsible behaviour or
- *the patient was admitted on the basis of a mental disorder independent of his/her learning disability

Signed…….. Designation……

Name (print)…… Date……

The Form H3A (local) (notification of detained patient) together with the completed application, medical recommendation(s) and Form H3 (record of detention in hospital) should be sent to the Mental Health Act Administrator, Mental Health Act Office, Cragside Court, QEH.

Note 1:

The nearest relative is a defined person within the meaning of the Mental Health Act 1983 Section 26. In each category the eldest takes precedence irrespective of gender.

A husband or wife or civil partner

B son or daughter

C father or mother

D brother or sister

E grandparents

F grandchild

G uncle or aunt

H nephew or niece

Note. A blood relative who lives with the patient or cares for the patient takes precedence.

For MHA office use only
Administration Scrutiny completed
Signed……..
Print Name……..
Designation……..
Date……..

NHS
Gateshead Health
NHS Foundation Trust

Form H3B (Local)
Certificate of information given to detained patient
Section 132 Mental Health Act 1983

To be completed by the named nurse / care co-ordinator for CTO patients

Name of Patient:……DOB:……

Responsible Clinician:……..Ward:……..

Section (Including CTO): ……Date of Section: ……Expiry of Section:…….

Consent to Treatment will be required on:(if applicable)…….

Section discharged on:……CTO Revoked on:……

This form is to be completed/updated by the named nurse or care co-ordinator for CTO after providing the patient with verbal or written information regarding their rights. A new form must be completed for each new section. Information must be given on the following occasions.

- As soon as practicable after detention/CTO
- At regular intervals during the period of detention (minimum of 3 monthly for long term sections)
- When a section is regraded
- When a section is regraded to a CTO
- When a section is renewed or CTO extended
- The patient is transferred
- There has been an unsuccessful appeal to the Mental Health Tribunal or Hospital Managers
- A CTO has been revoked
- The patient becomes informal

Information should include:

a) Grounds/reasons for detention or compulsion under Supervised Community Treatment
b) Implications of section under which detained or subjected to compulsion
c) Rights to apply to the Mental Health Review Tribunal
d) Rights of their nearest relative to apply for discharge
e) Information about their rights to apply for displacement of nearest relative in certain circumstances
f) Information about the consent to treatment provisions
g) Right to request a review of detention by the Hospital Managers Panel
h) Information about the Care Quality Commission
i) Information about support from an Independent Mental Health Advocate and how to apply
j) How to make a complaint

PLEASE COMPLETE THE REVERSE OF FORM

Name of Patient:……DOB:……

Date and which rights explained (e.g. a,b,c	Name and designation of nurse giving information.	Assessment of patient's understanding.	Signature of patient (if unwilling/unable to sign please state).

To be filed with MHA Section Papers in Mental Health records.

Nursing staff should ensure they are fully conversant with Chapter 4 of the MHA Code of Practice 2015

Date & sign when H17 discontinued:

Gateshead Health NHS Foundation Trust

H17 (Local) Authority for Leave of Absence from Hospital under Section 17 Mental Health Act 1983. For completion by the Responsible Clinician only.

Name of Patient -	Ward -	Hospital No.
Responsible Clinician (RC) -		
I, the undersigned being the responsible clinician, do grant the above named patient leave of absence during his period of detention from this hospital as follows:		
Short Term (Day) Leave		
From: Date	**To**: Date	
between the hours of am/pm*, and am/pm*		
For periods of hours on the following days (e.g. 2 hours Monday/Tuesday, Wednesday etc.)		
The above is at the discretion of the Nursing Staff.		
Conditions of leave, if any, are as follows: e.g. escorted, no alcohol intake, destination of leave, accompanied by relatives Review Date(s)- RC Signature- Date- **NB**: Only the patient's RC can grant a detained patient leave of absence. Where leave has been prevented by Nursing staff the RC should be informed as soon as possible and a record made in the patient's notes. Where a restriction order is in place, approval from the Ministry of Justice is required. **New forms should be completed once leave arrangements have been reviewed and all previous forms cancelled.** All leave forms should be filed in the relevant section of the health records folder.		
B. Overnight/longer term leaves including leave lasting more than 7 consecutive days.		
From: Date: Time:	**To**: Date: Time:	
From: Date: Time:	**To**: Date: Time:	
Conditions of leave, including address of overnight leave. **NB - if conditions change a new form must be completed** Review Date(s)- RC Signature Date **NB**: Only the patient's RC can grant a detained patient leave of absence. Where leave has been prevented by Nursing staff the RC should be informed as soon as possible and a record made in the patient's notes. Where a restriction order is in place, approval from the Ministry of Justice is required. **New forms should be completed once leave arrangements have been reviewed and all previous forms cancelled.** All leave forms should be filed in the relevant section of the health records folder.		
Risk assessment: The leave is granted on the basis of a recorded risk assessment. An assessment of risk should also be carried out immediately prior to leave by the allocated nurse and a record made of this.		

	Location of risk assessment (ie Nursing/Clinical notes)	Date Completed
Responsible Clinician		
Qualified Nurse		

For completion when leave granted for more than 7 consecutive days	
I have considered whether the patient should go on to Supervised Community Treatment (SCT) instead of S17 leave and in my opinion SCT is not appropriate at this time. I have made an entry in to patient's health record to reflect this decision.	**Yes/No**
If you experience any problems while on leave please contact one of the following:	
Ward Telephone Number- Care Coordinator Number-	

Continue overleaf

Informing Others – The Nurse in Charge is responsible for informing all persons concerned of impending leave and providing them with copies of this Form. The following persons have been notified:

	Date	Tick Box	Nurse Signature
Patient			
Carer/Nearest Relative			
G.P.			
Care Coordinator			
Other (please specify)			
MHA Office			

Section 17 – Leave of Absence – Checklist

All staff to ensure that all applicable questions have been satisfactorily completed prior to the granting of Section 17 Leave.

- Has the patient been involved in the planning of the leave and do they understand the dates, times and conditions of that leave? (where mental capacity allows).
- Has a risk management plan been formulated in relation to the leave?
- Are the outcomes of this reflected in the care plan, leave arrangements and conditions of leave?
- Has the Section 17 Leave of Absence been fully completed with clear and concise instructions?
- Has the patient been given a copy of the leave form?
- Have all the people concerned (professionals and carers) been informed of impending leave?
- Have all those who are to be involved in the period of leave been given a copy of leave form?
- Is their Ministry of Justice authorisation permitting the leave and conditions for those patients who are restricted?
- Has a Community Treatment Order been considered if the leave is to last for 7 or more consecutive days?
- consider the benefits and any risks to the patient's health and safety of granting or refusing leave
- consider the benefits of granting leave for facilitating the patient's recovery
- balance these benefits against any risks that the leave may pose for the protection of other people (either generally or particular people)
- consider any conditions which should be attached to the leave, eg requiring the patient not to visit particular places or persons
- be aware of any child protection and child welfare issues in granting leave
- take account of the patient's wishes, and those of carers, friends and others who may be involved in any planned leave of absence
- consider what support the patient would require during their leave of absence and whether it can be provided
- ensure that any community services which will need to provide support for the patient during the leave are involved in the planning of the leave, and that they know the leave dates and times and any conditions placed on the patient during their leave
- ensure that the patient is aware of any contingency plans put in place for their support, including what they should do if they think they need to return to hospital early
- liaise with any relevant agencies

Form H23 (Local)
Notification of discharge from detention
by Responsible Clinician
Section 23 Mental Health Act 1983

To the Managers of

(Name of Hospital) _____

(Name of Responsible Clinician) I _____

being the clinician in charge of the treatment of

(Name of Patient) _____

Who is currently detained in ward _____ of this hospital under Section _____ of the Mental Health Act 1983

hereby order his/her discharge absolutely from detention in accordance with Section 23 of the Act

and

*delete as applicable The patient *will/will not remain in hospital as an informal/voluntary patient

Signed _____

(Responsible Clinician)

Date _____ Time _____

A copy of this form was given to the patient by……..

(Name of nurse)

This form should be forwarded to the Mental Health Act Office, (Cragside Court, QEH) (BY HAND) **IMMEDIATELY** after signature to ensure appropriate documentary action.

Gateshead Health NHS Foundation Trust

Standard Operating Procedure
for the administration of statutory Mental Health Act (MHA) papers

CONTENTS

1. Aim of the procedure

To provide guidance around the management of Mental Health Act papers following the detention of a patient in order to:-

- Ensure uniformity in the management of MHA papers
- Streamline the workload involved in the handling and administration of papers
- Ensure everyone who receives papers at each stage is aware of their responsibilities.

2. Scope of the Procedure

The procedure is aimed at anyone who handles MHA papers. This will most regularly pertain to the following staff:-

- Qualified nurses
- MHA Administration Office

3. Receipt and Scrutiny of Detention Papers

The MHA Code of Practice 2015, Chapter 35, gives guidance as to the receipt and scrutiny of MHA papers.

When a patient is detained to a Trust ward the organisation has the responsibility to ensure that the detention documents are valid and constitute authority to legally detain the patient.

This duty is initially delegated to the nurse in charge of the ward who has the responsibility to receive the papers and check that they do not contain an error that would undermine the authority to detain.

The papers are then passed to the Mental Health Act office who further scrutinise them for accuracy, arrange medical scrutiny and for any rectifiable errors to be amended.

General Procedure

3.1. The authority to receive the statutory paperwork by signing Form H3, is delegated to the nurse in charge. A failure to complete this form at the time of receipt would not in itself invalidate the authority to detain, it is good practice and the expectation of the Trust is that it is completed at the time the patient and detention papers are received.

3.2. When checking papers for errors, the receiving nurse in charge should accept in good faith and at face value the information in them. Minor errors that can be rectified should not prevent the section being accepted.

Wherever possible the Doctors making the medical recommendations should remain on the ward until the papers have been checked to avoid having to return to rectify errors.

If the receiving nurse in charge believes there are major or fundamental errors, which cannot be rectified, the section cannot be accepted. They should consider holding the patient under Section 5 powers until a new assessment under the Act can be arranged. In the first instance, where possible, staff should contact the MHA Admin team for advice before any decisions are reached on Ext. 5714.

3.3. All papers must undergo administrative and medical scrutiny to ensure that they are technically correct and that the clinical reasons given are sufficient for detaining the patient under the Act. On completion of all papers, the nurse in charge will arrange for the papers to be collected/taken to the Mental Health Act Administration Office for scrutiny.

The MHA Admin team will carry out the administrative scrutiny and a consultant psychiatrist who is not involved with the patient concerned will undertake the medical scrutiny.

Once scrutinised and any errors corrected the original papers will be stamped as such by the MHA Admin team and kept in the MHA Admin Office, QEH. A duplicate will be sent to the ward to be kept in the patient's notes. Any earlier copies (which may still show uncorrected errors) should be destroyed.

3.4. Any detained patient who is receiving care from Gateshead Health NHS Foundation trust, and requires transfer to another ward for medical treatment will transfer under Section 19 of the Mental Health Act 1983. A patient does not need a Section 17 leave form if they are going to remain within the boundaries of the area managed by our Hospital Managers.

In order to track the location of detained patients in the event of transfer between Wards a local Form H4B is to be completed. Wards must complete a new H4B for each move.

The Mental Health Administration Office should be contacted in each instance to notify staff that a detained patient has been transferred, giving details of the originating ward and confirming that a local form H4B has been received or requested.

3.5. If the patient is not receiving psychiatric care from Gateshead Health NHS Foundation Trust and is transferred to QEH from another hospital using Section 17 leave for medical treatment of a physical illness/condition. In this instance notify the MHA Admin team at QEH that a detained patient is currently being cared for on the ward and send them a copy of the H17 leave form.

3.6. All deaths of detained patients require notification to the Mental Health Act Administration Office immediately, within office hours, of a death of a detained patient. The Administration Office will subsequently inform the Care Quality Commission.

4. Out of Hours

In the event of a patient being detained outside the hours of the MHA Administration office the papers are to be retained on the ward until such a time as a member of the Administration office is available. Each ward manager must ensure they have process in place to ensure that when receiving detention papers Out of Hours the Mental Health Act Administration team are informed the next working day and the papers are available for them to scrutinise.

The MHA Administration Office is contactable on extension 5714.

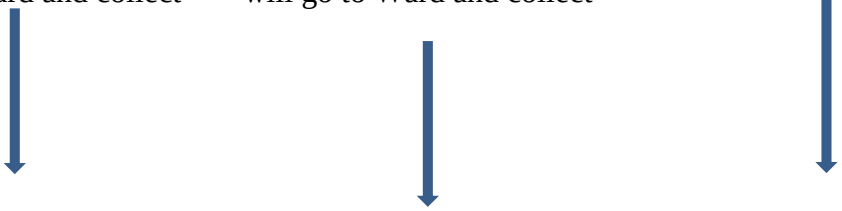
5. Discharge of detention

On discharge from detention under the MHA the Nurse in charge requests the ward clerk to replace the copies in the mental health notes with the original documents held in the MHA administration office. The copies are then to be destroyed.

Appendix 1

Lifecycle of Mental Health Act papers

SUNNISIDE UNIT	CRAGSIDE COURT	OTHER WARDS
On receipt of papers – photocopy papers and put in **Blue** medical notes. Contact MHA Office on ext. 5714 and a member of team will go to Ward and collect	On receipt of papers – photocopy papers and put in **Blue** medical notes. Contact MHA Office on ext. 5714 and a member of team will go to Ward and collect	On receipt of papers - photocopy papers and place in medical notes. Contact MHA Office on ext. 5714 and a member of team will go to Ward and collect



Mental Health Act office will process the papers and return copies to Ward.

Patient Discharged. Papers kept in MHA Office and retrieved if patient is readmitted under Mental Health Act.

When patient is **deceased** MHA Papers to be sent to Old Age Psychiatry secretaries based at Bensham Hospital to be placed with patient's Mental Health notes.

Appendix 2

Mental Health Act 1983 Forms

The Statutory Forms, including the H3, can be located and downloaded at:-

http://www.mentalhealthlaw.co.uk/Mental_Health_Act_1983_Statutory_Forms